Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Maine** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

C. Waiver Number:ME.0467
Original Base Waiver Number: ME.0467.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)

Approved Effective Date of Waiver being Amended: 01/01/21

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

General:

- Updated the Brief Waiver Description for clarity and readability.
- Ensured compliance with MaineCare Benefits Manual (MBM) Ch, I, Section 6, Global HCBS Waiver Person-Centered Planning and Settings Rule.
- Where applicable, revised language to align and create consistency with Maine's four other 1915(c) waiver authorities - ME.1082 (MBM, Section 18), ME.0276 (MBM, Section 19), ME.0995 (MBM, Section 20), and ME.0159 (MBM, Section 21).

Appendix A Waiver Administration and Operation:

- Updated information about agencies/entities with whom the Department contracts.

Appendix B Participant Access and Eligibility:

- Strengthened safeguards for waiver Participants by adding a "Request for Exceptions" process to ensure that Participants receive adequate and appropriate services and supports in the most integrated setting to meet their needs, consistent with the ADA, and with health and safety requirements
- Updated number of individuals served in B-3 a., Unduplicated Participants Served and B-3 b., Number of Participants Served at any Point in Time, for accuracy and to align with historical trends.

Appendix C Participant Services:

- Updated, expanded, and/or clarified, where applicable, the descriptions, limits, and provider qualifications within Service Specifications (C-1/C-3), including adding service descriptions for the new Self-Direction program.
- Strengthened safeguards regarding the hiring of employees by including requirements that providers perform background checks with Adult and Child Protective Services and clarified provisions for the same within Criminal History and/or Background Investigations (C-2).
- Included a provision to allow agency providers to hire direct support staff who are seventeen (17) years of age.
- Added basic requirements for enrollment and regular re-enrollment responsibilities for providers of waiver services, consistent with MaineCare regulations and statutory requirements.

Appendix D Participant-Centered Planning and Service Delivery:

- Revised and updated to ensure providers comply with Maine's Global HCBS Waiver Person-Centered Planning and Settings Rule (MBM, Ch. I, Section 6).

Appendix E: Participant Direction of Services:

- Expanded opportunities for Participants to manage and control service and service delivery by adding Self-Direction under this waiver as descried in Appendix E.

Appendix F Participant Rights:

- Updated and revised Opportunity to Request a Fair Hearing and State Grievance/Complaint System for clarity and readability.

Appendix G Participant Safeguards:

- Updated and revised Response to Critical Events or Incidents, Safeguards Concerning Restraints and Restrictive Interventions, and Medication Management and Administration for clarity, readability, and consistency with ME.0159 (MBM, Section 21).
- Updated and revised Quality Improvement: Health and Welfare, to align with Performance Measures in ME.0159 (MBM, Section 21).

Appendix H Quality Improvement Strategy:

- Revised and updated the description of System Improvements.
- Expanded upon quality assurance activities by adding a Plan of Corrective Action ("POCA") process to ensure providers

comply with
service requirements, have sufficient clinical and administrative capability to carry out the intent of the service, and have taken
steps to assure the safety, quality, and accessibility of the service.

- Revised and updated the description of the process for monitoring and analyzing the effectiveness of system design changes for
clarity and readability.

Appendix I Financial Accountability:

- Updated and revised Financial Integrity and Accountability for clarity and consistency with Maine's other 1915(c) waivers.
- Substantially revised Rates, Billing and Claims to reflect recently passed State legislation providing annual Cost of Living Adjustments (COLA) and requiring rates to provide for direct care staff reimbursement at (minimally) 125% of the State minimum wage.

Appendix J Cost Neutrality Demonstration:

- Updated Cost Neutrality and Derivation of Estimates for the final two years of this waiver cycle (through December 31, 2025).

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Brief waiver description
☒ **Appendix A Waiver Administration and Operation**	A.2.b., A.3, A-6,
☒ **Appendix B Participant Access and Eligibility**	B.2.c, B.3.a., B.3.b., B.3.c., B.3.f.
☒ **Appendix C Participant Services**	C-1/C-3, C-2
☒ **Appendix D Participant Centered Service Planning and Delivery**	D-1.a., and D-i. c. thru g., D-2. a.
☒ **Appendix E Participant Direction of Services**	Newly added
☒ **Appendix F Participant Rights**	F-1, F-3. b. & F-3. c.
☒ **Appendix G Participant Safeguards**	G-1-b. thru e.; G-2-a.; G-2-b-i.; G-2-c.; G-3-c.ii., iii., and iv.; PMs
☒ **Appendix H**	H-1.a.i., H-1.b.i., H-1.b.ii
☒ **Appendix I**	I-1, I-2.a., I-2.b., I-2.d.

Component of the Approved Waiver	Subsection(s)
Financial Accountability	
☒ Appendix J Cost-Neutrality Demonstration	J-1, J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☒ **Revise service specifications**
- ☒ **Revise provider qualifications**
- ☒ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☒ **Add participant-direction of services**
- ☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Maine** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: ME.0467
Draft ID: ME.013.03.02

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/21
Approved Effective Date of Waiver being Amended: 01/01/21

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so

that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

A Non-Emergency Medical Transportation (NEMT) 1915(b) waiver has been in place in Maine since 2012 and runs concurrent with the 1915(c) waiver. The 1915(b)(4) Prepaid Ambulatory Health Plan Model (PAHP) authority is for the provision of transportation provided by transportation brokers throughout each of the State's eight transportation regions.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☒ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The goal of this Waiver is to offer an array of services to adults diagnosed with Intellectual Disabilities or autism spectrum disorder who meet the ICF- IID level of care. Support services are for adults who either live with their families, live on their own or with a residential provider. The goal is that individuals will have the highest possible level of independence.

The Department of Health and Human Services (DHHS), Office of MaineCare Services (OMS) administers the Medicaid programs including this waiver. The Office of Aging and Disability Services (OADS) is responsible for the day-to-day operations of the waiver program, including oversight of eligibility processes, service delivery by qualified enrolled providers and contracted agents, and ongoing quality monitoring.

Maine's network of qualified service providers deliver waiver services to Participants including the development and implementation of the Person-Centered Service Plan (PCSP). The provider community varies in composition from sole proprietors to small single service organizations to large comprehensive for profit and not-for-profit entities. Waiver services are offered in provider managed sites, private homes and other community settings including places of employment. This diversity in Maine's provider community assures that Participants have a range of options throughout the state.

A Non-Emergency Medical Transportation (NEMT) 1915(b) waiver has been in place in Maine since 2012 and runs concurrent with the 1915(c) waiver. The 1915(b)(4) Prepaid Ambulatory Health Plan Model (PAHP) authority is for the provision of transportation provided by transportation brokers throughout each of the State's eight transportation regions.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least

annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except

when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The State followed HCBS regulations in 42 CFR § 441.301 and requested public input on this waiver amendment from _____ through _____. Tribal Consultation was done at a meeting on _____, and in writing on _____. On _____, the waiver amendment was posted online. A provider listserv was done on that date to all MaineCare providers and interested parties. Comments were accepted from _____ through _____. In addition, a notice appeared in five (5) newspapers with the highest circulation in the State on _____. Public comments on the proposed changes were accepted until 11:59PM, _____.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Leet

First Name: Thomas

Title: Long Term Services and Supports Manager

Agency: DHHS, MaineCare Services

Address: 11 State House Station

Address 2: 242 State Street

City: Augusta

State: **Maine**

Zip: 04333

Phone: (207) 624-4068 **Ext:** ☐ **TTY**

Fax: (207) 287-1864

E-mail: thomas.leet@maine.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Fales

First Name: Derek

Title: Public Services Manager II

Agency: DHHS- The Office of Aging and Disability Services

Address: 11 State House Station

Address 2:

City: Augusta

State: **Maine**

Zip: 04333

Phone: (207) 287-6656 **Ext:** ☐ **TTY**

Fax: (207) 287-9229

E-mail: derek.fales@maine.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Probert

First Name: Michelle

Title: Director

Agency: Office of MaineCare Services

Address: 109 Capitol Street

Address 2:

City: Augusta

State: **Maine**

Zip: 04330

Phone: (207) 287-2093 **Ext:** ☐ **TTY**

Fax:

(207) 287-2675

E-mail:

Michelle.Probert@maine.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State has made changes within this amendment to conform to the approved Final Statewide Transition Plan for HCBS. All provisions and requirements outlined for clarification or inclusion as a result of the assessment and findings of the approved Final Statewide Transition Plan are included within this amendment.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

* 1 Due to character limit - From App C QIS sub-assurance c. - 3rd PM:
Numerator: Total number of DSPs who completed the Department's required training in Reportable Events & Adult Protective Services, Regulations Governing Behavioral Supports, Rights & Basic Protections 36 months after completing the initial DSP certification and every 36 months thereafter. Denominator: Total number of DSPs required to complete the training requirements within 36 months of completing the DSP certificate and every 36 months thereafter that were reviewed.

*2 - Due to character limit reached in G-1.d.
Each business day, Incident Data Specialists (IDS) review and route reportable events electronically to the appropriate entity based on type of incident. Case Managers and Case Management Supervisors are alerted when a reportable event is logged for a Participant receiving services from that provider. Providers are required to conduct an administrative review within 30 days of a reportable event to discover the cause of the event and implement any actions to either reduce or prevent recurrence. These efforts are documented on the Provider Follow-up Report and attached to the record of the individual receiving services. The Case Manager reviews the reportable event, consults with the provider to discuss the proposed remediation action steps, and ensures the Participant and Guardian (as applicable) has input into the action steps to either reduce or prevent recurrence. The Case Manager documents this contact in the Participant's record, attached to the Reportable Event and makes changes to the PCSP, when necessary.

OADS has developed an electronic Critical Incident Dashboard that includes reportable events as reported by community-based providers, case managers, and individuals with ID/DD. Information regarding critical incidents, 30-day follow-up reports, deaths and any identified trends are reviewed and discussed with community providers quarterly. Importantly, the Critical Incident Dashboard when matched to claims data from emergency department events ensures that community-based providers are reporting these incidents and links all deaths with the State's Vital Records Death Registry.

Components of the Critical Incident Dashboard include:
Total number of individuals receiving services under the waiver.
Total number of critical incidents submitted by provider, by individual, by type and event category.
Location of incident.
Timeliness of reporting the incident and the 30-day follow-up report.
Emergency department claims matched to a reportable event.
Ability to trend/monitor data over time.

As previously noted above, this data is used at quarterly provider meetings and, if needed, to implement plans of correction to ensure provider compliance and improved health and safety outcomes for Participants.

*3 Due to Character limit reached in I-2. d.:
The State of Maine DHHS Service Center and the State of Maine Claim Processing System are programmed to ensure FFP recoupments. Annual audit reviews are part of the State of Maine Single Audit and cash management.

For Transportation Services, the Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the state Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Office of Aging and Disability Services (OADS)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Maine Department of Health and Human Services, Office of Maine Care (OMS) is the single State Medicaid Agency (SMA) for Maine. OMS responsibilities include the administration of the Medicaid Program and this waiver. This authority can be found (listed under the General and Administrative Section of the MaineCare manual). The Office of Aging and Disability Services (OADS) is the operating agency for all services provided to the target group. OMS delegates day-to-day operational authority of the waiver to OADS. This delegation means OADS is responsible for meeting the following assurances and sub-assurances: Appendix B – Participant Access and Eligibility; Appendix C – Participant Services; Appendix D – Participant Centered Service Planning and Delivery; Appendix F – Participant Rights; Appendix G – Participant Safeguards and Appendix H – Quality Improvement. As the SMA, OMS retains ultimate authority and oversight for the waiver including Appendix A – Waiver Administration and Operation; Appendix I – Financial Accountability and Appendix J – Cost – Neutrality Demonstration. In addition, OMS and OADS meet weekly discuss the waiver, rule, and policies in an effort to improve services and supports.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions

on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Department of Health and Human Services contracts with Transportation Brokers to organize and provide Transportation Services. Transportation is provided under a 1915b Non-Emergency Transportation Waiver (Me.19).

The Department of Health and Human Services contracts with Gainwell Technologies for MMIS Services.

The Department of Health and Human Services contracts with Burns & Associates, a health policy consultant, for assistance with rate setting.

The Department of Health and Human Services contracts with Change Health Care, a professional services organization, for the data collection and data entry for prior authorization of selected waiver services. The operating agency retains authority over the approval of requests for prior authorization.

The Department of Health and Human Services contracts with Keystone Peer Review Organization (KEPRO) Health Care for Prior Authorization of selected waiver services.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Office of MaineCare Services has a dedicated position to manage the contracts with the transportation brokers for the Me.19 NEMT Transportation waiver as well as contract managers for the Gainwell (MMIS), the KEPRO, and the Change Health Care contracts.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Performance Measures included in the 1915b waiver (Me.19) contracts with transportation brokers must be reported monthly. OMS reviews the performance measures that the broker reports on a monthly basis.

The Gainwell Technologies contract includes a service level agreement that is reviewed and monitored monthly.

KEPRO and Change Health Care submit quarterly performance standard reports measuring performance indicators. If indicators are not met, payment is reduced according to the contract standards.

Burns and Associates is only involved in one of the 12 functions of A-7 (establishment of statewide rate methodology), and the final decision on rate implementation lies with the Office of MaineCare Services and the State of Maine Legislature after Burns completes each contracted rate study.

When conducting a rate study, Burns follows a prescribed process for evaluating rates that includes collecting data from a variety of sources including state policies, provider and stakeholder input, published sources (e.g., Bureau of Labor Statistics wage data, IRS mileage rates), and special studies. Members of MaineCare's Rate Setting Unit and the State's operating agency are involved in all provider meetings and responses to provider comment. The MaineCare Rate Setting Unit oversees the contract (including oversight and assessment) between Burns and Associates and the Office MaineCare services.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☐
Level of care evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☒
Execution of Medicaid provider agreements	☒	☐	☒
Establishment of a statewide rate methodology	☒	☒	☒
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of waiver providers who have a current executed provider agreement. Numerator: Total number of waiver providers with a current executed provider agreement.
Denominator: Total number of waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Discovery of issues related to the administration and operation of the waiver is a shared responsibility between OMS, OADS and the contracted agencies. Issues are identified through audits of provider enrollment, claims and site reviews. Remediation activity occurs when a deficiency is discovered. Specific activities including a description of the deficiency, timelines and resolution are maintained using a Corrective Action Template.

The State Medicaid Agency operates a provider relations unit to address and solve any concerns or problems that may arise with processing claims. Providers will contact their provider relations specialist if the provider experiences any problems with claims processing. The provider relations specialist assists with claims research to identify the specific problem. All contact between the provider relations specialist and the provider is documented in the State Medicaid Agency's MMIS.

Additionally, OMS and OADS meet weekly to discuss deficiencies and remediations, waiver policies and amendments and rule changes. Minutes are kept for each meeting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	18		☒
	☐	**Developmental Disability**			☐
	☒	**Intellectual Disability**	18		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

To be eligible for this waiver a Participant has been diagnosed with an Intellectual Disability, autism spectrum disorder, or Rett Syndrome (for individuals diagnosed prior to 2013) as defined by the DSM.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ( ) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- (●) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit is not to exceed 50% of the ICF/IID cost. The limit is based upon review and analysis of claims data indicating this limit is sufficient to allow a Participant access to the service options available under this waiver based upon their assessed needs as documented in their PCSP. When the services available under this benefit are insufficient to assure the Participant's health and welfare, the Participant may be referred to the Section 21 (ME.0159) waiver and/or available State Plan services for which the Participant qualifies. Participants may receive a combination of waiver services and state plan services to assure health and welfare of the waiver Participant. PCSPs are entered in the State's client data system which tracks waiver authorizations and expenditures to ensure the limit is uniformly applied.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

◉ **The following percentage that is less than 100% of the institutional average:**

Specify percent: 50

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Prior to formal determination of eligibility for Section 29 waiver services, 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. It is compared to benchmark identified in Item B-2-a. The State provides notice of the opportunity for an applicant to request a Fair Hearing if enrollment is denied.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following

safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☒ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

When there is a change in the Participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the Participant's health and welfare, the Participant and the Planning Team will consider a combination of other MaineCare state plan services (including consideration of ICF-IID), state funds, and informal supports may be utilized to meet additional needs. If the Participant is receiving additional services under the State plan, specified limits on those services apply.

Participants may be authorized to receive additional services that exceed the cost limit identified in Section B-2-a. The Department complies with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134 and, as such, has policy and procedures in place to receive and process Title II modification requests, including requests to modify financial limitations pursuant to the ADA.

Additionally, MaineCare Benefits Manual's (MBM) Section 29, Ch II describes the following procedures for authorizing additional services that exceed the cost limit:

Participants who receive services through this Benefit and participants 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 participants receive adequate and appropriate services and supports in the most integrated setting appropriate to their needs, consistent with the ADA, and with the health and safety requirements outlined in Section 29 of the MBM. To achieve that outcome, participants may submit a Request for Exceptions to seek services in excess of otherwise-applicable Section 29 waiver monetary and/or unit caps.

Participants or their Representatives may seek Exceptions by submitting a written request on a department-approved form by the Participant, the Participant's Representative, or the Participant's Case Manager.

The Department, or its Authorized Entity, may approve a Request for Exceptions so long as the exception(s) are fully documented within the Participant's Person-Centered Service Plan, and the Participant has demonstrated all of the below criteria:
1) The requested service is a Covered Service.
2) The Participant reasonably requires the Exception to receive services in the community, or failure to grant the Exception will place the Participant at serious risk of institutionalization or segregation.
3) The Participant 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 Participant's needs will be met in the most integrated setting appropriate to their needs.

Procedures and requirements for the Department's review and decision regarding a participant's Request for Exceptions appear in MBM, Ch. II, Section 29. The Department shall issue a written decision ("Decision") on the Request for Exceptions within sixty (60) days of receipt of all materials submitted by the participant or requested by the Department.

The participant's Case Manager, the participant, or the participant's Representative shall note the approved Exception(s), including the duration, in the participant's Person-Centered Service Plan. Exceptions granted to a participant under this provision shall expire as set forth in the Decision. Procedures for requests for renewal of an Exception appear in MBM, Ch. II, Section 29.

The Department may deny a participant's Request for Exceptions if the Department has previously denied a substantially similar Request for Exceptions from the participant, or if the participant 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 participant's need for the requested Exception.

Additionally, the Department may deny a Request for Exceptions (even if the participant demonstrates the participant needs the Exception to live in the most integrated setting appropriate to the participant's needs) if the Department determines that any or all of the below applies:
1) The Participant's proposed community placement is not appropriate.
2) The Participant's health and safety cannot be assured in the community even if the Exception is granted; or
3) The Exception, if granted, would fundamentally alter these HCBS waiver services.

A Participant 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.

Filing a Request for Exceptions is neither a waiver of nor a substitute for the Participant'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.

All exceptions are subject to Utilization Review.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3215
Year 2	3575
Year 3	3755
Year 4	3755
Year 5	3755

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	3050
Year 2	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	3410
Year 3	3590
Year 4	3590
Year 5	3590

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

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

Individuals apply for this benefit with the assistance of the Case Manager. Based on review of the Assessment, referral form and the PCSP, a Qualified Intellectual Disability Professional designated by DHHS determines the individual's medical eligibility for services under this Section.

DHHS notifies each individual or the individual's guardian in writing of any decision regarding the individual's medical eligibility, as well as the availability of openings under this benefit.

If there are no funded openings, the State maintains a Waiting List for this benefit. The MaineCare Benefits Manual Ch. II, Section 29 defines the Waiting List protocol. Individuals who are on the waiting list for the benefit shall be served chronologically based on the date that OADS determines eligibility for the waiver.

When there is a funded opening available, OADS sends a letter to the individual or the individual's guardian. The individual or the guardian has 60 days to accept or decline the benefit. The individual or guardian submits a signed choice letter documenting the decision to receive services under this benefit. If there is no response, the individual will be removed from the waiting list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ◉ **§1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ◉ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

-Children under Age 19 (between the 18th and the 19th year given minimum age requirement for this waiver is 18 years of age) as specified in §435.118
-Parents and Other caretaker relative as specified in §435.110
-Pregnant Women as specified in §435.116
-Children with Non-IV-E Adoption Assistance as specified in §435.227
-Former Foster Care Children as specified in §435.150
-Children Aged 19 and 20 as specified in §435.222
-Adult Group as specified in §435.119

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a**

community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - (●) **A percentage of the Federal poverty level**

    Specify percentage: 200
  - ( ) **Other standard included under the state Plan**

    Specify:

- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ◉ **A percentage of the Federal poverty level**

  Specify percentage: 200
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The person conducting the assessment must meet the standard of Qualified Intellectual Disability Professional (QIDP) as outlined in 42 CFR 483.430(a). Specifically, the individual must have a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and/or psychology. In addition, the individual must have at least one year of experience working directly with persons with Intellectual Disability or other developmental disabilities.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

ICF-IID level of care criteria are identified on the medical eligibility instrument utilized in this program. (form BMS-99) In 1999, this assessment form was submitted to CMS for comparative analysis of this form and the form used for admission to an ICF-IID and determined that the outcomes of the evaluation are equivalent.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating

waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Evaluation: The Case manager submits the Person-Centered Service Plan (PCSP), Choice Letter, and the BMS 99 to OADS/DHHS. The PCSP and the BMS 99 contain information used to determine level of care. A Qualified Intellectual Disabilities Professional (QIDP) at OADS reviews submitted information for level of care determination and ensures a Participant meets and maintains level of care criteria for waiver services.

Reevaluation: The reevaluation process does not differ from the initial evaluation process. On an annual basis the Case Manager submits a current PCSP and BMS 99 assessment form to a QIDP for reevaluation.

The BMS 99 is the assessment tool used to determine the level of care. Additionally, the Case Manager conducts a comprehensive assessment that informs development of the PCSP. The PCSP establishes and documents the services available through the waiver to address the Participant's needs based on the level of care determination.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Maine's electronic database system generates a "tickler" notification to the case manager and supervisor as well as an overall report of upcoming reevaluations. This will occur with a 60-day advance notice.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Office of Aging and Disability maintains records at the DHHS central office site in Augusta, Maine. Case management providers must maintain records in retrievable formats at their business locations, including evaluations, "for a period of not less than five (5) years from the date of service or longer if necessary to meet other statutory requirements," in accordance with Ch I, Section 1, General Administrative Policies and Procedures, of the MaineCare Benefits Manual (MBM).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of initial applicants with documentation where evaluation for LOC was provided and reviewed by QIDP. Numerator: Total number of initial applicants with documentation where an evaluation for LOC was provided and reviewed by QIDP. Denominator: Total number of initial applications received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
% of LOC determinations made using the processes & instruments described in the waiver are applied appropriately & according to the description to determine participant LOC. Numerator: # of LOC determinations made using the processes & instruments described in the waiver are applied appropriately & according to the description to determine LOC. Denominator: Total # of LOC determinations reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

n/a

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

As part of the discovery and remediation process, OADS Data & Compliance will conduct reviews on all initial level of care assessments and re-evaluations to ensure timeliness and the use of the approved waiver tool and processes. When a problem is identified, Data & Compliance will report the issue to OADS senior management for corrective action, if appropriate. OADS senior management will determine corrective action that effectively addresses any individual or systemic problems. Data & Compliance will continue to monitor on a quarterly basis to ensure that the issue has been resolved. At the end of each quarter Data & Compliance will document findings, recommendations and improvements and report to both the Office of Medicaid Services (SMA) and to OADS senior management.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

After a Participant receives notification of a funded offer the planning team meets. At that meeting, the Case Manager informs the Participant/guardian of all available service options including waiver services. The Participant/guardian signs the Choice Letter for Waiver services. An electronic copy of this document is kept in the Participant's electronic record. If there is a paper copy with an original signature, that is kept with the Case Manager of record.

The Case Manager is responsible for, initially and on an ongoing basis, identifying and documenting service needs of participants as well as exploring service provision options and alternatives to include waiver and institutional services. Additionally, the case manager is responsible for informing Participants and/or their legal guardians about their freedom of choice between all feasible service options.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Freedom of Choice forms will be electronically stored in the Enterprise Information System (EIS). Any original paper copy is retained by the Case Manager of record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Case Managers are informed of OADS/DHHS resources to support Participants/guardians with limited English proficiency. Support includes interpreters for all interactions between the CM and Participant/guardian. Interpreter Services are covered in the MaineCare Benefits Manual, Ch. I, 1.06-2, Interpreter Services.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Community Support**		
Statutory Service	**Home Support-1/4 hour**		
Statutory Service	**Respite**		
Statutory Service	**Work Support- Group**		

Service Type	Service		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Individual Goods and Services		
Supports for Participant Direction	Supports Brokerage		
Other Service	Assistive Technology		
Other Service	Career Planning		
Other Service	Employment Specialist Services		
Other Service	Home Accessibility Adaptations		
Other Service	Home Support-Remote Support		
Other Service	Non-Medical Transportation		
Other Service	Shared Living Services		
Other Service	Work Support-Individual		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Community Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Support is a service that increases or maintains a Participant'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 delivered according to the Member's choice and needs as documented in the Member's PCSP.

Community Support is delivered 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 and must not duplicate Home Support Services.

Community Support may be delivered in a non-disability specific setting or community places of the Member's choosing or may be in a Disability-Specific setting that complies with the Global HCBS Rule, Section 6, Ch II, of the MBM.

Service delivery begins with exploration and discovery: a process that allows the Member to voice and explore areas and activities of interest, to discover potential places for community involvement, and to develop a better understanding about what the community has to offer. Exploration and discovery activities may include, but are not limited to, volunteering, employment exploration, accessing community events and businesses, increasing health and wellness, and increasing citizenship skills. Crucially, the process and activities shall support the Member to acquire new skills, to develop relationships and natural supports, increase community integration and contribution, and ultimately increase independence and self-determination.

Community Support allows for career and employment exploration including the benefits of working. Activities and services related to work should be relevant to the Member's employment interests, their individual strengths as related to employment, employment goals, and the conditions for success on a job. Use of Job Clubs, business tours, soft skill building curriculums, volunteer opportunities and skill building all are allowable under Community Supports to assist the Participant on a Path to Employment and must be documented in the Member's PCSP.

Community Support may also facilitate supported retirement activities. As some Participants 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. 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 as documented in the Member's PCSP.

The community support tiers are as follows:
A. Community Only-Individual – services provided by one staff to one Member at a time (1:1) within community settings.
B. Community Only-Group – services provided by one staff to two Members at a time (1:2) within community settings.
C. Community Center-Based – services provided by no less than one staff for three Members at all times (1:3) within or from a facility/center.

"On Behalf of" is included in the established authorization for Community Support Services and is not a separately billable service. For details related to covered and non-covered "on Behalf Of activities see MBM, Ch II, Section 29.16.

Medical Add-On, when reviewed and approved by OADS, is included in the established authorization for Community Support Services and is not a separately billable activity. For detailed requirements and the process to request authorization for Medical Add-On see MBM, Ch II, Section 29.16.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An individual is limited to a combined amount of 30 hours per week of Community Support (Community only and Community center-based) and that combined amount may not exceed the individual budget limit.

There is an annual limit of $84,689.28 on any combination of the following services: Home Support, Shared Living, and Community Support.

Community Support may not be provided at the same time as Home Support, Shared Living, Career Planning, Work Support, or Employment Specialist Services.

Nothing prohibits one-to-one (1:1) service delivery. Community Support can be provided one Participant to one DSP (1:1) but shall not exceed a ratio of three Participants to one DSP (3:1) in any setting.

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.

Community Support may not be delivered in a PNMI, high school setting, Agency Group Home, Shared Living or any institutional setting, or in the Participant's place of employment.

Payment for Provider-Managed, Community Only-Individual service is not made directly, or indirectly, to members of the Participant's immediate family.

Payment for Self-Directed, Community Only-Individual services, may be made to friends or family members of the Participant, including their spouse or the legal guardian.

When the guardian is also acting as the Representative on behalf of the Participant, the guardian may not also deliver direct support to the Participant.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency
Individual	Individual Employee

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Support

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

none

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

Other Standard *(specify):*

The Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel records:
A) Prior to providing services to a Participant 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
B. 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;
5. DSPs, regardless of capacity and prior to provision of service to a Member, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. DSPs must be at least seventeen (17) years of age. DSPs eighteen (18) years of age or older are eligible for hire and 17-year-olds will remain eligible for employment following their 18th year in the absence of a high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other requirements of the position.
D. DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by the Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, Division of Licensing and Certification (DLC), and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Support

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community Support-Individual may be provided by an individual who meets the requirements for employees for self-directed services. The standards for training are set by the Participant or Representative (as applicable) directing services. The Participant or Representative is responsible for the hiring and training of the employee. As part of this process, the Participant or Representative must maintain documentation that the employee received adequate orientation to assure that the employee can meet the needs of the Participant and demonstrate competency in all required tasks. The Participant or Representative is required to undergo skills training which prepares and assists the in fulfilling these responsibilities. Employees may be members of the Participant's family. If a Representative is directing services on behalf of the Participant, the representative may not be paid to provide care. The guardian may not be paid to provide care to the Participant.

Employees must be 17 years of age or older.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Participant or Representative choosing to self-direct with background checks facilitated by the Fiscal Intermediary (FI) providing Financial Management Services (FMS).

Frequency of Verification:

Verification occurs at time of hire.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Home Support-1/4 hour

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Support-Quarter Hour is an individually tailored support that assists Participants with acquisition, retention, or improvement in skills related to living in their own home or with others (either owned or leased) in their community who need less than 24-hour (1:1 in person) staff support per day. Support includes assistance with ADLs, IADLs, building self-reliance and adaptive skills, control of personal resources, transportation, and facilitating opportunities to seek employment and to work in competitive, integrated settings. Providers must develop methods, procedures, and activities to facilitate meaningful days and independent living choices about activities, services, and staff for the Participant.

Home Support-Quarter Hour may include assisting the Participant to:
A. Develop and maintain independence with self-care, including ADLs, IADLs.
B. Develop and use adaptive cognitive and communication skills.
C. Develop and demonstrate use of replacement behaviors identified in the Participant's Positive Behavior Support Plan. This may include effectively addressing situations and antecedents of frequently occurring maladaptive or challenging behavior. In- Home Supports providers may work under the direction of an assigned professional to assist the Participant to develop skills necessary to reduce or eliminate episodes in which the Participant becomes a danger to self or others.
D. Explore and engage in prevocational and/or work-related activities.

In addition to the above, the PCSP must document the Participant's health and safety needs and the supports needed to meet them. Procedures must be in place for individual(s) to access needed medical and other services to facilitate health and well-being.

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

Medical Add-On is the enhanced rate paid to address short or long-term medical needs and is reviewed and approved by OADS and is included in the established authorization for this service. It is not a separately billable activity. Medical Add-On supports Participants with intermittent or longer duration medical conditions including but 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 Participants 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. The requirements and process for application for Medical Add-On, including the role of the Participant’s PCSP team, are detailed in MBM Ch. II, Section 29.

On Behalf Of is a component of Home Support and is included in the established authorization and rate and is not a separately billable activity. When certain activities are conducted “On Behalf Of” the Participant but are not necessarily direct face-to-face services, they may be reimbursable. This may include activities and time that are directly related to the Participant, associated with their PCSP, associated with family events/family reunification, or related to Participant safety. Details related to activities that are covered and those that are non-covered are specified in MBM Ch. II, Section 29.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home Support may not be provided at the same time as Community Support, Shared Living, Career Planning, Work Support, or Employment Specialist Services.

There is an annual limit of $84,689.28 on any combination of the following services: Home Support, Shared Living, and Community Support.

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

Payment for provider-managed, Home Support- Quarter Hour services is not made directly, or indirectly, to members of the Participant's immediate family. Payment for self-directed Home Support- Quarter Hour services, may be made to friends or family members of the Participant, including their spouse or the legal guardian. When a Representative is directing services on behalf of the Participant, neither the Representative nor the Participant’s guardian may not be paid to deliver services to the Participant.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Support-1/4 hour

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

Other Standard *(specify):*

The Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel records:
A) Prior to providing services to a Participant 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
B. 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 Participant, 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;
5. DSPs, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. DSPs must be at least seventeen (17) years of age. DSPs eighteen (18) years of age or older are eligible for hire and 17-year-olds will remain eligible for employment following their 18th year in the absence of a high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other requirements of the position.
D. DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Support-1/4 hour

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Home Support-Quarter Hour may be provided by an individual who meets the requirements for employees for self-directed services. The standards for training are set by the Participant or Representative (as applicable) directing services. The Participant or Representative is responsible for the hiring and training of the employee. As part of this process, the Participant or Representative must maintain documentation that the employee received adequate orientation to assure that the employee can meet the needs of the Participant and demonstrate competency in all required tasks. The Participant or Representative is required to undergo skills training which prepares and assists the in fulfilling these responsibilities. Employees may be members of the Participant's family. If a Representative is directing services on behalf of the Participant, the representative may not be paid to provide care. The guardian may not be paid to provide care to the Participant.

Employees must be 17 years of age or older.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Participant or Representative choosing to self-direct is responsible for employee verification procedures with background checks facilitated by the FI delivering FMS to the Participant.

Frequency of Verification:

Verification occurs at time of hire by the Participant or Representative.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 09011 respite, out-of-home

Category 2: 09 Caregiver Support

Sub-Category 2: 09012 respite, in-home

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Respite Services are provided to Participants who are unable to care for themselves that are furnished on a short-term basis because of the absence of or need for relief to those individuals who normally provide care for the Participant.
Respite may be provided in the Participant's home or other location as approved by DHHS (ex. motel in case of emergency).

Respite Services are Provider-Managed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite Services are limited to 11 days or 88 hours (352 quarter hour units) annually.

Respite Services are reimbursed by a quarter (1/4) hour billing code or on a per diem basis. If more than thirty-three (33) quarter hour units of Respite Services would be delivered on the same date of service, the provider must bill using the per diem billing code for that date of service.

If a Participant uses a combination of per diem and quarter hour Respite Services, each day of per diem Respite Services will be considered by DHHS as 32 quarter hour units, for the purpose of calculating adherence to the overarching limit of 352 quarter hour units.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

Other Standard *(specify):*

The Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel records:
A) Prior to providing services to a Participant 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
B. 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 Participant, 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;
5. DSPs, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. DSPs must be at least seventeen (17) years of age. DSPs eighteen (18) years of age or older are eligible for hire and 17-year-olds will remain eligible for employment following their 18th year in the absence of a high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other requirements of the position.
D. DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Work Support- Group

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Work Support-Group is Direct Support delivered at the Participant's place of employment to improve a Participant's ability to independently maintain 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 Participants. Mobile work crews, and business-based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed. Regardless of the model, the primary focus of service delivery is job related including adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

Work Support-Group must promote integration into the workplace, interaction between Participants and people without disabilities in those workplaces, and contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations.

The Participant's position must be available to and include the same duties and expectations for job performance and attendance as any other employee at the worksite. The Participant must be able to work under conditions similar to employees without disabilities in similar positions, including access to lunchrooms, restrooms, and breaks. The Participant cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities.

Staff delivering Work Support or Employment Specialist Services at the worksite are not considered employees without disabilities when determining the level of integration the Participant experiences while employed.

Provider agencies delivering Medicaid-funded HCBS to Participants should not be the same entity that employs the Member. For any entity related to the provider, subject to Department review and approval, the provider agency must ensure conflict-of-interest safeguards are in place to protect the Participant if such a relationship exists. In these circumstances, the provider must supervise the Participant in a manner identical to other employees. The Department may approve the provider agency to supervise the Participant when the appropriate conflict-of-interest safeguards are in place.

To receive this service, a Participant 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 PCSP.

The outcome of this service must be sustained paid employment and work experience leading to further career development and individually integrated community-based employment for which the Participant 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.

The provider must maintain documentation in the Participant's file 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-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 an individual'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) Participants at one time may be supervised by a Direct Support Professional. The appropriate group rate must be billed.

The provider must inform each Participant at least yearly that career planning and individual employment are available to support the Participant in making an informed decision regarding the services the Participant 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.

Work Support-Group is a Provider-Managed Service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Work Support may not be provided at the same time as Community Support, Career Planning, Home Support, Employment Specialist Services or Shared Living.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Supported Employment Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Work Support- Group

Provider Category:

Agency

Provider Type:

OADS Approved Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

In addition to the requirements outlined for Direct Support Professionals, Job Coaches must successfully complete, prior to provision of services, the additional employment modules through the Maine College of Direct Support. Or Completed the College of Employment Services Job Coach Maine Certificate.

Other Standard *(specify):*

The Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel records:
A) Prior to providing services to a Participant 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
B. 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 Participant, 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.
5. DSPs, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. DSPs providing employment supports must be at least eighteen (18) years of age.
D. DSPs providing employment supports must have graduated from high school or acquired a GED.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Financial Management Services are a critical support for self-direction, making payments through a Fiscal Intermediary that performs financial transactions (paying for Individual Goods and Services or processing payroll for the Participant's employees and tracking expenditures against the self-directed budget) on behalf of the Participant.

This service includes:
a) Explanation of program rules and requirements including providing skills training for the Participant or Representative on their responsibilities in exercising both employer and budget authority consistent with authorized services.
b) Enrollments for Employer/Employer-of-Record and Employees.
c) Payroll processing for employees to address federal, state and local employment tax, labor and workers' compensation insurance rules, required background checks, and other requirements that apply when the Participant functions as the employer of workers.
d) Tracking spending and approving expenditures that align with the Department- approved Spending Plan Tool, including changes/additions to the list of Goods and Services.
e) Making financial transactions on behalf of the Participant within the scope of select services for self-direction.
f) Providing a monthly financial report to the Participant which includes projected and actual spending to ensure the Participant stays within the individual budget based on approved service authorizations.
g) Assisting the Participant with resolving employee questions and complaints and remediating as appropriate.
h) Informing the Participant that the Department does not require employers to offer health insurance coverage, but they may negotiate a stipend or wage adjustment to assist employee with costs of procuring their own benefits, such as healthcare coverage.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Participant must receive Financial Management Services in order to access Self-Directed Services.

Payments for services must not be made directly to a Participant, either to reimburse the Participant for expenses incurred or enable the Participant to directly pay a service provider or employee.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Financial Management Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OADS-approved agency providers must meet expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, quality management, compliance with all HCBS Settings requirements, and comply with federal Internal Revenue Service (IRS) codes. FMS entities must use an electronic platform that is HIPPA compliant and ensures accessibility and efficiency for the Participant to engage in Self-Directed Services. Agencies must demonstrate high quality customer service to effectively and efficiently support the Participant and Representative choosing Self-Direction including, but not limited to, the ability to process timesheets and payroll, manage and disburse payments for the Participant's Individual Goods and Services budget (and monthly reports to the Participant/Representative for the same), and other needed management functions.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individual Goods and Services include services, equipment, or supplies not otherwise provided through this Benefit or through State Plan. The specific goods and services must be documented in the Department approved Individual Goods and Services Request form as an addendum to the PCSP and clearly linked to an assessed need established in the PCSP. Services, equipment, and/or supplies should promote autonomy and independence, improve or ensure access to competitive integrated employment, improve or maintain a Participant's opportunities for full community integration and membership, or improve or maintain access to non-emergency transportation.

With support and assistance from the Support Broker, the Participant will use the Department-approved Spending Plan Tool to list the allowable Goods and Services, the cost associated with each item or service, and the accounting of whether available funds are sufficient to purchase items immediately or at a future time. The Participant and Support Broker must review the spending plan at regular intervals to meet the Participant's budgeting needs and as the Participant's needs for additional or alternate Goods and Services dictate. The Support Broker will ensure the Participant seeks approval of the spending plan, including updates and changes to the same, from the FI.

Individual Goods and Services must meet one or more of the following requirements:
1) Decrease the need for other Medicaid services;
2) Promote inclusion in the community; or
3) Increase the Participant's safety within the home environment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Participant must use personal funds to purchase services, equipment, or supplies when available. When the Participant does not have personal funds or funding through another source, the Participant may access funds available in the Participant-directed budget. Availability of funds for Individual Goods and Services is contingent upon the combined cost of mandatory self-directed services, optional self-directed services, and traditional waiver services identified in the PCSP. The Participant must develop a spending plan that details all service-related costs according to the Participant's authorized budget limits and calculates any remaining funds available for identified Goods and Services documented within the PCSP.

Individual Goods and Services that are not allowable:
• Cash Payments
• Gifts or loans for Participant-directed workers, family, or friends
• Food, beverages, or nutritional supplements
• Entertainment equipment or downloadable files/applications or supplies
• Air conditioners, heaters, fans, generators, and similar items
• Illegal drugs, alcoholic beverages, tobacco products, or vaping devices
• Costs incurred by the employee associated with travel such as airfare, lodging, meals, etc. for vacations or entertainment
• Utility costs, rental costs, or mortgage payments
• Clothing, shoes, or other apparel
• Household linens, towels, or drapes
• Paint and related supplies
• Cleaning for other household members or areas of a home that are not used as part of the Member 's personal care
• Medications, vitamins/herbal supplements
• Experimental or prohibited treatments/procedures
• Household cleaning supplies
• Vehicle expenses including routine maintenance and repairs, insurance or gas money for a personal vehicle or a family member's vehicle who performs tasks they are responsible for outside of personal care (non-emergency transportation is reimbursed in the form of mileage at the federal reimbursement rate)
• Landscape and yard work
• Pet care
• Massages, manicures, pedicures or any cosmetic service or supply
• Items or activities that are solely recreational in nature
• Room and Board costs
• Any other item not specified which does not meet the scope of service

Individual Goods and Services are subject to an annual cap of ten-thousand dollars ($10,000.00).

A Participant may not "cash out" their services for the sole purpose of generating or increasing the available funds for Individual Goods and Services.

A Participant may not rollover unspent Goods and Services funds across fiscal years.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Individual Goods and Services

Provider Category:

Agency

Provider Type:

Financial Management Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

In order to administer and distribute funds for Individual Goods & Services, a provider must qualify for, and be approved as, a Financial Management Services (FMS) agency. The FMS agency administering funds for Individual Goods & Services must be able to screen, approve, and reimburse vendors, in compliance with the Service Specifications for Individual Goods & Services, and the participant's PCSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver

includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Supports Brokerage

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supports Brokerage is the delivery of support and information to ensure that the Participant understands the responsibilities involved with Self-Direction. Duties of the Supports Broker include, but are not limited to, coaching, and advising the Participant about the responsibilities of being an employer, managing their personal budget, or implementation of their PCSP. The PCSP must identify the extent of the assistance the Supports Broker furnishes to the Participant or Representative. This service does not duplicate other services, including case management or financial management services.

Following Department-approved Supports Brokerage training, service delivery includes:
A. Offering support, including effective communication and problem-solving strategies, to enable Participants or Representatives to
recruit, hire, train, and manage employees independently.
B. Supporting Participants in person-centered service planning for Self-Directed Services).
C. Supporting Participants to project and track costs associated with services, staffing, wages, and allowable Individual Goods and
Services, using the Department-approved Spending Plan Tool.
D. Working closely with the Case Manager and FI to ensure the PCSP identifies the mix of services (employment, State Plan, Provider-
Managed Services and Self-Directed Services) and natural supports to maximize the Participant's flexible individual budget of Self-
Directed Services.
E. Assisting in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports
and services.
F. Supporting and monitoring Participants to carry out their employer responsibilities such as recruitment activities, education of
employees and scheduling.
G. Completing community mapping of all services and supports available to Participant.
H. In conjunction with the FI, supporting the Participant to monitor spending using the Department-approved Spending Plan Tool.
I. Supporting the Participant to request adjustments to the PCSP as needed and ensuring those authorized adjustments are reflected in
the updated Spending Plan Tool.
J. Supporting the Participant in meeting Electronic Visit Verification requirements and daily documentation requirements.
K. Reporting overutilization/scheduling of more staff than the budget can cover, to the OADS resource coordinator.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is a fee-for-service with an annual maximum of 200 units.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Supports Brokerage

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

he OADS-approved agency will ensure Support Brokers meet the following minimum qualifications: High School Diploma or equivalent; completion of Department-approved Support Brokerage Training; minimum 1-year community experience in supporting people with disabilities; demonstration of knowledge of community services, MaineCare services, person-centered planning, business processes, Home and Community Based Services, health and social services systems; and problem solving and positive engagement and interpersonal skills.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Supports Brokerage

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The individual must complete an application to become an OADS-approved provider. Requirements include High School Diploma or equivalent; completion of Department-approved Support Brokerage Training; minimum 1-year community experience in supporting people with disabilities; demonstration of knowledge of community services, MaineCare services, person-centered planning, business processes, Home and Community Based Services, health and social services systems; and problem solving and positive engagement and interpersonal skills.

Verification of Provider Qualifications

Entity Responsible for Verification:

The individual/provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Assistive Technology (AT): Assistive Technology service means a service that directly assists a Participant in the selection, acquisition, or use of an assistive technology device. 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 the Member.

Assistive Technology Services include;

A. AT Assessment:
1. Evaluation of the assistive technology needs of a Participant, 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 Participant;
2. 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. Training or technical assistance for the Participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the Participant; and
4. 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 the Participant.

AT Assessment is a Provider-Managed Service.

B. AT Devices:
1. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for Participants; and
2. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

AT Devices can be a Provider-Managed Service or a Self-Directed Service.

C. AT Transmission:
1. Fee associated with the transmission of data required for the AT Devices via internet or cable utility or cell phone service (prepaid or monthly fee). Assistive

AT Transmission can be a Provider-Managed Service or a Self-Directed Service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Assistive Technology Services are not covered under this waiver if they are available under another MaineCare program.

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 $6815.22 annually, per state fiscal year.
3. Assistive Technology- Transmission (Utility Services) are limited to $54.12 per month.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Occupational Therapist
Speech Pathologist

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

IN addition to the above, a Direct Support Professional (DSP) delivering AT Services 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).

Other Standard *(specify):*

The Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel record:
A) Prior to providing services to a Participant 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
B. 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 Participant, 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.
5. DSPs, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. DSPs must be at least seventeen (17) years of age. DSPs eighteen (18) years of age or older are eligible for hire and 17-year-olds will remain eligible for employment following their 18th year in the absence of a high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other requirements of the position.
D. DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

Additionally, minimum requirements for equipment may include compliance with:
Local and state codes
Underwriters Laboratories
FCC
NFPA Life Safety Code
ADA

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Career Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03030 career planning
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Career Planning is a person-centered, comprehensive employment planning and direct support service delivered in a variety of community settings such as a Career Center or local business. As a result of engaging in this service the Participant may obtain, maintain, or advance in achieving Competitive Integrated Employment or self-employment. Additionally, in order to receive Career Planning services, the PCSP 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 assists in identifying skills, priorities, and capabilities determined through an individualized discovery process. This may include facilitating experiential learning opportunities and exploring career opportunities consistent with the Participant's skills and interests, and/or identifying the need for resources to increase independence in the workplace (i.e. assistive technology, benefits counseling, Vocational Rehabilitation, etc.).

Career Planning is a focused, time-limited service engaging a Participant to identify career interests, employment skills and abilities, and ultimately developing a Career Plan that supports the Participant to achieve their career goals. The Career Planner must submit the Career Plan to OADS at two intervals for review to ensure the service is provided consistent with the Participant's goals and that opportunities for Competitive Integrated Employment or self-employment will yield wages at or above the State's minimum wage.

When the Participant is seeking Competitive Integrated Employment, the Career Planner will assist with an application to the Bureau of Rehabilitation Services and for Benefits Counseling as prerequisites to receiving other employment supports.

When the Participant identifies an interest in self-employment the Participant will have the opportunity to explore similar businesses and determine potential steps necessary to develop a business.

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

Career Planning is a Provider-Managed Service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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. Career Planning may not be provided at the same time as Community Support, Home Support, Work Support, or Employment Specialist Services.

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).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Career Planning

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

In addition to the requirements outlined for Direct Support Professionals, a Career Planner must successfully complete the Maine College of Direct Support Work Support Modules or have successfully completed the Association of Community Rehabilitation Educators (ACRE) Employment Specialist certification, and successfully complete the Maine Career Planning 12-hour certification (approved by OADS). Career Planners must receive six (6) hours of continuing education in employment annually to maintain Career Planning certification.

Supervisors shall be required to meet all of the requirements of the DSP/Career Planner position.

Other Standard *(specify):*

The Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel records:
A) Prior to providing services to a Participant 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
B. 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 Participant, 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.
5. DSPs, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. DSPs providing employment supports must be at least eighteen (18) years of age.
D. DSPs providing employment supports must have graduated from high school or acquired a GED.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Employment Specialist Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Employment Specialist Services include services necessary to support a Participant in maintaining employment. Services include:
(1) periodic interventions on the job site to identify a Participant'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 Participant's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the Participant in acclimating to a new job; and
(3) Employment Specialist Services for job development, if Vocational Rehabilitation denies services under the Rehabilitation Act, or the services are not available to the Participant. If Employment Specialist Services are used for job development, a provider must submit, and retain in the Member's record, current documentation of the lack of service availability or ineligibility from Vocational Rehabilitation.

The PCSP must document the need for continued Employment Services to maintain employment over time.

Employment Specialist Services are delivered at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. Employment Specialist Services assist a Participant 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.

"On Behalf of" is included in the established authorization for Employment Specialist Services and is not a separately billable service. For details related to covered and non-covered "On Behalf Of" activities see MBM, Ch II Section,29.16.

Medical Add-On, when reviewed and approved by OADS, is included in the established authorization for Employment Specialist Services and is not a separately billable activity. For detailed requirements and application process for Medical Add-On see MBM, Ch II Section, 29.17.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Employment Specialist Services are provided on an intermittent basis with a maximum of 10 hours each month.

Employment Specialist Services cannot be provided at the same time as Work Support-Group or Work Support-Individual.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Supported Employment Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Specialist Services

Provider Category:

Agency

Provider Type:

OADS Approved Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

Additionally, a DSP who provides Employment Specialist Services must have 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, as well as the additional employment modules within the DSP curriculum. Employment Specialist National (ACRE approved) Certification may be substituted for College of Direct Support and employment modules as it is a higher level of staff certification.

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.

Other Standard *(specify):*

The provider agency must have:
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement and additional Developmental Services Rider to said Agreement.
2. Received approval from OADS for provision of waiver services as required in MIHMS.

The Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel record:
A) Prior to providing services to a Participant 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
B) 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 Participant, 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.
5. DSPs, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C) In addition to the requirements outlined for above, the following requirements apply to Employment Specialists:
a. Received supervision during the first six months of hire from a Certified Employment Specialist.
b. Graduated from high school or acquired a GED and is at least eighteen (18) years of age.
c. 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Accessibility Adaptations are physical adaptations to the private residence of the Participant or the Participant's family as documented in the PCSP, and necessary to ensure the health, welfare and safety of the Participant or enable the Participant to function with greater independence in the home. These include adaptations that are not covered under other sections of the MaineCare Benefits Manual, determined medically necessary as documented by a licensed physician or other medical professional, and approved by DHHS.

Common adaptations may include, but are not limited to, the following:

- 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); or
- Specialized flooring (to improve mobility and sanitation).

DHHS does not cover adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the Participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating is not allowable. General household repairs are not included in this service.

All services shall be provided in accordance with applicable local, state or federal building codes. All providers must be appropriately licensed or certified in order to perform this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home Accessibility Adaptations are limited to $10,494.00 in a five (5) year period with an additional annual allowance up to $314.82 for repairs and replacement per year. General household repairs are not included in this service. All items in excess of ($524.70) 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.

This service applies to a Participant-owned or a Participant's family-owned home only; it is not available in provider-owned or provider-managed residential settings. Home Accessibility Adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. If the family is a paid provider, this service is not available.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Specialized independent service provider such as: plumber, electrician, etc.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Specialized independent service provider such as: plumber, electrician, etc.

Provider Qualifications

License *(specify):*

State Licensure if applicable

Certificate *(specify):*

Professional Certification, if applicable. Any other requirements set forth by the Department or participant IF applicable.

Other Standard *(specify):*

Minimum requirements may include compliance with: Local and state building codes, Underwriters Laboratories,
FCC, NFPA, Life Safety Code, or ADA.

Verification of Provider Qualifications

Entity Responsible for Verification:

OADS will perform verification of independent service providers (plumber, electrician, etc.) as needed. The provider agency is responsible for securing and maintaining documentation of independent service providers and will submit invoices to OADS for approval, prior to submitting to MaineCare for reimbursement.

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:

Provider verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Support-Remote Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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 well as health monitoring equipment. This assistive technology links each Participant's residence to the Remote Support provider.

If a Participant chooses this service, the Participant's PCSP must include a safety/risk plan identifying the emergency back-up arrangements.

The use of this service is based upon the Participant's needs as identified by the assessment of functional need completed during the PCSP planning process and resulting in the PCSP. The PCSP reflects the Participant's consent and commitment to the plan elements including all assistive communication, environmental control and safety components. Prior to the finalization of the PCSP, the Planning Team will ensure the appropriateness of the identified assistive technology.

Home Support-Remote Support provides staffing to deliver one of two types of Remote Support: Interactive Support and Monitor Only. Interactive Support includes only the time that staff is actively engaging a Participant 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 Participant without interacting.

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.

Home Support- Remote Support is a Provider-Managed Service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Support-Remote Support

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

Other Standard *(specify):*

The provider agency must have:
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS)
2. Received addition approval from OADS for provision of waiver services as required in MIHMS Provider.
3. Copies of contracts or service agreements when the provider manages services delivered by another provider, thereby documenting the cooperative, affiliated service, or the subcontracting agreement. This agreement shall be updated and renewed at least annually.
4. Outlined the business structure in an organizational chart, identifying management, staff and other individuals compensated by the provider for assisting in the care of Participant (s) and illustrating the supervisory responsibilities; include credentials as required for the service delivery.
5. Developed a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns, and volunteers.
6. Developed personnel policies that include a description of the education, experience, and training required for Direct Support Professionals, Supervisors, and Program Directors.
7. Maintained policies governing essential elements of service provision including but not limited to; Behavioral Regulations, Rights and Protection, Reports of Abuse, Neglect and Exploitation, Duration of Care , and Medication Management.
8. Developed 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 Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel records:
A) Prior to providing services to a Participant 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
B. 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 Participant, 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;
5. DSPs, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. DSPs must be at least seventeen (17) years of age. DSPs eighteen (18) years of age or older are eligible for hire and 17-year-olds will remain eligible for employment following their 18th year in the absence of a high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other requirements of the position.
D. DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Non-Medical Transportation (NMT) enables Participants to gain access to Section 29 services, activities and resources, and other community services specified and documented within the PCSP. This service 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 shall not replace them.
Whenever possible, a Participant may access transportation from family, neighbors, friends, or community agencies.

Relatives and Legal guardians may be reimbursed by the transportation broker if they are unable to transport at no charge, or there is no other viable option, and the Planning Team recommends the same.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services must be coordinated through a broker.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	broker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

broker

Provider Qualifications

License *(specify):*

The driver must have a current and valid Driver's license, registration and insurance.

Certificate *(specify):*

Other Standard *(specify):*

Transportation services are managed through a 1915 (b) waiver run concurrently with this waiver and managed through a broker. The qualified broker, as selected through a request for proposal process, must maintain documentation of liability insurance, ability to obtain payment and performance bonds, and meet other specifications as detailed in the request for proposal. The State verifies the broker's qualifications through the RFP process and then through ongoing contract monitoring.
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement and additional Developmental Services Rider to said Agreement.
2. Received approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The transportation broker must enroll with the Medicaid agency including the Provider Agreement, and verify the qualifications of each individual driver.

Frequency of Verification:

Verification occurs upon enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Shared Living Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Shared Living (Foster Care, Adult) is individually tailored residential habilitation, personal care (e.g., homemaker, chore, attendant care, companion), protective oversight and supervision, and medication oversight (to the extent permitted under State law). These supports assist the Participant with acquiring, retaining, and developing skills necessary for living in the most integrated setting appropriate to their needs including but not limited to: adaptive skill development, assistance with ADLs and IADLs, community inclusion, transportation, and social and leisure skill development. The service facilitates the Participant'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. Services are delivered according to the Member's PCSP.

The Shared Living Provider delivers services to the Participant with whom they share a home. There may be only one Shared Living Provider in a home who may deliver Shared Living to one or two Participants in that home. The Shared Living Provider is a contractor of an Administrative Oversight Agency who supports the provider in fulfilling the requirements and obligations agreed upon by DHHS, the Administrative Oversight Agency, and the Participant's Planning Team as documented in the Participant's PCSP.

The Department may approve an Increased Level of Support for Participants receiving Shared Living Services based on the Participant's increased medical, behavioral, and/or individual safety needs. The PCSP must accurately document the need and reason for, amount, and duration of the increased staffing pattern. The increased level of support is not to be used as respite or in place of the primary provider.

Shared Living is a Provider-Managed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is an annual monetary limit on the combined total expenditure of $84,689.28 when participants have a need for any combination of Home Support, Shared Living, and Community Support.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Shared Living Services

Provider Category:

Agency

Provider Type:

OADS Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

Other Standard *(specify):*

The provider agency must have:
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS)
2. Received addition approval from OADS for provision of waiver services as required in MIHMS Provider.
3. Copies of contracts or service agreements when the provider manages services delivered by another provider, thereby documenting the cooperative, affiliated service, or the subcontracting agreement. This agreement shall be updated and renewed at least annually.
4. Outlined the business structure in an organizational chart, identifying management, staff and other individuals compensated by the provider for assisting in the care of Participant (s) and illustrating the supervisory responsibilities; include credentials as required for the service delivery.
5. Developed a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns, and volunteers.
6. Developed personnel policies that include a description of the education, experience, and training required for Direct Support Professionals, Supervisors, and Program Directors.
7. Maintained policies governing essential elements of service provision including but not limited to; Behavioral Regulations, Rights and Protection, Reports of Abuse, Neglect and Exploitation, Duration of Care , and Medication Management.
8. Developed 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 Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel records:
A) Prior to providing services to a Participant 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
B. 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 Participant, 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;
5. DSPs, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. DSPs must be at least seventeen (17) years of age. DSPs eighteen (18) years of age or older are eligible for hire and 17-year-olds will remain eligible for employment following their 18th year in the absence of a high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other requirements of the position.
D. DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, DLC, and OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Work Support-Individual

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Work Support-Individual is Direct Support delivered to the Member to improve the Participant's ability to independently maintain employment. 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. Work Support-Individual is delivered in a Participant's place of employment but may be delivered in a Participant's residence in preparation for work if it does not duplicate Home Support, Community Support or Employment Specialist Services.

Work Support-Individual must be delivered in an integrated employment setting in the general workforce. The Participant must be compensated at or above the State's 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.

The service must promote integration into the workplace, interaction between Participants and people without disabilities in those workplaces, and contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations.

The Participant's position must be available to and include the same duties and expectations for job performance and attendance as any other employee at the worksite. The Participant must be able to work under conditions similar to employees without disabilities in similar positions, including access to lunchrooms, restrooms, and breaks. The Participant cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities.

Staff delivering Work Support or Employment Specialist Services at the worksite are not considered employees without disabilities when determining the level of integration, the Participant experiences while employed.

The Participant may access Work Support-Individual Services under this Section when 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 PCSP, along with the Member's health and safety needs within the workplace.

Work Support-Individual may be delivered to self-employed Participants in operating their own business.

Work Support may be used to customize employment for Participants with severe disabilities including 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.

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.

Work Support-Individual is a Provider-Managed Service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Work Support may not be provided at the same time as Community Support, Career Planning, Home Support, Employment Specialist Services or Shared Living.

The provider must maintain documentation in the Participant's file 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 Participant'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.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Supported Employment Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Work Support-Individual

Provider Category:
Agency
Provider Type:

OADS Approved Supported Employment Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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.

DSPs must have current CPR and First Aid Certification.

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.

Supervisors shall be required to meet all of the requirements of the DSP position.

In addition to the requirements outlined for Direct Support Professionals, Job Coaches must successfully complete, prior to provision of services, the additional employment modules through the Maine College of Direct Support. Or Completed the College of Employment Services Job Coach Maine Certificate.

Other Standard *(specify):*

The provider agency must have:
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement and additional Developmental Services Rider to said Agreement.
2. Received approval from OADS for provision of waiver services as required in MIHMS.

The Provider Agency must attest to and retain documentation of completion of the following requirements in the personnel record:
A) Prior to providing services to a Participant alone, the Employment Specialist/Job Coach 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
B. Employment Specialists/Job Coaches 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. Employment Specialists/Job Coaches, regardless of capacity and prior to provision of service to a Participant, 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;
5. Employment Specialists/Job Coaches, regardless of capacity and prior to provision of service to a Participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).
C. Employment Specialists and Job Coaches must be eighteen years of age or older and must be graduated from high school or acquired a GED; and
D. Employment Specialists or Job Coaches providing Work Support must have 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Private agencies approved and certified pursuant to 14-197 C.M.R. ch. 10, Certification Requirements for Agencies Seeking to Provide Community Based Targeted Case Management for Adults with Intellectual Disability and Autism, or state employees deliver case management to waiver participants.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a. Provider agencies must conduct criminal background checks for prospective employees including Direct Support Professionals
and supervisors.
b. State Police Background checks will be conducted by the provider prior to employment of the direct care worker.
c. The Provider agency will verify and attest that all staff have a criminal history check as required prior to enrollment and
annually thereafter. For Participants who self-direct, the FMS facilitates a criminal background check on behalf of the
Participant or Representative for all prospective employees. The FMS also conducts background checks when the self-directing
Participant requires or chooses a Representative. Division of Licensing and Certification (DLC), Office of Program Integrity
(PIU), and OADS provide oversight through ad hoc audit and by complaint. For those providers who are licensed, DLC routinely
looks at personnel records to ensure that the background checks are conducted on all direct care workers. Program Integrity
reviews credentials and background checks when conducting investigations or reviews.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) In accordance with state statute, 22 M.R.S. §1812-G, the State of Maine must maintain a registry of Direct Care Workers who have criminal convictions in the last ten years and/or substantiated findings of abuse, neglect, or misappropriation of property which is maintained by the Department of Health and Human Services.

Additionally, the provider will contact the Child and Adult Protective Services units within DHHS 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 substantiated incident of abuse, neglect or exploitation by a prospective employee, it is the provider's responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with regulation.

(b) The registry must contain a listing of certified nursing assistants and direct care workers including, but not limited to the following positions: direct support professionals; mental health rehabilitation technicians; personal care or support specialists; certified residential medication aides; and mental health rehabilitation technicians.

(c) The Provider agency will verify that all staff have a criminal history check as required prior to enrollment and annually thereafter. Division of Licensing and Certification (DLC), Office of Program Integrity (PIU), and OADS provide oversight through ad hoc audit and by complaint. For those providers who are licensed, DLC routinely looks at personnel records to ensure that the background checks are conducted on all direct care workers. The PIU reviews credentials and background checks when conducting investigations or reviews.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- (●) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives who provide waiver services must meet the same standards as providers who are unrelated to the individual. See Appendix C-3. The State authorizes the reimbursable services and providers must document that all services are delivered in conjunction with the authorized services in the PCSP. The State performs post-payment claims reviews of the authorized services, provider documentation, and employee staff schedules to ensure claims submitted align with services delivered.

Family, neighbors, friends, or community agencies able to provide Transportation Services without charge are utilized whenever possible. 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 person-centered service planning team.

The State allows payment to a family member or legal guardian (when the legal guardian is a parent, step-parent, sibling, step-sibling, or other biological family member) for Shared Living Services.

The familial relationship is identified and options for potential service delivery are discussed with the case manager, the Shared Living Oversight Agency, and within the person-centered planning process. Furthermore, the Person-Centered Planning Team collectively determines whether relatives or legal guardians who are relatives are the ideal shared living provider for the Participant.

Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the Participant’s parent, sibling or other biological family member. This provision will not be avoided by adult adoption.

The Targeted Case Manager is responsible for ensuring the Participant’s health and safety needs are identified and for monitoring authorized services.

Persons appointed by a 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 provision.

Self-directed services may be delivered by friends or family members of the Participant, including their spouse or the legal guardian. If a Participant requires or has selected a Representative to direct services on their behalf, the Representative may not also be paid to provide care to the Participant. When a Representative is directing a Participant’s services, the Participant’s guardian may not be paid to provide care to the Participant.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any person or entity showing interest in various MaineCare programs may enroll as a provider so long as all necessary qualifications are met including holding a Medicaid provider agreement to deliver the service, except for transportation 1915(b) brokers.

The State has on-going open enrollment and State staff available to assist with the qualifications and enrollment process. OADS reviews and approves all provider applications. Provider recruitment is conducted by state DHHS staff as necessary. Provider requirements and procedures to qualify to deliver services are on the Department's website. Verification that Providers meet these requirements must be provided prior to enrollment.

Further, in accordance with Ch. I, Section 6 of the MaineCare Benefits Manual, to provide home and community-based waiver services, a provider must be enrolled in MaineCare as a provider by the Office of MaineCare Services, be in compliance with the Provider's MaineCare Provider Agreement, and satisfy all provider qualification requirements set forth in the applicable HCBS waiver regulations.

Finally, in accordance with Sec 29, Ch II of the MBM, the provider agency must have:
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement and additional Developmental Services Rider to said Agreement.
2. Received additional approval from OADS for provision of waiver services as required in MIHMS Provider.
3. Maintained and retained copies of contracts or service agreements when the provider manages services delivered by another provider, thereby documenting the cooperative, affiliated service, or the subcontracting agreement. This agreement shall be updated and renewed at least annually.
4. Outlined the business structure in an organizational chart, identifying management, staff and other individuals compensated by the provider for assisting in the care of Participant(s) and illustrating the supervisory responsibilities; including credentials as required for service delivery.
5. Developed a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns, and volunteers.
6. Developed personnel policies that include a description of the education, experience, and training required for waiver service delivery including but not limited to, Direct Support Professionals, Supervisors, Program Directors, and administrative staff.
7. Developed and maintained policies governing essential elements of service provision including but not limited to, Behavioral Regulations, Rights and Protection, Reports of Abuse, Neglect and Exploitation, Duration of Care, and Medication Management.
8. Developed written policies and procedures governing the identification and oversight of services delivered or monitored by a legal guardian/family member, as well as development and maintenance of an effective quality management program to ensure quality service delivery consistent with federal and state laws and regulations.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
% of providers (by type) who initially & continually meet required licensure/certification requirements & other standards prior to providing services.
Numerator Total number of providers who initially & continually meet required licensure/certification requirements & other standards prior to providing services.
Denominator: Total number of all licensed/certified providers reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of non-licensed/certified providers by type that meet waiver requirements. Numerator: Total number of non-licensed/certified providers by type that meet waiver requirements. Denominator: Total number of non-licensed/certified providers by type reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
% of DSPs who completed the DHHS sponsored training in Reportable Events & Adult Protective Services, Regulations Governing Behavioral Supports, Rights & Basic Protections within 6 months of hire. Numerator Total number of DSPs who completed the trainings above within 6 months of hire. Denominator Total number of DSPs required to complete the training within 6 months of hire that were reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = 95% Confidence Level with a +/- margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of newly employed Direct Support Professionals (DSPs) who complete the five (5) required modules before working with a participant. Numerator: Total number of newly employed DSPs who complete the required modules before working with a participant. Denominator: Total number of newly employed DSPs reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
% of DSPs who completed the Department's required training in Reportable Events & Adult Protective Services, Regulations Governing Behavioral Supports, Rights & Basic Protections 36 months after completing the initial DSP certification and every 36 months thereafter. (Numerator/Denominator listed in Main Optional Information Section *1 due to character count limit).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Completion of the Maine College of Direct Support is required for Direct Support Professionals supporting waiver participants. The OADS State Administrator for the College of Direct Support works with local/agency administrators to monitor the learning management system and ensure completion of all required modules prior to the provision of waiver services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Through formal and informal review, the OADS quality management unit reviews license/certification for all licensed and non-licensed providers of waiver services on an annual basis through on-site or desk review. In addition, the QM unit works with provider agencies on a quarterly basis to ensure that DSP waiver requirements are initially and continually met. Providers who fail to meet licensing or certification are referred to OADS senior management, Division of Licensing and Certification and Program Integrity. Additionally, the Operating Agency reports any concerns about training to the Office of MaineCare Services Program Integrity Unit.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Licensure, certification, or training is verified upon enrollment and when any license, certification or training is up for renewal.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☒ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Any combination of Home Support, Shared Living, and Community Support may not exceed $84,689.28 annually.

Services authorized at provider-owned or controlled residential settings or disability-specific settings cannot be delivered out of state. Other services, such as those that address personal assistance needs, may be delivered out of state, to Participants who travel to another state to visit family members or for other purposes. Authorizations for services to be provided out of state will not exceed sixty (60) days of service within a given fiscal year and will not exceed sixty (60) days within any six (6) month period except as provided in 42 C.F.R. §431.52(b). When services are delivered out of state, they are subject to the same monitoring and documentation requirements as if they were delivered in-state.

Because legislation requires that Participants do not lose hours of service when individual rates are increased, the combined monetary limits are reviewed regularly and may be changed accordingly. In this amendment, the combined annual limit for Home Support, Shared Living, and Community Support is increased to $84,689.28 due to individual rate increases for each service. The Department ensures that individual Participants will not experience a reduction in hours of services authorized in the PCSP if a Participant's utilization increases to the authorized amount resulting in the Participant's services to exceed the combined cost limit.

Additionally, exceptions to this limit are made periodically for Participants who need 2-to-1 staffing for health and safety reasons. Case managers work with Participants to make sure that Home Support, Shared Living, Community Support or any combination of these do not exceed the limit.

OADS staff works with Case Managers to explore other services to meet the Participant's needs including state plan services, state funded programs, and/or informal supports.

Any limit on services needed by a Participant is discussed at the planning meeting and the plan is written accordingly. When the limit is changed in the waiver and the MaineCare rule, information is available through the public comment process, and through information updates provided to case managers.

A Participant is informed of the individual budget limit and any specific service limits during the development of the person-centered plan. The service plan development process includes identifying the Participant's health and welfare needs and identifying the mix of natural and paid supports that can be utilized to ensure the Participant's health and welfare. A Participant who requires an exception to a service limit due to health or welfare may request an exception through the "Request for Exceptions Process" detailed in Section 29, Ch II rule of the MBM. The PCSP must outline the specific needs associated with the Participant's request for exception. For example, a Participant may outline the number of hours needed above the cap, or limit and fully describe the health and welfare issues. Any exception must be tied to specific needs and include the length of time for which the exception is requested and the agency's efforts to meet the needs within available limits or caps.

The Participant or guardian (as applicable) reviews the services and service limits available within the waiver during the person-centered planning process. Case managers have a spreadsheet "calculator" to determine whether proposed services are within limits and/or budget caps and to drive current and future discussions with Participants regarding waiver services. The operating agency reviews services as proposed/delivered by the provider agency or targeted case manager as applicable.

When the Operating Agency receives a request that is over approved budget or service limits, they notify the case manager, providing an opportunity to gather further information to guide decision making based upon promulgated regulation. Any decision which results in a reduction or termination is followed by formal written notification to the Participant or guardian (as applicable). The notice is mailed certified, return-receipt and includes information regarding appeal rights.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1. The State is transitioning Participants and providers over to the new HCBS rules using the timelines noted in the Approved Statewide Transition Plan. The state has modified its regulations to embed the regulatory criteria for HCBS compliance into ongoing operations to ensure assessment of all providers for initial compliance and a process for conducting ongoing monitoring for continued compliance. All providers subject to the transition to compliance process has provider-level remediation plans in place and monitored by the State.

2. Please see Transition Plan for detail on remediation and assurances on settings.

3. In January 2022, Maine promulgated Ch. 1, Section 6, Global HCBS Waiver Person Centered Planning and Settings Rule to ensure compliance with federal HCB Settings requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Service Plan (PCSP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Case Managers working for agencies certified pursuant to 14-197 C.M.R., Chapter 10, Certification Requirements for Agencies Seeking to Provide Community Based Targeted Case Management for Adults with Intellectual Disabilities and Autism, are responsible for the development of the Person-Centered Service Plan (PCSP) in conjunction with the Participant's planning team. Minimum qualifications of a Case Manager are outlined below:

1. A case manager must have a minimum of a bachelor's degree from an accredited four (4) year institution of higher learning with a specialization in psychology, behavioral health, social work, special education, counseling, rehabilitation, nursing, or a closely related field and one (1) year experience in one of the areas listed above.

2. Individuals who are between the ages of 18-21 have the choice to access case management services through an adult Case Manager (as identified in #1 above), or a children's Case Manager or Health Home Coordinator.

A) Children's Case Manager requirements are outlined in the MaineCare Benefits Manual Section 13, Chapter II, Targeted Case Management and include:

a. A bachelor's degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field, OR
b. A master's degree in social work, education, psychology, counseling, nursing or closely related field from an accredited graduate school, OR
c. A bachelor's degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience.

B) Health Home Coordinator requirements for Participants with Serious Emotional Disturbance (SED) are outlined in the MaineCare Benefits Manual Chapter Section 92, II, Behavioral Health Homes Services and include:

a) A bachelor's degree from an accredited four (4) year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR
b) A bachelor's degree from an accredited four (4) year educational institution in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience; OR
c) A master's degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school; OR
d) The candidate has been employed since August 1, 2009, as a case manager providing services under Chapter II, Section 13 of the MaineCare Benefits Manual.

3. Individuals who are dually eligible as an adult with Intellectual Disability/Autism and who experience Mental Illness, have a choice to receive adult Case Management from a Case Manager defined and outlined in #1 above, from a Community Integration Worker (see below), from a Health Home Coordinator (see below), or from a Human Services Caseworker/Social Worker (see below).

A) Community Integration Services qualifications are outlined in MBM Ch II, Section 17, Chapter II, Community Support Services and include:
a) The candidate has received certification as a Mental Health Rehabilitation Technician/Community (MHRT/C).

B) Health Home Coordinator for Participants with Serious Emotional Disturbance (SED) qualifications are outlined in MBM Chapter II, Section 92, Behavioral Health Homes Services and include:

a) A bachelor's degree from an accredited four (4) year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR
b) A bachelor's degree from an accredited four (4) year educational institution
in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience; OR
c) A master's degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school; OR
d) The candidate has been employed since August 1, 2009, as a case manager providing services under Chapter II, Section 13 of the MaineCare Benefits Manual.

C) Health Home Coordinator for Participants with Serious and Persistent Mental Illness (SPMI) qualifications are outlined in MBM Chapter II, Section 92, Behavioral Health Homes Services and include: –

a) The candidate has received certification as a Mental Health Rehabilitation Technician/Community (MHRT/C).

4. State Employee- Human Services Caseworker

a) A master's degree from an accredited educational institution in Social Work, Psychology, Special Education, Child Development, or directly related human services field, OR
b) a bachelor's degree from an accredited educational institution in Social Work, Psychology, Special Education, Child Development, or directly related human services field and three (3) years' experience in providing support services and/or direct care to clients and families with developmental disabilities, or directly related human service field. WORK EXPERIENCE CANNOT BE SUBSTITUTED FOR EDUCATION REQUIREMENTS IN THIS CLASSIFICATION.

☒ **Social Worker**

Specify qualifications:

1. State Employee- Human Services Caseworker

a) A bachelor's degree from an accredited educational institution in Social Work/Social Welfare; OR
b) A bachelor's degree in a related social service/social welfare/social work area which includes at least 12 courses in behavioral science, social science, or social work; AND
c) must have or be eligible for conditional or full licensure as a Licensed Social Worker (LSW) as determined by the Maine State Board of Social Worker Licensure.
d) Licensing requirements include; full or conditional licensure as a Licensed Social Worker (LSW) as issued by the Maine State Board of Social Worker Licensure.

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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.

a. Case Managers shall meet with the Participant prior to each planning meeting to provide the information that the individual needs so that they can lead the planning process as much as possible, make informed choices and decisions, and ensure conflict-free planning. The planning process must reflect the Participant's cultural preferences and provide information in plain language that is accessible to the Participant and, when applicable, his or her legal representative. The case manager will also document if the Participant considered other settings, including non-disability specific settings.

In addition to the above, and according to Title 34-B §5466, Participants are entitled to have access to an advocate. Providers must ensure Participants are aware of this entitlement prior to the planning meeting to allow for inclusion of an advocate when the Participant so chooses.

b. The Participant will determine the composition of the Planning Team. Additionally, the Participant's guardian should have a participatory role, as defined by the Participant, unless state law confers decision-making authority to the legal guardian.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Who develops the plan, participants and timing of the plan:
The Case Manager develops and drafts the Person Centered Service Plan (PCSP). The initial PCSP is developed within thirty days of entering Case Management services and is redeveloped by the planning team at least annually.
Pursuant to MBM, Section 13, Ch. II, Targeted Case Management, "Re-evaluation of the individual plan of care must occur as a change in the Participant's needs occurs or at a minimum every ninety (90) days." This 90-day review may be completed by the Case Manager.

(b) Assessments:
A comprehensive assessment (psycho-social) and the BMS99 (or the Department's current approved assessment) are completed annually to inform and support the development of the PCSP. The comprehensive assessment and BMS99 address the Participant's strengths, needs, and expressed preferences which are incorporated in his/her PCSP. The assessments identify and summarize the Participant's medical, mental health, daily living skills, treatments/services/needs etc. as appropriate for the team's review.

(c) How the participant is informed of services under the waiver:
Prior to waiver enrollment, the case manager discusses with the Participant and guardian (if applicable) what the Participant wants and needs regarding services and supports, as well as what to expect. The case manager explores potential services offered through the waiver, Medicaid State Plan, and other community resources and natural supports that might meet the Participant's needs. The Case Manager describes all services available, discusses options for qualified providers of the services, and emphasizes Participant choice. The case manager reviews this information at least annually during the annual planning process and during the service monitoring process throughout the year.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:
In accordance with Maine's Global HCBS Rule (MBM, Chapter 1, Section 6), the PCSP must reflect the services and supports that are important for the Participant to meet the needs identified through an assessment of functional need, as well as what is important to the Participant with regard to preferences for the delivery of such services and supports.
In order for the Plan to be authorized and meets the Participant's identified needs and goals, the Plan must document approval by: (1) the Participant and guardian (as applicable), (2) the Case Manager, and (3) the individuals and providers responsible for the plan's implementation.

(e) How waiver and other services are coordinated:
The Case Manager is the lead in assisting the Participant and guardian (if applicable) in coordinating the services through the PCSP process. The planning process identifies natural supports, waiver supports, Medicaid State Plan and other generic community supports regardless of funding source. The PCSP documents all identified services and the Case Manager provides continuous and ongoing coordination and monitoring of service implementation.

Following the planning meeting, the Case Manager enters the PCSP in a web based application as it was discussed and agreed upon during the planning team meeting including the amount, type, frequency, name of service provider, service funding source, and start/end dates of the service.

As noted, the PCSP identifies the providers selected by the Participant to deliver services. In accordance with the PCSP, each chosen waiver provider, with the Participant and guardian (if applicable), develops a service plan that specifies how services will be implemented and delivered to support the Participant in meeting goals identified within the PCSP. The service provider then acts in a clerical manner and enters (or attaches) the service plan into the PCSP within the web-based application noted above. The Case Manager independently verifies and documents agreement with the Participant and guardian (if applicable) that the service plan is consistent with the needs and desires of the Participant.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

As previously noted, the PCSP lists the waiver services that are authorized for the Participant including the amount, type, frequency, name of service provider, service funding source, and start/end dates of the service as well the natural/generic supports. During the PCSP planning meeting, the team discusses and documents the responsibilities for service delivery and support for each member of the Participant's team.

The Case Manager, Participant and guardian (if applicable) are responsible for the day-to-day oversight, monitoring, and implementation of the PCSP. Minimally, and unless otherwise specified in the PCSP, the Case Manager meets monthly

with the Participant to review the PCSP implementation. Additionally, the Case Manager will conduct more in-depth monitoring through home and program visits every six months.

(g) How and when the plan is updated/changes to the plan

The PCSP must be reviewed, and revised upon reassessment of functional need as required by 42 C.F.R. § 441.365(e), at least every 12 months, when the Participant's circumstances or needs change significantly, or at the request of the Participant or guardian (if applicable).

Changes in circumstance or need may include, but are not limited to: changes relating to the Participant's physical, social, behavioral, medical, communication, or psychological needs; when the Participant has made significant progress toward his or her goals; or when the Participant is moving locations where services are received.

The Case Manager must reconvene the Planning Team to revise and update the PCSP. Notably, for times when the Participant is moving locations, planning meetings must be held both prior to and thirty (30) days subsequent to the planned move of a Participant to a new service location in order to coordinate and to evaluate the Participant's satisfaction with the change.

The revised PCSP, reflective of all changes, must be approved by the Participant, guardian (if applicable), case manager, and any providers responsible for implementing the changes within the PCSP.

Additionally, the Case Manager must review the PCSP every 90 days as part of monitoring of the services and plan, and in accordance with MBM, Ch II, Section 13, Targeted Case Management.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The comprehensive assessment identifies potential risks for the Participant across all life domains and settings including but not limited to cognitive decision making, mental health / behavioral health needs, self-harm, harm to others, risk of victimization, criminal behavior/legal issues, access to health care, sleep/nutrition, family issues, and housing/ environmental safety.

The PCSP documents the Participant's risks and needs as well as interventions and supports to mitigate any risks identified through the comprehensive assessment process. Additionally, the PCSP planning team reviews any Reportable Events involving the Participant over the past 12 months (including remediation, action steps, and outcomes). The PCSP must address rights restrictions and behavioral support interventions pursuant to 14-197 C.M.R. ch. 5. The plan must document less intrusive methods and/or other approaches to mitigate risks in the immediate and over time.

Positive Support plans and any behavior management plans are attached to the PCSP and approved by the Review Committee consisting of participants from DHHS, the Maine Developmental Services Oversight and Advisory Board (OAB), and Disability Rights Maine (DRM).

The planning team may develop a preventative back-up plan if crisis services are involved. DHHS has district crisis teams able to respond to emergency situations on a 24/7 basis. If a district crisis team intervenes three or more times within a two-week period, it will trigger an Individual Support Team meeting, focusing on the crisis situation and developing an interim plan or altering the current plan to reduce the risk to the Participant and prevent continued crisis involvement.

Additionally, provider issues are identified and addressed through the reportable events system including investigations of abuse, neglect, and exploitation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Choice of providers is assured by the Case Manager during the PCSP process. Prior to the planning team meeting, the Case Manager meets with the Participant and guardian (if applicable) to review the options available for qualified providers of services in Maine. Additionally, choice for the Participant is assured by two complementary processes:

The Office of Aging and Disability Services (OADS) promotes individual choice through a "vendor call" process. Once a Participant 's team has made a service recommendation, the need is made known to all potential providers. A brief de-personalized description of the Participant 's needed services and any individualized specifications are sent to all providers electronically. Providers that express interest and have capacity to potentially support the Participant, respond affirmatively and contact information is provided to the Participant and guardian (if applicable) and/or case manager for follow up.

OADS also maintains a provider directory on its website for Participants, guardians, and others to access. Listings are voluntary and must be initiated by the provider. The OADS Resource Development Manager reviews the provider list annually and removes non-qualified providers from the list. OADS facilitates the posting of qualified providers. The directory is located at: http://www.maine.gov/dhhs/oads/provider/developmental-services/directory/index.html.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Office of MaineCare Services (OMS) MaineCare as the State Medicaid Agency delegates authority to approve individual service plans the Office of Aging and Disability Services (OADS), the Operating Agency.

The PCSP lists the Participant’s waiver services based on an assessment of functional need. It also lists generic services and natural supports the Participant receives. OADS reviews and authorizes necessary waiver services, up to prescribed service caps.

Additionally, OADS staff conduct a retrospective quality review of the Person Centered Plans (PCSP) as part of the certification requirements under 14-197 C.M.R ch. 10. The quality review evaluates whether PCSPs are being conducted consistent with the Department’s standards outlined in OADS Person-Centered Service Planning Process-Instruction Manual.

The Resource Coordinators review services and limits within the person-centered plan and approve the limits both annually and when there is any change in service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**

◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☒ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) Case managers are responsible for monitoring the delivery and implementation of services and supports identified within the PCSP including ensuring the health, welfare and safety of the individual. Additionally, State Resource Coordinators review plans at least annually, for level of care renewal, and whenever a change in waiver services is proposed/requested.

(b) The Case Manager conducts regular, focused reviews of the Participant's needs and goals as identified and documented within the PCSP. The Case Manager supports the Participant in obtaining and maintaining all waiver and non-waiver services identified in the plan.

The Case Manager makes frequent checks with the Participant and his/her guardian (as applicable) to discuss if the back-up plan is working and makes modifications as needed until the full need is met/provider is identified. Case Managers use multiple assessment tools such as the home visit tool and reportable events system to ensure the health, safety and welfare of the Participant. Upon identification of a service need, the Case Manager assists the Participant in a vendor search to solicit interested, qualified providers. Through the on-going case management process, the Case Manager and other members of the Participant's service team address and coordinate a Participant's access to non-waiver services in the service plan including health services. The State maintains the assessment information, case management contacts, monthly notes, participant medical information, to be aggregated at any point in time. If a problem is identified in relation to the Participant, the Case Manager will assess the acuity and respond accordingly.

(c) Unless otherwise specified in the PCSP, Case Managers make at least monthly contact with Participants to review the recommendations and progress toward meeting identified goals included in the PCSP.

Identified problems can be addressed through the state's Grievance Process and through MaineCare appeal when services have been reduced, denied or terminated. The operating agency's data and compliance team collects data and review of the PCSP.

Quarterly, the Compliance Team, selects a random sample of current PCSPs for review. This review ensures that all assessed needs (including health and safety risks) and personal goals have been addressed through waiver services or other means and that interim plans are in place for all unmet needs. Results of the analysis are shared with the Waiver Manager and the State Medicaid Agency.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participant service plans that address participant's goals as indicated in the initial and/or annual assessment. Numerator: Total number of participant service plans that address participants' goals as indicated in the initial and/or annual assessment. Denominator: Total number of participant service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System (EIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participant service plans that address all assessed needs including health and safety risks. Numerator: Total number of participant service plans that address all assessed needs including health and safety risks. Denominator: Total number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System (EIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participant service plans that were revised due to change in needs of the participant. Numerator: Number of participant service plans that were revised due to changing needs of the participant. Denominator: Total number of participant service plans reviewed that required a revision due to change in participants' needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System (EIS)

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participant service plans that were updated on or before the participant's annual review date. Numerator: Total number of all participant service plans that were updated on or before the participant's annual review date. Denominator: Total number of participant service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System (EIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participants who receive services in duration and frequency in accordance with their person-centered plan. Numerator: Total number of participants who received the services in duration and frequency in accordance with their person-centered plan. Denominator: Total number of person-centered plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participants receiving the scope and amount of services as described in their person-centered plan. Numerator: Total number of participants receiving the scope and amount of services described in their person-centered plan. Denominator: Total number of participant person-centered plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Percent of participants receiving the type of services described in their person-centered plan. Numerator: Total number of all participants with a paid claim for service type as described in their person-centered plan. Denominator: Total number of participant person-centered plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participants with signed evidence of choice of services and providers. Numerator: Number of participants with signed evidence of choice of services and providers. Denominator: Total number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

When individual problems are discovered, they are reported to the appropriate staff at OADS and OMS, including senior management, as necessary. OADS may conduct audits as a result of any problems that arise. Additionally, the Compliance Team, selects a random sample of current PCSPs for review each quarter. This review ensures that all assessed needs (including health and safety risks) and personal goals have been addressed through waiver services or other means and that interim plans are in place for all unmet needs. Results of the analysis are shared with the Waiver Manager and the State Medicaid Agency.
Transportation is provided through a brokerage system in Maine, via a 1915(b) waiver (Me.19). The transportation broker collects extensive data on performance measures for reporting on the 1915(b) waiver. The data will be provided to the 1915(c) waiver administrators for inclusion in the quality review process on an annual basis. Office of MaineCare Services and the program offices responsible for 1915(c) waiver administration (i.e., Program Integrity and Fiancial Accountability) will work together to discover, identify and remediate any problems as they arise.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Annually, the quality management unit pulls a representative sample of client records to ensure that there is evidence to support that all participants have a signed Freedom of Choice; that each plan addresses the participant's identified needs for waiver services, health care and other ancillary services in accordance with their expressed preferences and goals; that services are delivered in the type, scope, amount, duration and frequency as specified in the service plan; and that significant changes in the needs of the participant have triggered a modification of the service plan. This information is tracked; any deficiencies are noted and reported to the Developmental Disabilities Program for corrective action. Information is also shared with the SMA.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: every 6 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The State will use the Fiscal Employer Agency (FEA) Employer Authority Model with budget authority for the delivery of self-directed services when the Participant elects self-direction and provided there is sufficient support available to the Participant as determined through the person-centered service (PCSP) planning process. The Participant or authorized Representative functions as the employing authority and may hire, train, supervise and discharge their own workers. The Participant chooses a Fiscal Intermediary (FI) to provide Financial Management Services (FMS) for both budget authority and employer authority. FMS is a minimum monthly service.

Additionally, depending upon which arrangement best meets the needs of the individual as detailed within the PCSP, Participants have budget authority to manage and allocate funds according to clearly defined parameters set forth in a "fixed budget" or in a "flexible budget".

A fixed budget includes state-specified, direct vendor-purchased services for which the Participant has only employer authority. The chosen FI pays the vendor who procures or delivers the service up to the monetary value of the authorized service. There is no flexibility in how the fixed budget is spent outside of the prior authorized amount.

A flexible budget includes state-specified services in which the Participant has both employer authority and budget authority. The flexible budget arrangement allows the Participant to exercise control over how their budget is spent on the services and supports needed to live in the community. The Participant can determine the wages of DSW's as well as the types of allowable and necessary goods and services under this flexible budget arrangement.

The process for developing the PCSP will not be different from that of traditional waiver services and must comply with the Global Person-Centered Planning and Settings Rule, Ch 1, Section 6 of the MBM.

The Participant's Planning Team will meet and develop the PCSP based on identified needs, expressed desires and preferences. The Case Manager will discuss the option of self-directed services and provide information about which services can be self-directed. Initially and annually thereafter, the case manager will utilize standardized written or electronic media materials about self-direction to inform the Participant and guardian about available self-directed opportunities.

The PCSP process will also determine if the Participant, not subject to full guardianship, can self-direct independently or if they require an authorized representative. Case managers will use a Department approved questionnaire and assessment tool to support the determination.

The Case Manager will submit the PCSP and a service authorization request to the Department for approval based on the Participant's documented goals and needs that specifies the units of service assigned to each identified waiver service. The authorization request can include both traditional and self-directed waiver services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the**

home of a family member.

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Shared Living arrangements

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

1) Participants under full guardianship must have a representative acting on their behalf.

2) Participants must access Supports Brokerage and Financial Management Services.

3) The PCSP process will support the Participant to clarify and weigh options for self-direction including completion of a tool that will identify the need for a representative.

4) Participants who wish to participate in Self-Direction, but who are unable or unwilling to function as the employing authority, may delegate related responsibilities to an authorized representative. The representative assumes all responsibilities as the employer on behalf of the Participant but may not be employed as a direct worker.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Case Manager will discuss the option of self-directed services and provide information about which services can be self-directed. Initially and annually thereafter, the Case Manager will utilize standardized written or electronic media materials about self-direction to inform the Participant and guardian about available self-directed opportunities.

During the planning phase of PCSP development, the Case Manager, at a minimum, will provide information about the benefits and potential risks associated with self-direction along with information about the Participant's responsibilities when they elect to direct their services.

To promote informed decision making, the Case Manager must provide information regarding opportunities for self-direction during the PCSP planning process. This will allow the Participant sufficient time to weigh the pros and cons of self-direction and seek additional information, if necessary, before electing this option.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

If a Participant requires or has selected a Representative to direct services on their behalf, the Representative may not also be paid to provide care to the Participant. When the guardian is also acting as the Representative on behalf of the Participant, the guardian may not also deliver direct support to the Participant.

A Participant under guardianship, can act as the employer of record, in name only for tax purposes, and have a Representative (the guardian or a person the guardian appoints) complete the employer duties on their behalf (including signing timesheets and managing employer responsibilities).

Involved service providers must report to the Department when there is an allegation, assertion, or indication that any of the following have occurred with respect to a Participant: Abuse, neglect, exploitation, unexplained death or a rights violation by an employee of or contractor, consultant, or volunteer for any program.

Involved service providers must report allegations of abuse, neglect, exploitation, or unexplained death to Adult Protective Services and other entities such as law enforcement as applicable.

Involved service providers must report complaints involving rights violations via the Department's Reportable Events reporting system.

Involved service providers must report incidents of a serious health and safety events such as an admission or assessment at an Emergency Department or Hospital via the Department's Reportable Events reporting system.

During the initial PCSP planning meeting, and annually thereafter, the Case Manager must discuss and provide information in writing to the Participant, guardian, and Support Broker regarding the procedures and contact information for filing a complaint or a grievance.

The Case Manager, Support Broker and FI must report to the Office of MaineCare Services Program Integrity Unit any complaints involving financial abuse, waste and fraud involving the Participant, guardian, Representative, or any entity funded through a self-directed budget. The FI must notify the Case Manager, and Office of Aging and Disability Services, which will result in a review and plan (as needed) for the Participant's immediate health and safety as a result of these allegations. At a minimum, the FI is required to provide information and education on financial abuse, waste and fraud to the Participant and Representative (as applicable) and Support Broker on an annual basis for reporting to Program Integrity.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Assistive Technology	☒	☐
Home Support-1/4 hour	☒	☒
Financial Management Services	☒	☐
Home Accessibility Adaptations	☒	☐
Community Support	☐	☒
Individual Goods and Services	☐	☒
Supports Brokerage	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services (FMS)

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

At a minimum, a Participant who wishes to self-direct must receive Financial Management Services and Supports Brokerage. As part of the PCSP process, the case manager will discuss Self-Direction to include a discussion and written information (as requested) regarding the availability of providers of FMS and Supports Brokerage.

Any willing and qualified provider may enroll as an FMS agency providing FI services. DHHS or its Authorized Entity requires agencies to provide high quality services that, at a minimum, meet the expectations of the Participants who utilize those services. Entities must be approved by OADS and enrolled in MaineCare in accordance with regulations outlined in Ch II, Section 29 and Ch I, Section 1 of the MaineCare Benefits Manual.

Prospective FMS agencies must meet expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, quality management, and compliance with all HCBS Settings requirements. OADS may authorize agencies to deliver FMS after an application, along with supporting documentation, has been submitted for review and approval.

As part of the provider application process, in addition to the above, prospective FMS entities must demonstrate a proven ability to provide customer service to Participants and the Department. This includes, but is not limited to, the use of an electronic platform offering electronic communication ensuring effective and privacy-protected exchanges regarding health information or other program and/or Participant-specific information necessary for the Participant to engage in and access Self-Directed Services.

Finally, the FMS provider must comply with Federal Internal Revenue Service Codes and procedures in matters related to the employment of support workers.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment for the FMS is through MMIS. The FMS is paid a set per person/per month rate for their fiscal management services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

The FI assists with criminal background check of workers, including an Office of Inspector General (OIG) check.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☒ **Other services and supports**

Specify:

The FI must ensure the Employer (Participant or Representative) is aware that they may negotiate a stipend or wage adjustment to assist the employee with costs of procuring their own benefits, such as healthcare coverage. The Department does not require employers to offer health insurance coverage.

Payments for services must not be made directly to a Participant, either to reimburse for expenses incurred or enable the Participant to directly pay a service provider or employee.

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☒ **Other**

Specify:

Demonstrate evidence of satisfactory customer service to Participants including but not limited to options for electronic communication.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or

entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS agency is subject to the current processes for oversight, monitoring, and financial integrity assurances enumerated in Appendix I-1 of this this waiver amendment, including integrity at the individual level and overall MaineCare integrity.

As noted, agency billing for delivered services requires medical eligibility, financial eligibility, the PCSP and the service authorization. Claims are rejected for any date where both medical and financial eligibility are not in place or when the PA does not match the individual classification code assigned.

The state Medicaid program is subject to an annual Single State Audit by the Office of the State Auditor on all programs by a State auditor and the Program Integrity Unit, a separate agency from the Office of the State Auditor, also conducts continuous and ongoing audits triggered by anomalies related to claims as well as complaints/inquiries made directly to the PIU.

The Operating Agency also oversees and monitors FMS entities through review of quarterly complaint logs, reports, annual surveys, as well as ad hoc reviews and inquiries based on complaint. The annual survey to Participants who choose self-direction includes questions related to experiences of the Participant with the FMS.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

During the planning phase of PCSP development and annually thereafter, the Case Manager, at a minimum, will provide information about the benefits and potential liabilities associated with self-direction along with information about the Member's responsibilities when they elect to direct their services.

Information on self-direction must be provided on a timely basis to permit informed decision making by the Member allowing sufficient time for the Member to weigh the pros and cons of self-direction and obtain additional information as necessary before electing this option.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Work Support-Group	☐
Assistive Technology	☐
Home Support-Remote Support	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Work Support-Individual	☐
Home Support-1/4 hour	☐
Respite	☐
Shared Living Services	☐
Employment Specialist Services	☐
Financial Management Services	☒
Home Accessibility Adaptations	☐
Career Planning	☐
Community Support	☐
Non-Medical Transportation	☐
Individual Goods and Services	☐
Supports Brokerage	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

In accordance with Title 34-B §5466, Participants are entitled to have access to an advocate. Case Managers must ensure Participants are aware of this entitlement prior to the planning meeting to allow for inclusion of an advocate if the Participants so chooses.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a Participant or a representative chooses to stop self-direction, the case manager or FI will assist the Participant in accessing self-direction through the appointment of another representative or accessing services through the traditional agency model, whichever is appropriate. All efforts will be made to transition the person without any gap in service.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The Department may deny or terminate a Participant's ability to utilize Self-Direction, if it determines that the Participant, or the Participant's Representative:

A. Has engaged in fraud, waste, or abuse, including submitting time sheets inconsistent with authorized services or do not accurately reflect services delivered to the Participant;

B. Provides fraudulent or repeatedly inaccurate information to the Department, Case Manager, Support Broker or Fiscal Intermediary in connection with obtaining or receiving services;

C. Refuses to comply with any of the requirements for Self-Direction;

D. Engages in course of conduct or performs an act deemed improper, abuse of the MaineCare Program, or continues such conduct following notification that said conduct should cease;

E. Demonstrates any other action having a direct bearing on the Participant's ability to adhere to the requirements for self-direction or to be fiscally responsible to the program for care, services or supplies to be furnished under the program, including actions by persons affiliated with the Participant; or

F. Demonstrates any other action which may affect the effective and efficient administration of the program.

Additionally, a Participant who overutilizes and schedules employees more hours than the authorized budget can cover, may receive a written warning from the Department. The written warning may include a requirement that the Participant receive increased assistance from the Support Broker to remedy the contributing factors leading to overutilization. Upon the third occurrence within a twelve-month period, the Department may issue a notice of suspension or termination of the option to self-direct.

Prior to, and as part of denying or terminating the Participant's ability to elect Self-Direction, the Case Manager will support the Participant to transition to another Representative or to Provider-Managed services, as appropriate.

Pursuant to Ch I of the MBM, the Department will provide written notice of the denial or termination including the Participant's right to appeal the denial or termination.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		0
Year 2		0
Year 3		150
Year 4		150
Year 5		150

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☒ **Other**

Specify:

In order to fulfill their employer responsibilities, the Participant and/or Representative, must successfully complete skills training. The FI will deliver skills training to the Participant and/or Representative in advance of conducting the employer functions including recruiting, hiring, orienting and training, supervising, or discharging employees.

Providers must ensure and retain documentation that staff members receive Department-sponsored training listed below within six (6) months of being hired and every thirty-six (36) months thereafter.

Required trainings:
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).

In collaboration with the FI, the Participant or Representative, as applicable, will recruit and hire prospective staff once the FI has verified that the employee is eligible for hire. The Participant and/or Representative must also set the standards for orienting and training newly hired employees to assure that the employee meets the individualized needs of the Participant and demonstrates competency in all required tasks. The Participant and/or Representative must maintain employee orientation and training documentation such as: CPR and First Aid certification cards, as well as a record of disability-related training for each staff member.

Direct Support Workers may be friends or family of the Participant, including their spouse or the legal guardian. If a Participant requires or has selected a Representative to direct services on their behalf, the Representative may not also be paid to provide care to the Participant. When a Representative is directing a Participant 's services, the Participant's guardian may not be paid to provide care to the Participant.

The Participant, with the assistance of a Support Broker, will have the ability to hire staff that meet provider qualifications as verified by the FI, establish the rate to be paid, use budgeted dollars to pay for additional hours of service if necessary, and utilize the Individual Goods and Services as outlined in the service description.

The staff member's rate of pay must be within the minimum wage and no more than two hundred (200) percent of the minimum wage set by the State of Local Authority.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the state's established limits**
- ☐ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The process for developing the overall budget for the Participant who has chosen Self-Direction does not differ from the budget development process as described in this rule. The Case Manager will develop a service authorization with units of service assigned to each waiver service based on the goals and needs identified in the PCSP. The Participant's annual budget is calculated by converting the units of service to a total dollar amount. The Case Manager submits the Participant's budget to the Department for final approval and communicates final approval to the Member, the Representative (as applicable), and the Support Broker. Budgets that do not include the costs of Financial Management Services and Support Brokerage will not be approved.

The Participant's Self-Directed Services, when converted to a dollar amount, must sufficiently meet the budget requirements for payment of Financial Management Services and Supports Brokerage. The Case Manager deducts the monthly expenditures for mandatory FMS (per member/per month reimbursement rate) and Supports Brokerage (quarter-hour fee-for-service, monthly minimum reimbursement rate) Services. The Participant and/or Representative, in collaboration with the Support Broker and FI, will develop a spending plan from the remaining budget amount using the Department-approved Spending Plan Tool. Based on the service authorizations and approved individual budget, the Participant may choose any combination of traditional, Provider-Managed Services and/or Self-Directed Services, determine staff wages, and plan for the use of conserved funds/Good and Services.

Any budget dollars not subsumed by authorized units; or saved through wage negotiations or tax changes can be applied to the Individual Goods and Services.

The Support Broker ensures the Participant's self-directed services meet the minimum health and well-being needs as identified through the PCSP planning process.

A Participant may not "cash out" their services for the sole purpose of generating or increasing the available funds for Individual Goods and Services.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget

amount.

The Case Manager shall submit the Participant's budget to the Department for final approval and communicate final approval to the Participant/authorized representative and the Support Broker.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

With full budget authority, the Participant is allowed to modify the frequency and amount of currently approved services within the established annual budget amount without prior approval or updates to the Service Implementation Plan or the PCSP. The FI will ensure the changes are allowed and fall within the Participant's authorized annual budget, and reflect the changes in the established budget on record.

Examples of allowable changes without prior approval may include adjusting hours of direct support services on any given day/week to meet individual needs, accessing a different vendor (i.e. a transportation company such as Uber or Lyft) under the Goods and Services budget limit for an approved purchase identified in the Participant's plan, or changing allowable Goods and Services when the Participant's need for additional or alternate items/equipment/services dictate.

Alternately, both the SIP and PCSP must be updated and signed when the Participant and/or Representative wishes to modify the budget by adding new waiver services or increasing hours of service that would require a new or updated authorization for services. The Case Manager, in collaboration with the Representative (when applicable), Support Broker, and FI, will support the Participant to reflect these changes within the PCSP and secure necessary authorizations.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Supports Broker, Case Manager and Fiscal Intermediary will work in conjunction to ensure the PCSP identifies the mix of services (employment, State Plan, Provider-Managed Services and Self-Directed Services) and natural supports to maximize Participant' flexible individual budget of Self-Directed Services.

A Participant must use personal funds or access another funding source (through this benefit or the state plan) to purchase services, equipment, or supplies when available. When the Participant does not have personal funds or funding through another source, the Participant may access funds available in the Participant-directed budget. The Participant and/or Representative, and FI must attest, using the Department-approved form, that the selected Goods and Services fall within the federal requirements for the same.

A Participant may not "cash out" their services for the sole purpose of generating or increasing the available funds for Individual Goods and Services.

A Participant may not rollover unspent Goods and Services funds across fiscal years.

A Participant may not exceed authorized individual budget limits unless the Participant has received an approved Request for Exceptions or Americans with Disabilities Act Accommodation.

A Participant who overutilizes and schedules employees more hours than the authorized budget can cover, may receive a written warning from the Department. The written warning may include a requirement to receive increased assistance from the Support Broker to remedy the contributing factors leading to overutilization. Upon the third occurrence within a twelve-month period, the Department may issue a notice of suspension or termination of the option to self-direct.

The FI or Supports Broker will review monthly expenditures and can provide reports and information to the Participant as needed regarding the Participant's real-time account balance of available funds, or use of funds over time, etc.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When Intake and Eligibility Specialists meet with individuals who may be applying for the waiver, they provide written information on Grievance and Appeals processes which include how to request a hearing. Case Managers provide the same written information, and document the same in the PCSP, to Participants and/or Guardians (as applicable) during annual service planning. All written notices that reduce, terminate, or deny services to any MaineCare Member include written information on Grievances and Appeals processes.

The State Medicaid Agency mails or delivers in person written notice when there has been a denial, termination, suspension or reduction of eligibility for MaineCare or covered services.

Specific information that must be in this notice includes:
1. A statement of the intended action;
2. An explanation of the reasons for the action, as well as a specific citation to the underlying state or federal regulations that support the action;
3. A statement that the Participant has a right to a hearing;
4. An explanation of exactly how to obtain a hearing;
5. A statement that a Participant may be represented by legal counsel, relatives, friends or a spokesperson and a list of selected legal service providers available to assist the Participant in arranging for legal counsel;
6. The name and telephone number of the person who should be contacted, should the Participant have questions regarding the notice; and
7. An explanation of the circumstances under which medical eligibility for MaineCare or covered services are continued if a hearing is requested.

Additionally, Notices requesting fair hearings are kept in the Medicaid Agency's Health Care Management Unit. The following is copied from Chapter 1, MaineCare Benefits Manual, General Administrative Policies and Procedures:

1.24-3 Procedure to Request an Administrative Hearing

A Participant may request an administrative hearing if he or she is aggrieved by any Departmental action that may deny, terminate, reduce, or suspend services provided by MaineCare. The Department may respond to a series of individual requests for a hearing by conducting a single group hearing. Participants must follow the procedures described in this section when requesting an administrative hearing.

A. A Participant or his/her authorized representative may request an administrative hearing.
B. Unless otherwise specified in this Chapter, a request for an administrative hearing must be received within sixty (60) calendar days of the date of written notification to the Participant of the action the Participant wishes to appeal.
C. Unless otherwise specified in this Manual, the request must be made by the Participant or his or her representative, in writing or verbally, to: MaineCare Member Services, P. O. Box 709, Augusta, ME 04332, or an address otherwise specified by the Department in a written notice, for a hearing with the Office of Administrative Hearings, Department of Health and Human Services. For the purposes of determining when a hearing was requested, the date of the hearing request shall be the date on which the request for a hearing is received by MaineCare Member Services. The date a verbal request for an administrative hearing is made is considered the date of request for the hearing. MaineCare Member Services may also request that a verbal request for an administrative hearing be followed up in writing, but may not delay or deny a request on the basis that a written follow-up has not been received. MaineCare Member Services shall send a fax or copy of all hearing requests to the Director of MaineCare Services, and to the Office of Administrative Hearings, within one (1) business day of receiving the request.
D. The hearing will be held in conformity with the Maine Administrative Procedure Act, 5 M.R.S.A. §8001 et. seq. and the Department's Administrative Hearings Regulations.
E. The hearing will be conducted at a time, date and place convenient to the parties and at the discretion of the Office of Administrative Hearings, and a preliminary notice will be given at least ten (10) calendar days, from the mailing date. Shorter notice may be given in order to comply with provisions of Section 1.14-1 governing denials of mental health services. When scheduling a hearing, there may be instances where the hearing officer may schedule the hearing at a location near the Participant or schedule the meeting via telephone or other interactive television system.
F. The Department and the Participant may be represented by others, including legal counsel and may have witnesses appear on
his or her behalf.
G. An impartial official will conduct the hearing.
H. The hearing officer on his or her own motion or at the request of either Department representatives or the Participant may request or subpoena persons to appear where that person can be expected to present testimony or documents relating to the issues at the hearing. The cost of the subpoena shall be borne by the Department.
I. When a medical assessment as defined in 42 CFR § 431.240 (3) (b) by a medical authority other than the one involved in the

decision under question is requested by the hearing officer or the Participant, and considered necessary by the hearing officer, it will be obtained at the Department's expense, and forwarded to the Participant or the Participant's representative and hearing officer allowing both parties to comment.
J. When the Participant, the Department, or an Authorized Agent of the Department requests a delay, the hearing officer may reschedule the hearing, after notice to both parties.
K. The decisions, rendered by the hearing authority, in the name of the Maine Department of Health and Human Services will be binding upon the Department, unless the Commissioner directs the hearing officer to make a proposed decision reserving final decision-making authorization to him or herself.
L. Any person who is dissatisfied with the hearing authority's decision has the right to judicial review under Maine Rules of Civil Procedure, Rule 80C.

Participants or their guardians may obtain additional information by writing or calling the Office of Administrative Hearings directly at the following address/telephone number: DHHHS, Office of Administrative Hearings
35 Anthony Ave 11 State House Station Augusta, ME 04333-0011/TEL: (207)624-5350, FAX: (207)287-8448,
TTY: 211(Hearing Impaired).

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

14-197 Chapter 8, Rule Describing Grievance Process for Persons with Intellectual Disabilities, Autism Spectrum Disorder, or Acquired Brain Injury describes the process by which persons with Intellectual Disabilities, autism spectrum disorder or acquired brain injury, who are receiving services or supports from the Department, can seek to enforce their rights or process their grievances. OADS operates the grievance process that is specific to persons with Intellectual Disabilities and Autism.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that

participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The nature of grievances/complaints addressed by the system are related the to the action or inaction of (1) the Department, or (2) an individual or agency providing services or supports to a Participant; or (3) a complaint which alleges a violation of the Participant's rights or the Participant's dissatisfaction with present services or supports.

The Department has established three levels of grievance resolution. Level I provides an opportunity for the Participant and his/her Case Manager to attempt to resolve the issue informally within a period of 8 business days. If the grievance cannot be resolved within 8 business days, the Case Manager shall refer for a Level II grievance with the OADS Program Administrator. The Level II grievance provides an opportunity for the OADS Program Administrator to participate and attempt to resolve the grievance within an additional 8 business days. If there is no resolution, the grievance proceeds to Level III grievance: a Formal Administrative Hearing. The Level III process allows the Participant ten (10) business to request a Formal Administrative Hearing. The Program Administrator will forward the appeal within five (5) business days to OADS Central Office. The Central Office will forward the appeal to the Administrative Hearings Unit within five (5) business days and shall request that a hearing be set within fifteen (15) business days of receipt of the request.

In addition to the grievance process above, when Participants are denied a service or receive a reduction in services, they are notified of their rights to request a fair hearing.

The Office of Aging and Disability Services maintains information regarding the grievance and fair hearings processes, including plain language documents regarding the grievance process and hyperlinks to the Fair Hearing process, on their public-facing website at the following link:
https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Grievance-Process_0.pdf

Additionally, in accordance with MBM, Section 29, Ch. II, all providers must ensure that notice of the grievance process outlined in 14-197 C.M.R. ch. 8, Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism, is regularly provided to Participant s served by the provider. Providing notice includes, at a minimum, ensuring that written notice of the grievance process is provided to the Participant 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.

The link to 14-197 Chapter 8 is https://www1.maine.gov/sos/cec/rules/14/197/197c008.docx

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines

for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In accordance with 14-197, C.M.R ch. 12, Reportable Events System and M.R.S. Title 34-B, ch 5, Intellectual Disabilities and Autism, all waiver service providers must inform OADS of certain events known as Reportable Events within one (1) business day of the event.

Further, 14-197 C.M.R. ch. 12, describes each incident type, reporting requirements, follow-up and timeliness of reporting. All reportable events are considered significant events and require reporting to OADS within one (1) business day. Reportable events include: death, suicide attempt, suicide threat, emergency department visit, planned or unplanned hospitalization, medication error, medical treatment outside of a hospital setting, serious injury, lost or missing individual, physical plant disaster, law enforcement intervention, transportation accident, physical assault, emergency restraint, and rights violation. Required reporters include individuals involved in the support of a Participant including, but not limited to, mandated reporters.

Waiver service providers or the OADS Incident Data Specialists (IDS) enter reportable events directly into an electronic database system. OADS expects all providers to conduct follow-up reviews on reportable events to determine and record the cause of critical incidents and develop strategies to reduce or mitigate the risk of future occurrences.

Additionally, all waiver service providers are mandated reporters, required to report known or suspected incidents of abuse, neglect, and exploitation of incapacitated or dependent adults, including individuals with intellectual disabilities or autism directly to Adult Protective Services pursuant to M.R.S. Title 22, Ch. 958-A, Adult Protective Services Act and 10-149 C.M.R. ch. 1, Adult Protective Services System. All reports of abuse, neglect and exploitation are currently entered into the Maine Adult Protective Services System which tracks referrals, investigations, and substantiations of abuse, neglect, or exploitation. OADS provides training to providers on mandatory reporting and adult protective investigations.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

OADS Intake and Eligibility Specialists provide information that is understandable and accessible to Participants, family members, and Guardians (when applicable) regarding rights and protections from abuse, neglect, and exploitation including the Department's Adult Protective Services hotline and online reporting information. Case Managers provide the same information during initial and annual service planning or more frequently when the Participant's needs dictate.

Additionally, Case Managers must inform Participants concerning protections from abuse, neglect, and exploitation, including how Participants (and/or families or legal representatives) can notify appropriate authorities.
Alternately, the Case Manager informs the Participant and Guardian (if applicable) of the availability of information through Adult Protective Services or the statewide Crisis hotline.

Training is available through the case management system, Disability Rights Maine (DRM), and local Self-Advocacy Groups. DRM's training specific to Behavior Rights and Regulations and supported decision making is reserved for Participants, families and guardians. However, DRM also offers training through the State Education Training Unit available to the general public.

Adult Protective Services offers in-person, state-wide trainings multiple times each year on the red flags of abuse, neglect, and exploitation and how to report to APS.

OADS offers an APS Mandated Reporter online training and includes a certificate based on successful completion of the content and accompanying quiz at the outset of the training at the following link: https://www.maine.gov/dhhs/oads/get-support/aps/mandated-reporters. Additionally, the website listed above also includes information and resources concerning violence prevention and protection from abuse, neglect and exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives

reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Office of Aging and Disability Services is launching a new electronic client database system called “Evergreen.” Evergreen will have the capacity to allow OADS to track progress on the performance measures included in this waiver. It is anticipated that the migration of data currently housed in EIS will be completed by August 2023. Prior to the launch of reportable events data migration to Evergreen, providers will receive training in the entry and use of the new case management database.

According to current practice, each District’s Operating Agency Quality Review Team reviews all reportable events, daily. Rights violations are reviewed and addressed by Disability Rights Maine. The reports are initially reviewed by the QA Supervisor who triages the event. The events are then forwarded to the QA Caseworker for review that may include either a desk or site review. In addition, all events concerning rights violations and restraint are reviewed by the Disability Services Crisis Case Managers.

Policies are in place to protect individual rights concerning the use of restraint and restrictive interventions (M.R.S. Title 34-B, ch. 5, Rights of Persons with Intellectual Disabilities or Autism and 14-197, C.M.R. ch. 5, Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism). Planning teams develop behavior management plans in consultation with qualified professionals for temporary restrictions of rights and/or the use of restraint. State statute specifies that review teams approve or disapprove these behavior management plans before implementation. Review teams consist of Participants from DHHS, the Maine Developmental Services Oversight and Advisory Board (OAB), and Disability Rights Maine (DRM). Emergency interventions include unplanned restraint, and removal of personal property. A provider must file a reportable event immediately after using an emergency intervention until a behavior management plan is approved. The Office of Aging and Disabilities Services (OADS) Crisis Case Manager monitors those reportable events daily.

All reports of rights violations and the use of restraints that are not part of an approved behavior management plan (i.e., not approved or improperly used) are sent the state’s protection and advocacy agency, Disability Rights Maine (DRM). DRM has access to the reportable events system and records the action taken with respect to rights violation and the inappropriate use of restraints.

Other matters that are categorized as rights violations are sent to DRM. As required by contract, DRM completes a preliminary investigation of reports tagged to advocacy to determine whether it warrants further investigation as a possible rights violation, should be closed out or referred to another entity for further review/follow up (e.g., APS referral). DRM is expected to reach out to 90% of adult clients with an alleged Rights Violation Reportable Event requiring a follow-up remedy and contact them within five (5) business days after the notification is received. DRM is also responsible for ensuring that the initial report gets entered into the department's case management system with 24 hours.

Adult Protective Services (APS) is responsible for all investigations of abuse, neglect and exploitation. APS shall document all steps taken to collect facts to reach a finding, including dates of phone calls, interviews, site visits, and document reviews. Subject to the confidentiality provisions of 22 M.R.S. §3474(2)(A), when APS receives a report that a person is suspected of Abusing, Neglecting, or Exploiting an Incapacitated or Dependent Adult, APS shall immediately report the suspected Abuse, Neglect, or Exploitation to the appropriate district attorney’s office, whether or not APS investigates the report.

Adult Protective Services reviews, prioritizes, and investigates reports in accordance with 10-149 C.M.R. ch. 1. Reports of abuse, neglect, and exploitation are received by APS Central Intake via a 1-800 number, email, fax, and an online form. Mandated reporters are required to call the 1-800 number to make reports in accordance with 22 M.R.S. § 3477. APS Central Intake receives reports 24/7. Summary information on all APS reports that are screened in is forwarded to the DA’s Offices for the counties were the client(s) reside.

All medication errors that result in serious injury are entered into the state’s case management database systems as a reportable event. Reportable events are monitored and reviewed by the Quality Review Team in the district offices. The Quality Review Team reviews every medication related reportable event and determines the level of harm: the event reported posed no harm; the person experienced injury or harm that required minimal treatment or the person experienced serious injury that required emergency room or hospitalization.

Based on prioritization, an APS Investigation may begin on the date the Report is received through APS Central Intake and will begin no later than five (5) business days from the date the Report is received. Final written findings shall be

entered into the electronic APS system by the assigned APS Caseworker no later than thirty (30) days from the date of assignment to the APS Caseworker. In the event an APS Investigation cannot be completed within thirty (30) days of assignment, the APS Caseworker shall document the reasons and estimate the number of days needed to complete the investigation in writing. An APS Supervisor shall review and approve the APS Investigation extension and document same. Any necessary subsequent extensions shall be reviewed and documented through the same process.

When APS issues a Substantiation finding against an individual, the individual shall be notified in writing and APS may include the potential consequences of the Substantiation. A Substantiation notice shall be accompanied by a written notice to the individual of the right to appeal the Substantiation finding to the Department's Administrative Hearings Unit. The written notice shall include a summary of the substantiation findings, information on the appeal process, and information on the right to request an expedited hearing.

When an individual who is found Substantiated by APS exercises the right of appeal, the hearing on the appeal shall be scheduled as soon as possible but no later than sixty (60) days after the appeal request is made, unless he or she requests an extension. The individual who was Abused, Neglected, or Exploited, his or her guardian if applicable, and Disability Rights Maine shall receive notice of the hearing and may request the status of an intervenor at the hearing.

In all APS investigations, information related to the investigation and the outcome of the same may be shared with Participants, family or legal representatives and other relevant parties in accordance with the confidentiality requirements outlined in 22 M.R.S. § 3474 and processes specified in 10-149 C.M.R. ch. 1.

Similarly, as noted above, within five (5) business days from receiving the report of a rights violation, DRM contacts the individual who is the subject of the reportable event and works with the individual to produce a positive outcome.

A Level 1 Substantiation will not be reported out to any State or national registry until the individual found Substantiated Level 1 has received the due process rights outlined herein and no report will be made to any provider, state agency, or national organization or any other person or entity, that there has been a substantiation, except to the Provider who employs the individual or to any person by court order or as permitted or mandated under the Adult Protective Services Act or provided in Rule.

A Level II Substantiation is not reported out to any State or national registry and does not trigger an individual's right to due process.

Please see attached rules governing the Adult Protective System.
https://www1.maine.gov/sos/cec/rules/10/149/149c001.docx

All Participant deaths are forwarded to APS Central Intake by IDS upon receipt of a death summary in the Critical Incident Management system. APS Central Intake routes each report of Participant death to the district office in the county where the Participant resided. An APS supervisor reviews the report, makes follow up calls as needed, and, if the information gathered suggests that the death may have been connected to or due to abuse, neglect, or exploitation, the supervisor contacts law enforcement (if not previously contacted) and the Office of the Chief Medical Examiner and assigns the case to a caseworker for further investigation.

Following the death of a Participant, the Case Manager must complete the Mortality Review Form in the critical incident management system within ten (10) business days. If the Case Manager is not available at the time of the Participant's death, the Case Management supervisor will complete the Mortality Review Form. As mentioned above, all deaths are sent to Adult Protective Services for review.

OADS completes individual death summaries that include a client profile, timeline of the death event, death information and the APS review. The summary is reviewed by OADS Senior Management.

In addition to APS and DRM, the Division of Licensing and Certification (DLC), the Office of Attorney General (OAG) Health Care Crimes Unit, and state and local law enforcement agencies conduct investigations when warranted and depending upon the severity of the case. Finally, individual provider agencies will typically conduct and document an internal investigation process that is distinctly maintained outside of the Participant's records.

The State has expectations for providers and Case Managers regarding the processes and timeframes for responding to

Reportable Events. Providers are required to complete an internal review and remediation for each and every reportable event. The review may include, but is not limited to, communication with the individual receiving services, communication with any witnesses to the reportable event, survey of the area where the reportable event occurred, and communication with the Participant's Case Manager to determine the cause of the reportable event and to identify remediation steps to prevent or reduce future incidences.

The Provider Follow-up Report is submitted through the reportable events system within 30 calendar days of the event and attached to the Participant's record. At a minimum, the report must include the following:
1) The date and time of the reportable event.
2) If reported more than one business day from the time of the reportable event, an explanation for the delay in reporting.
3) A summary of the circumstance that resulted in the reportable incident.
4) An outline of any remediation steps that were taken following the event to prevent or decrease recurrence.
5) The date of implementation of remediation steps including the party responsible for implementing remediation steps; and
6) The explanation as to why no remediation action steps are necessary, if appropriate.

Due to Character limit - See *1 Main-Additional Needed Information, for remainder of this section.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OADS is responsible for overseeing and response to critical incidents. The abovementioned Critical Incident Dashboard affords OADS the capability to search and review critical incidents by provider agency during a specified timeframe. The OADS Developmental Disability Crisis Case Manager monitors reportable events daily.

The following information is displayed and reviewed during quarterly provider meetings: total number of critical incidents by agency; total number of Participants served by agency; total number of critical incidents by Participant; highest number of critical incidents by Participant and event category; a narrative description of each critical incident; provider timeliness of critical incident reporting; list of clients with late reports (greater than one (1) business day); timeliness of submitting Provider Follow-Up Reports; a list of clients with no Provider Follow-up Report submitted; total number of deaths and a narrative description of the death. As noted, this information is discussed quarterly with providers along with the implementation and effectiveness of remediation steps by critical incident that occurred during that same timeframe.

OADS completes (issues) a Critical Incident Trend Analysis Report that highlights, in aggregate, the same information listed above. The purpose is to communicate information about trends and use the data to plan, prioritize and implement proactive initiatives to reduce or prevent incidents from recurring.

APS provides a report that describes the total number of investigations where the individual was determined to be a recipient of Home and Community Based Services. The report captures the total number of substantiated allegations by the following categories/types: self-neglect, exploitation, physical abuse, safety issues/at risk, caretaker neglect, sexual abuse, emotional abuse, inability to give informed consent, and financial abuse. The report also includes the remediation of substantiated incidents of abuse, neglect and exploitation.

The critical incident data including incidents of abuse, neglect and exploitation is reviewed, analyzed, and results in recommendations regarding incident management. Significant finding(s) are reviewed by the waiver management team who makes recommendations to OMS and OADS Executive Management Teams for provider and/or systemic follow up.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraint: means a mechanism or action that limits or controls a Person's voluntary movement against his or her will. Restraint deprives a Person of the use of all or part of the Person's body or maintains a Person in an area through physical presence, physical limitation or Coercion. Restraint includes Blocking, as well as the Coercive movement of a Person to a place where the Person does not wish to go. Restraint also includes any inaction that limits or controls a Person's voluntary movement, such as refusing to give support to meet a Person's mobility needs. Some forms of Restraint are Prohibited Practices.

Blocking: means a momentary deflection of a Person's movement, without holding, when that movement would otherwise be destructive or harmful. Blocking is considered a Restraint.

Chemical Restraint: means the use of a prescribed medicine when the primary purpose of the medication is a response to behavior rather than a physical condition; and the prescribed medication is a drug or dosage that would not otherwise be administered to the Person as part of a regular medication regimen; and the prescribed medicine impairs the Person's ability to engage in or accomplish the Person's usual activities of daily living (as compared to the Person's usual performance when the medicine is not administered) by causing disorientation, confusion, or an impairment of physical or mental functioning. Medications that help a Person sleep during the Person's regular sleeping hours are not considered Chemical Restraints.

Escort: means physical assistance to support a Person to stand or walk when the person who is providing the support follows the lead of the Person being supported. The use of physical force, the threat of the use of physical force, or the use of any coercive action to move or compel a Person to move is not an Escort. It is a Restraint.

Mechanical Restraint: means an apparatus employed to restrain a Person, or the act of using an apparatus to address Challenging Behavior. A Mechanical Restraint is any item worn by or placed on the Person to limit behavior or movement and which cannot be removed by the Person. Mechanical Restraints include, but are not limited to, devices such as mittens, straps, arm splints and helmets. They do not include positioning or adaptive devices when used prescriptively in accordance with 34-B M.R.S. §5605, Rights and Basic Protections of a Person with Intellectual Disabilities or Autism.

Specialized Restraint: is an individualized Restraint approved by the Department to meet a Person's specific needs that cannot be met through a nationally recognized or certified behavior management program.

Restraint practices prohibited by the Department include:
1) Certain Physical Restraints - Restraints involving excessive force, punching, hitting, head hold; Prone Restraint, in which the Person is held face down; Restraints that have the Person lying on the ground or in a bed with a worker on top of the Person, on the back or chest, or straddling or sitting on the torso; Restraints that restrict breathing or inhibit the digestive system; Restraints that hyper-extend a joint; Restraints that put pressure on chest; Restraints that rely on pain for control; Restraints that rely on a takedown technique (in which the Person is not supported, allowing for free fall to the floor) or force the Person to his or her knees or hands and knees; Restraint that involves physical contact covering the face; any Restraint that is face first against walls, railing or post; A Restraint or physical intervention which puts the Person off balance not part of a physical restraint program approved by the Department.
2) Certain Mechanical Restraints - Totally Enclosed Crib; Camisole or straitjacket; Restraint Chairs; Harnesses; Bed netting; Swaddling, from which the Person cannot remove him or herself; Swaddling from which the Person can remove him or herself but to which the Person or the Person's guardian communicates an objection; Prone Mechanical Restraint in which the person is held face down.
3) Emergency use of Chemical Restraint - Any Emergency use of Chemical Restraint.
4) Routine use of Emergency Intervention - When an IST is required under and a justification to address the Challenging Behavior without a Behavior Management Plan has not been approved by the Review Team.

Safeguards for Restraint:
Planning Teams follow a hierarchy (Levels 1-5) of supports, interventions, and restrictions and a detailed process that must be followed prior to implementation of each level of support or intervention. The process, including implementation and monitoring, can be accessed within 14-197 C.M.R. ch. 5 at the following link: https://www1.maine.gov/sos/cec/rules/14/197/197c005.docx

The Planning Team develops a Behavior Management Plan in consultation with a qualified professional. The Planning Team ensures that a Psychological Assessment has been conducted in the past six months and is considered in the design of the Behavior Management Plan. The psychological assessment must include, but is not limited to: review, consideration and clarification of current and historic diagnoses; a conceptualization of the challenging behavior and recommendations regarding the necessity and anticipated impact of positive supports, environmental modifications, restrictions of rights and the use of restraint.

When the continued use of Restraint is recommended in the Behavior Management Plan, the Psychological Assessment must be updated at least every three years. Restraint is authorized only when there is documentation that less intrusive attempts to address the behavior have been unsuccessful. Restraint cannot be used to change behavior or for the convenience of staff. It may only be used to keep the recipient of services or the community safe. When Restraint is used, it must be kept to a minimum in terms of frequency, duration, and degree of physical intrusion.

When the Behavior Management Plan includes Restraint, the Planning Team must ensure that it specifies strategies for continuous monitoring and assessment of the person's (1) physical condition, breathing, circulation or pain; criteria for attempting release and reengage the restraint if necessary; indicators, and (2) that identify when the restriction of rights or the use of restraint should cease; and how the person should be supported to resume normal activities.

When a Behavior Management Plan includes restraint, the Planning Team must ensure completion of a physician's evaluation, in which a physician or a physician's assistant (PA) evaluates the Person no more than thirty (30) days prior to the implementation of the Behavior Management Plan and yearly thereafter. Whenever a significant change in physical or medical condition occurs, a new evaluation must be conducted. In order for a Behavior Management Plan including restraint to be implemented, the physician's evaluation must state in writing that the proposed Plan is safe, given the person's physical and emotional condition, and the behavior cannot be better treated medically.

When a Behavior Management Plan includes a Specialized Restraint, the Planning Team must consider the particular medical condition of the Person, the Person's history of physical or sexual trauma, or other relevant factors that necessitate the use of a Specialized Restraint. In addition to all other required elements, the Behavior Management Plan must identify the need for and description of the Specialized Restraint.

The Department acknowledges that emergencies and unforeseen circumstances will occur in which a Person's Challenging Behavior presents an Imminent Risk to the safety of the Person or community. The criteria for response to these circumstances include:

- Emergency Interventions, including Specialized Restraints, otherwise permitted in this regulation may be used on an Emergency basis if a Person's challenging behavior presents imminent risk to the safety of the person or the community.
- When emergency intervention is utilized, the least restrictive technique necessary to make the situation safe must be used;
- Any emergency intervention must be terminated as soon as the need for protection is over, no further restriction must be used;
- An emergency intervention may include temporary removal of personal property to protect the Person or the community from imminent risk of injury, so long as the property is returned as soon as it is safe to do so;
- Whenever emergency intervention is used, it must be reported to the Department through the reportable events system;
- Prohibited practices must not be used;
- If emergency intervention occurs repeatedly, an Individual Support Team (IST) must convene, in accordance with Department regulation.

The Planning Team must ensure a Functional Assessment is developed or updated and the Positive Support Plan is reviewed for effectiveness when:
a) An emergency restraint is used three (3) times or more in a two-week period or six (6) times in any 365-day period, or is used in a recurring pattern; or
b) Another Emergency Intervention (Specialized Restraint or removal of personal property) is used three (3)

times in a 365-day period then.

Additionally, if the Planning Team determines a Behavior Management Plan is warranted, an IST must convene to develop and submit an appropriate Plan within sixty (60) days. If the IST is not able to develop an appropriate plan within sixty (60) days, the Planning Team must identify it as an unmet need.

If the Planning Team does not develop a Behavior Management Plan, the Planning Team must submit to the Review Team for approval a justification explaining why a Behavior Management Plan is not necessary. The Review Team may require that a Behavior Management Plan be developed to address recurring challenging behavior.

Pursuant to MBM, 10-144 Ch II, Sec 21, direct support staff are required to complete OADS-approved training within the first six (6) months of hire and every thirty-six (36) months thereafter regarding the Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Office of Aging and Disability Services (the State Operating Agency) is responsible for overseeing the use of restraints. All Behavior Management Plans that include Restraint are classified as either Level 4 or Level 5. Planning Teams are responsible for obtaining the designated level of approval prior to implementation of any plan. The Planning Team, the Person or Guardian, and Case Manager must review and approve all plans before they are implemented or sent for further review. A Review Team is responsible for review and disposition of all Behavior Management Plans at Level 3 or above. The Statewide Review Panel is responsible for review of all Behavior Management Plans at Level 5, prior to review by the Commissioner or designee.

Review Teams must be maintained as governed by a Memorandum of Understanding (MOU) between the Department, the Protection and Advocacy Agency, and the Maine Developmental Services Oversight and Advisory Board. Each team shall be composed of one representative each from the Department, the Protection and Advocacy Agency, and one designated by the Maine Developmental Services Oversight and Advisory Board.

The role of the Review Team is to ensure compliance with Review Procedures and Requirements.

- Positive Support Plans at Levels 1 and 2 may be implemented with Planning Team and Case Manager approval.
- Each proposed plan must be reviewed at the appropriate level corresponding to the most intrusive proposed restriction of Rights or the use of Restraint before it can be implemented.
- At each level of review, the requirements for the preceding level of review must have been met and approval obtained.
- Any member of the Planning Team may request review or involvement by an Advocate. The Advocate must be notified when a Planning Team is considering a Behavior Management Plan at Level 3 or above.
- Plans requiring approval at Level 3 and above must have the approval and signature of the Case Manager and Case Management Supervisor.

Review Team Practices: The approval of the Behavior Management Plan at Level 3 and above requires both voting members to vote in favor of the Behavior Management Plan or the Behavior Management Plan with conditions. The two voting members of the review team are the representatives from the Department and the Maine Developmental Services Oversight and Advisory Board (OAB). The Protection and Advocacy representative is a participating non-voting member of the Review Team. The Review Team may require additional information prior to approval of any plan and have the discretion to determine duration of the Behavior Plan up to a maximum of one year. If less than one year, the duration of Behavior Plan approval must be indicated in writing.

The voting members of the Review Team may elect to approve part of a plan or provide time-limited or conditional approval based on written conditions to be met as defined by the voting members of the Review Team. If either voting member of the Review Team does not approve all or part of a Behavior Management Plan, the voting members of the Review Team must specify the reasons for disapproval in writing.

The Case Manager or Case Management Supervisor must participate in the review process. After initial approval of a Behavior Management Plan, the Review Team may refer cases for continued monitoring to the Planning Team, the Case Manager and the Case Management Supervisor. The Review Team must review for approval each Behavior Management Plan at least once a year.

The Review Team may, at its discretion, refer any Behavior Management Plan for review by the Statewide Review Panel. The Review Team should consider a referral in cases where resources are an issue in meeting the Person’s support needs without the use of Behavior Management.

No Behavior Management Plan component requiring approval at Level 3 or above shall be implemented without appropriate approval as provided by these regulations.

Each Review Team must establish a process for review and disposition of Behavior Management Plans requested for emergencies. The Review Team may grant written provisional approval of all or part of an emergency Behavior Management Plan. Provisional approval must be agreed upon by the representative of

the Department and Maine Developmental Services Oversight and Advisory Board and must not exceed sixty (60) days. After sixty (60) days the Planning Team must meet all regular requirements for review and disposition of the Behavior Management Plan.

Exceptions: Behavior Management Plans requiring approval at Level 5 are rare exceptions and must meet a higher standard of review and approval. Level 5 Behavior Management Plans must have been approved by the Review Team and reviewed by the Statewide Review Panel before being submitted to the Commissioner for disposition. Prior to submitting a Behavior Management Plan for initial approval at Level 5, the Planning Team is required to seek a second opinion from a licensed psychologist or psychiatrist. At the discretion of the Review Team a second opinion may be requested before any annual review. That clinician shall meet with the Person and the Person's support staff and confer with the Person's family if they are involved, and the Guardian, if there is one, and Correspondent, if one has been appointed. The clinician must provide a written opinion of the potential risks and benefits of the proposed program. If the clinician providing the second opinion concurs in the need for the program, the Statewide Review Panel will review the plan and make recommendations to the Commissioner. If the Commissioner approves the Behavior Management Plan, the Review Team will assume responsibility for monitoring the Behavior Management Plan. Level 5 Behavior Management Plans must comply with the foregoing review and approval requirements.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State does not permit the use of aversive methods to modify behavior. The State defines aversive methods as an intervention or action intended to modify behavior that could cause harm or damage to a Participant, or could arouse fear or distress in that Participant, even when the intervention or action appears to be pleasant or neutral to others.

Restrictions to Participant rights are authorized only when there is documentation that less intrusive attempts to address the Challenging Behavior have been unsuccessful. Restriction of rights may only be used for keeping the Participant or community safe from harm, not to change behavior or for staff convenience.

Rights restrictions must be kept to a minimum in terms of frequency, duration, and degree of physical intrusion. Restricting Basic Rights (inhumane treatment or restricting the right to vote, work, or hold a religious belief) is a Prohibited Practice.

Restriction of Activities or Contact with Family or Significant Others is a Prohibited Practice (will not be approved and must not be implemented at any level of intervention). Regularly scheduled social activities (such as specified in the PCSP) cannot be restricted as part of Behavior Modification or Behavior Management. This includes denial of communication or visitation with family members or significant others for the purpose behavior modification or behavior management.

The State has several safeguards in place regarding allowable restrictions upon Participant movement and restrictions upon Participant access to other individuals, locations, or activities:

In-Home Stabilization means a limited period of time for which a Participant, whose challenging behavior has placed that Participant or the community at imminent risk of harm, may be denied access to the community for safety and assessment. When In-Home Stabilization is utilized, the Planning Team must develop an In-Home Stabilization Plan. In-Home Stabilization must be used only to ensure the safety of the Participant or the community and upon assessment that the Person’s Challenging Behavior may continue to pose imminent risk to the Participant or the community. In-Home Stabilization must be tied directly to safety and not used as a teaching or behavior modification technique.

The Participant’s functional assessment must address the challenging behavior and the justification for the use of In-Home Stabilization. The justification must include the history of the challenging behavior and the types of problems it poses and how the In-Home Stabilization addresses those problems.

The proposed use of In-Home Stabilization must be described in an In-Home Stabilization Plan which includes: a clear description of the specific challenging behavior that initiates a period of In-Home Stabilization; criteria that is used for assessment of discontinuing the In-Home Stabilization; criteria that will be used for assessment of continuing the In-Home Stabilization; the identity of the person who will conduct the assessment of risk and a description of when those assessments will occur; and a description of how staff will support the Participant to transition to regular activities after the period of In-Home Stabilization.

The proposed use of In-Home Stabilization for a period not to exceed one hour is a Level 2 intervention. A Level 2 In-Home Stabilization Plan must be derived from the Functional Assessment and incorporated into the Positive Support Plan. A plan for In-Home Stabilization of one hour or less must have the approval of the Planning Team and the Case Manager prior to implementation.

The proposed use of In-Home Stabilization for a period greater than one hour, but not to exceed 24 hours, is a Level 3 intervention. The use of a Level 2 In-Home Stabilizations three times or more during any two-week period of time requires review and approval as a Level 3 Plan. A Level 3 In-Home Stabilization Plan must be incorporated into the Behavior Management Plan, and is subject to all requirements for Behavior Management Planning, review and approval prior to implementation

In-Home Stabilization at Level 2 or Level 3 must not be applied cumulatively. Once the criteria for safety have been met, or the identified time period has expired, In-Home Stabilization must end and the Participant must be supported to transition to regular activities, or be supported to seek emergency medical attention.

When the Planning Team identifies a need for In-Home Stabilization beyond 24 hours, the Planning Team

must submit an In-Home Stabilization Plan for a Level 4 intervention. The Level 4 In-Home Stabilization Plan must be justified by the Functional Assessment and documentation of prior interventions.

The Level 4 In-Home Stabilization Plan must be incorporated into a Behavior Management Plan proposed for review at Level 4. A Level 4 In-Home Stabilization Plan must include, but is not limited to: all information required in the In-Home Stabilization Plan; A safety assessment describing the criteria to be used at the end of the 24-hour period to determine if there is a need for continued In-Home Stabilization; and a plan for an in-person safety assessment of the Participant by the qualified professional overseeing the plan.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Office of Aging and Disability Services (the State Operating Agency) is responsible for monitoring and tracking the Behavior Management Plans. Monitoring the Behavior Management Plan includes but is not limited to the following:

The Statewide Review Panel is responsible for monitoring the quality and consistency of the Behavior Management Plans. This includes reviewing all new Level 4 Behavior Management Plans for quality assurance purposes, including concerns regarding the review process, inconsistencies and/or the quality of Behavior Management Plans. The Statewide Review Panel may request a random sample of Behavior Management Plans for a quality review. The Statewide Review Panel reports and advises the Department regarding interventions that may put consumers at risk and assure the applicable policies, regulations and laws are being followed.

The Planning Team and the responsible qualified professional must monitor the implementation of an approved Behavior Management Plan and make modifications as necessary. Responsibilities include but are not limited to the following:

- The qualified professional must oversee implementation of the plan and monitor and document progress at least monthly. Documentation must include a description of the current and baseline measurements of the frequency, duration, intensity and/or severity of each Challenging Behavior, the interventions used and the result(s). Documentation must also include recommendations about continuation or modification of Plan elements. The qualified professional must meet and observe the individual at least twice annually.
- At a minimum, one representative from each agency responsible for the implementation of the approved Plan must be present during these monthly clinical reviews with the qualified professional. Their role is to provide documentation and discussion regarding the effectiveness of the approved Plan and to provide other pertinent input regarding less restrictive alternatives.
- The individual’s guardian and assigned Case Manager must also be provided the option to participate in the monthly clinical reviews with the qualified professional.
- The Planning Team, in consultation with the qualified professional must review, monitor and document the effectiveness of the Plan at least quarterly.
- Any increase of restrictive measures must be approved by the Planning Team and the Review Team prior to implementation.
- All modifications of the Behavior Management Plan which include a reduction of restrictive measures must be approved by the Planning Team prior to implementation, and the revised Behavior Management Plan must be sent to the Review Team within thirty (30) days.
- When a Person has a Behavior Management Plan, the Case Manager must conduct an in-person review of the implementation of the Plan at least quarterly. When the Person does not have a Case Manager, the Q.I.D.P. must monitor the Behavior Management Plan.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is defined as the solitary, involuntary confinement of a Participant for any period of time in a room or a specific area from which egress is denied by a locking mechanism, barrier or other imposed physical limitation.

The Office of Aging and Disability Services (the State Operating Agency) has the responsibility to detect the unauthorized use of seclusion. This is not permitted at any time (a Prohibited Practice), and it must be reported through the reportable events system and may also be detected through reports to Maine's APS system.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication monitoring focuses on events related to medication taken by an individual receiving services that leads to a health or safety concern of a serious nature based on inappropriate prescription, packaging, dispensing, administration, monitoring or an individual's refusal to take medication where serious health or safety implications can result.

Providers who hold license(s) and certification(s) have ongoing responsibility for monitoring Participant medication regimens. 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. The methods for conducting and monitoring depend on the level of license and certification.

Only medications (including over the counter medications) prescribed by written order from a physician may be administered by certified staff. The prescribing physician or other appropriate monitoring entity must review the Participant's medication regimen every six months or more frequently as the Participant's needs dictate. A certified staff member must document in the Participant's record all medications administered to a Participant daily.

All providers must monitor the health and safety of Participants related to administration of medications, including those that self-administer medications. Many provider agencies employ or contract registered nurse consultants who oversee and monitor medication administration within their agencies. The Department requires provider agencies to have policies requiring that the Participant and/or the Guardian (as applicable) and/or family members (when authorized) are notified and authorize/agree to medication changes.

A medication error is an event involving the incorrect or inappropriate prescribing, packaging, dispensing, administering, monitoring, or an individual's refusal to comply with medications orders that may result in serious health or safety implications for the Participant.

All medication errors are entered into the state's EIS system as a reportable event. Reportable events are monitored and reviewed by the Quality Review Team in the district offices. The Quality Review Team reviews every medication related reportable event and determines the level of harm: the event reported posed no harm; the person experienced injury or harm that required minimal treatment or the person experienced serious injury that required emergency room or hospitalization.

Reportable events are monitored daily by the Quality Assurance District teams. The operating agency has four regional offices in which one or more caseworker is assigned as a member of the quality assurance team. These teams are managed by a regional program administrator.

Reportable Events are reported by the providers, case managers, etc. and reviewed daily by the Quality Assurance District Teams. QA Supervisors determine the level of harm (see above), at this point the individual and incidents may be monitored for reoccurrence or sent directly to a QA Case Manager for a more intensive review; either a desk level or site review. This level of review involves reading case notes, calls to providers and case managers and others determine if corrective action needs to be initiated.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The State utilizes the Reportable Events System to receive information relative to inappropriate medication management. Potentially harmful practices are identified by the provider or the State Operating Agency. The Office of Aging and Disability Services is responsible for oversight and ensuring appropriate follow-up. Anyone assisting in the administration of medication in a licensed facility must complete a Certified Residential Medication Assistant (CRMA) training and be re-certified every two years. This training is monitored by the Department's Division of Licensing and Certification (DLC), and includes training and certification of Registered Nurse instructors. This training includes the nurse trainer observing the trainee administering medication.

Reportable Events are reported by the providers, case managers, etc. and reviewed daily by the Quality Assurance District Teams. QA Supervisors determine the level of harm, at this point the individual and incidents may be monitored for reoccurrence or sent directly to a QA Case Manager for a more intensive review; either a desk level or site review. This level of review involves reading case notes, calls to providers and case managers and others determine if corrective action needs to be initiated.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In accordance with state licensing regulation and MBM, Section 29, Ch. II, anyone assisting in the administration of medication in a licensed residence must successfully complete a Certified Residential Medication Assistant (CRMA) training and be re-certified every two years. This training is monitored by DLC, and includes training and certification of Registered Nurse instructors. This training includes the nurse trainer observing the trainee successfully administering medication prior to certification. Waiver rules require the same training for Community Support, Work Support and Home Support.

Similarly, Providers who operate unlicensed Adult Foster Care/Shared living homes must have completed the abbreviated medication administration course designed specifically for such homes. Again, any staff member assisting with medication administration must complete a medication course taught by a Registered Nurse (RN) and must be re-certified every two years. This training includes the RN trainer observing the trainee successfully administering medication prior to completion of the course. Many provider agencies employ or contract for nurse consultants who monitor medication administration within their agencies. This requirement is included in the MBM, Section 29, Ch. II rules that govern this waiver.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

The Office of Aging and Disability Services, designated State Operating Agency.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record and report any medication error, in the Reportable Events System, that leads to a health or safety concern of a serious and immediate nature due to any of the following:
(a) Refusal to take a prescribed medication;
(b) Taking medication in an incorrect dosage, form, or route of administration;
(c) Taking medication on an incorrect schedule;
(d) Taking medication which was not prescribed;
(e) An allergic reaction to a medication; or
(f) Incorrect procedure followed for assisting an Individual Receiving Services with self-medication.

(c) Specify the types of medication errors that providers must *report* to the state:

Same as above.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

OADS is responsible for monitoring the performance of providers through the Reportable Events System. Monitoring is accomplished through the Reportable Events Dashboard. Medication events are aggregated by provider, Participant and type of medication event. The findings are discussed with the provider at quarterly intervals with the goal of ensuring the health, safety and welfare of the Participant.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percent of all reportable events that are reported according to the time frames outlined in 14-197 C.M.R. Ch. 12. Numerator: Total number of all reportable events that are reported according to the time frames as outline in 14-197 C.M.R. Ch. 12. Denominator: Total number of reportable events reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of reports of abuse, neglect & exploitation that are investigated by APS. Numerator: Total number of reports of abuse, neglect & exploitation that are investigated by APS. Denominator: Total number of reports of abuse, neglect & exploitation that were referred for investigation by APS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of deaths reviewed by APS for abuse, neglect, or exploitation. Numerator: Total number of deaths reviewed by APS for abuse, neglect, or exploitation. Denominator: Total number of deaths reported to APS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
% of participants/legal guardians who received information on how to identify and report instances of abuse, neglect, exploitation and unexplained death. Numerator Total PCPs with documentation that the participant or legal guardian received information on how to identify and report instances of abuse, neglect, exploitation and unexplained death. Denominator Total number of PCPs reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95 Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of abuse, neglect, exploitation and unexplained death incidents

reviewed/investigated within the required timeframes. Numerator: Total number of reports of abuse, neglect, exploitation, and unexplained death incidents that are reviewed/investigated within the required timeframes. Denominator: Total number of abuse, neglect, exploitation and unexplained death incidents received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
% of provider follow-up reports required to be submitted within 30 days from the date of the reported incident reported within 30 calendar days of the reported incident. Numerator All provider follow-up reports submitted within 30 days from the date of the reported incident. Denominator All provider follow-up reports required to be submitted w/in 30 days from the date of the reported incident.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Critical Incident Management System (EIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☒ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Percent of critical incidents where a cause was identified in the provider follow-up report. Numerator: Total number of critical incidents where the cause was identified in the provider follow-up report. Denominator: Total number of provider follow-up reports required to be submitted.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Critical Incident Management System (EIS)/Off-site review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of critical incident with an identified cause where systemic intervention was implemented. Numerator: Total number of critical incidents with an identified cause where systemic intervention was implemented. Denominator: Total number of critical incidents with an identified cause.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of providers that have policies in place that prohibit the use of seclusion. Numerator: Total number of providers that have policies in place that prohibit the use of seclusion. Denominator: Total number of provider policies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System (EIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of restraints and restrictive measures that were used according to the policies described in the approved waiver. Numerator: Total number of restraints and restrictive measures that were used according to the policies described in the approved waiver. Denominator: Total number of restraint and restrictive incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Management System (EIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Percent of incidents of restraint/restriction that did not include the use of seclusion. Numerator: Total number of incidents of restraint/restriction that did not include the use of seclusion. Denominator: Total number of incidents of restraint/restriction.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Management System (EIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of providers that have policies in place for the appropriate use of restraints and restrictive interventions. Numerator: Total number of providers that have policies in place for the appropriate use of restraints and restrictive interventions. Denominator: Total number of provider policies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System (EIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participants who received an annual physical health exam as evidenced by a paid claim. Numerator: Total number of participants who received an annual physical health exam as evidenced by a paid claim. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of individuals on a medication regimen with evidence in their record that appropriate monitoring has taken place no less than every 6-months. Numerator: Total number of individuals on a medication regimen with evidence in their record that appropriate monitoring has taken place no less than every 6-months. Denominator: Total number of individual records on a medication regimen reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Responsibility for monitoring the healthy, safety and welfare of the waiver participant is a shared responsibility between the Office of Aging and Disability Services, Developmental Disability & Brain Injury Services, Quality Management, Case Managers and Providers. OADS developed a Critical Incident Dashboard that includes critical incident data as reported by community-based providers. The information from the Critical Incident Dashboard is used at quarterly quality provider meetings to address any issues that have arisen during that quarter with the goal of ensuring the health, safety and welfare of the individual. OADS compares Medicaid claims for emergency department visits to ensure compliance that all emergency department incidents are reported to the State. OADS compares all deaths reported against the States Vital Statistic Death Registry to ensure that all deaths have been reported. Finally, OADS requests a data pull of all waiver participants from APS to monitor and review instances of abuse, neglect and exploitation of waiver participants.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Office of Aging and Disability Services, Quality Management Unit monitors and reviews data gathered quarterly for each of the performance measures. Issues and concerns that are discovered are sent to the Developmental Disabilities Unit for remediation. Systemic concerns, such as timeliness of reporting or failure to report that involve provider agencies are addressed during the quarterly quality provider meetings. Concerns and issues involving individuals are addressed with the Case Manager who assists the individual with resolving immediate issues and/or addressing those issues in the PCP.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Office of MaineCare (OMS), the State Medicaid Agency and the Office of Aging and Disability Services (OADS), the designated Operating Agency work together to ensure the health, safety and welfare of the individuals receiving services and supports through this waiver. The Operating Agency and Medicaid Agency meet at least monthly for system monitoring.

OADS and OMS have adopted the HCBS Quality Framework as a guide to ensure desired outcomes in the seven focus areas. HCBS Quality Framework sets the stage for quality through the perspective of the provider, individual and the system. Each of these areas has a focus on discovery, remediation and quality improvement, which is described in the previous appendices for this waiver application.

OADS has two primary dashboards that enable it to collect and synthesize data; the Reportable Events Dashboard and the Waiver Dashboard. The Reportable Events Dashboard includes all reportable events as reported by community providers and includes date of incident, critical incidents by provider, location of incident, number of incidents by individual, incidents by type, timeliness of reporting, completeness of 30-day follow- reports and trends over time. On a quarterly basis the information housed in the Reportable Events Dashboard is reviewed with community providers to discuss the reduction or prevention of incidents and opportunities for improvement. In addition, each quarter deaths of individuals are matched against the State's Death registry to ensure that all deaths are reported by community providers and critical incidents are matched against emergency department Medicaid Claims data to ensure that all critical incidents are reported to OADS.

The Dashboard allows the user to review expenditures by waiver, procedure code, Participant, provider and service location. This data can be trended on a quarterly or annual basis. The data comes from Medicaid's Data Analytics Platform (DAP).

In addition to the two primary dashboards, OADS has developed a provider agency and settings list that is used to capture information regarding remediation activities, including Notices of Deficiency and corrective actions, to assure timeframes are met and remediation objectives are achieved.

Instances of abuse, neglect and exploitation identified by mandated reporters or through the reportable event review process, are referred to Adult Protective Services (APS) for investigation and may result in substantiation. Summary information on all APS reports that are screened are forwarded to the DA's Offices for the county where the Participant resides. Concerns regarding provider quality identified during APS investigations are sent electronically to the OADS District Offices for routine system and provider monitoring.

A performance measures workplan has been developed for this waiver that identifies lead staff, assigned staff start and end dates, data sources and status ensuring that each sub-assurance and performance measure are completed on a quarterly or annual basis. Values are compared against minimum expectations by OADS staff on a quarterly basis and measures needing improvements are addressed using a variety of strategies up to and including corrective actions.

Developmental foundations, including needed statutory changes, are complete and a Mortality Review Panel is staffed and writing procedures for operation. The Panel will review discrete mortality events as well as aggregate mortality data At present, all mortality events are reviewed by Adult Protective Services to screen for indications of abuse, neglect, or exploitation.

OADS is committed to evaluating consumer experience. Use of the National Core Indicators In-person Survey has been placed on a pause during the pandemic and OADS is evaluating options assessing user experience that is both valid and holds value for individuals receiving services and other stakeholders.

Beginning in 2023, OADS plans to resume collecting experience of care data by piloting a new survey. The new survey is the Consumer Assessment of Healthcare Provider and Systems, Home and Community Based Services version. Results from future surveys will be shared with both internal and external stakeholder groups. OADS will consider survey findings as part of our overall future quality improvement efforts.

Finally, all providers in this waiver must comply with all applicable federal and state laws, including applicable Maine licensing laws and regulations. The Department developed and promulgated in the MBM, Section 21, Ch. II rule a Plan of Corrective Action (POCA) process to expand upon the quality assurance activities and provide

increased protections for Participants by ensuring providers comply with service requirements, have sufficient clinical and administrative capability to carry out the intent of the service, and have taken steps to assure the safety, quality, and accessibility of the service for Participants. The process includes noticing providers of specific deficiencies as well as the timeframes for correcting, and remediating identified problems and may require the provider to submit a Plan of Corrective Action.

The plan of corrective action must meet specific criteria including, but not limited to, the following:
a) The POCA must be a specific plan which describes how the deficiency (event, incident or risk) will be corrected, including the actions which will be taken to bring about correction.
b) The POCA must address correction of the specific event(s) cited.
c) The POCA must identify actions steps to prevent the deficiency/risk from recurring/occurring.
d) The POCA must clearly delineate the frequency each element of the plan is to occur.
e) The POCA must identify by title the individual(s) responsible for the implementation and monitoring of the plan.
f) The POCA must provide date(s) by which all components of the plan will be implemented, and the corrections completed.

OADS is in the process of developing several desk-level procedures (DLPs) to guide remediation work, including a DLP for handling corrective actions. The DLP describes the actions and criteria for evaluation of suspected deficiencies as well as criteria for request of a POCA and the procedure for working through a POCA to resolution. A tracking system assures all procedural steps and articulated timeframes are met.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

OADS (the Operating Agency) and OMS (the Medicaid Agency) have the primary responsibility for monitoring the effectiveness of the system design changes. This team regularly reviews data reports on each of these areas.

Focus Area 1- Participant Focus:
Choice forms are completed for either institutional care or HCBS services.
Reporting critical incidents in particular abuse neglect and exploitation.
Case managers conduct 90-day reviews unmet needs.
Annual preventive health care visits.
Level of Care assessments are reviewed and approved by qualified staff .
District quality staff meet quarterly with providers to review aggregate data as well as Participant -specific data, looking for trends and changing conditions.

Focus Area 2 – Participant-Centered Service Planning:
Annual review of PCSP plans to ensure that the plan addresses health and safety risks, and goals.
PCSPs are based on assessed needs.
Critical incidents and reports of abuse, neglect and exploitation are addressed in the plan, if appropriate.
Behavioral health plan is reviewed quarterly to assure health, safety and welfare.

Focus Area 3 – Provider Capacity and Capabilities
All providers are enrolled as MaineCare (Medicaid) providers.
Providers are approved based on meeting all HCBS skills, competencies and qualifications.
All providers maintain licensure and certification.
Settings where waiver services are provided are reviewed for compliance for HCBS standards.
Agency providers meet quarterly with district staff to review data and trends.

Focus Area 4 – Participant Safeguards:
Critical Incident Dashboard is monitored to protect Participants.
30-day follow-up plans address the causes and provider actions to reduce or prevent future occurrence.
Case Managers conduct psychotropic medication reviews, if appropriate every 6-months.
Restrictive interventions are monitored.
All reportable events are reviewed to assess for proper reporting of abuse and neglect, provider compliance with rules and regulations, and to assess for necessity of corrective actions.

Focus Area 5 – Participant Rights and Responsibilities:
Notification of rights appeals process and grievances.
Grievance and appeals are resolved timely, according to rule.

Focus Area 6 – Participant Outcomes and Satisfaction:
Participants are satisfied with the services and supports they receive
Participants are integrated into the community.
Participants are employed.

Focus Area 7 – System Performance:
Data is collected, reviewed, and shared quarterly with management.
Continuous quality improvement is implemented to ensure quality outcomes.
Financial accountability is reviewed quarterly and shared with responsible parties.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The State Medicaid Agency and the Operating Agency and other contracted entities review, assess and make recommendations for continuous quality improvements to the system. The two agencies meet periodically to review CMS updates related to the HCBS Quality Measure Set.

Tools, such as the Critical Incident and Waiver Dashboard are regularly monitored and enhanced to provide the internal users the best opportunity to review data on individuals, providers and the system. Results of these reviews may prompt changes in performance measures/indicators, data sources, rules, procedures and policies, and roles and responsibilities of personnel to name a few in order to have a system that is responsive to the individual.

Within the Operating Agency, the Quality Manager supervises the district quality staff, as well as the Corrections Coordinator and Quality Liaison. Focus areas for the Quality Manager are provider agency quality, data trending, and event management. The Quality Manager works closely with both the Data Analytics and Compliance Manager and the Waiver Manager(s) to assure Operating Agency quality goals are met.

The Data Analytics and Compliance Manager and team collect data from multiple sources and perform analyses. Data Analytics and Compliance also engages in provider quality and compliance audits, while working closely with both the Waiver and the Quality Managers to identify opportunities and improvement strategies.

The Waiver Manager(s) closely monitor trends related to Participant access, experience, and needs. The Waiver Manager(s) work closely with the Manager of Data Analytics and Compliance to evaluate data related to Participant experience, waiver service provision, and provider capacity.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Integrity of payments at the individual level:
Maine has developed a subsystem to its MMIS system that provides checks and balances to assure that medical eligibility determination and prior authorization have occurred and are valid for the dates of services billed. The classification dates entered 1) match the time period of medical eligibility determined as part of the assessment for waiver services and 2) provide system authorization to assure the Participant has been determined eligible for a specific MaineCare program to allow claims to be paid for specific procedure codes. Medical eligibility classification codes are not entered into the subsystem without verification that financial eligibility has been determined. Claims are rejected for any date where both medical and financial eligibility are not in place. The subsystem also tracks persons under appeal to assure continued payment of services if a timely appeal was filed. Each program requiring medical eligibility determination and/or prior authorization of the service has an individual classification code.

Overall Medicaid program integrity:
Chapter I of the MaineCare Benefits Manual (MBM), (https://www.maine.gov/sos/cec/rules/10/ch101.htm) Section 1.16 for Audits states that The Division of Audit or duly Authorized Agents appointed by the Department of Health and Human Services (DHHS) have the authority to monitor payments to any MaineCare provider by an audit or post-payment review. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements. Additionally, on an annual basis, the MaineCare (Medicaid) Program is wholly subjected to a Single State Audit conducted by the Office of the State Auditor.

The Division of Audit conducts audits and issues final cost settlements on all MaineCare cost reimbursed programs. MaineCare's Program Integrity Unit (PIU), as a duly authorized agent, is tasked with identifying fraud, waste and abuse within the MaineCare program and reviews MaineCare providers to ensure compliance with the MaineCare Benefits Manual including documentation, medical necessity, coding, and billing compliance.

For this waiver, rates are published by the Department and the services are subject to compliance reviews. The Department may recover any amounts due the State based on MBM, Chapter I. Unless the services are of an institutional nature, a yearly independent financial audit is not required. Under Chapter III (Allowances for Services) of the MBM, providers are responsible for maintaining adequate financial and statistical records and making them available when requested for inspection by authorized representatives of DHHS, Maine Attorney General's Office, or the Federal Government. Providers shall maintain accurate financial records for the services provided separate from other financial records.

The Program Integrity Unit conducts continuous and on-going audits on providers through post-payment reviews of MaineCare providers based on complaints, referrals, and/or data analytics. The methods that are used to audit include the use of statistically valid random samples, complaint-focused reviews, and full reviews. Data-driven reviews may not require a review of records or may require the provider to do a self-audit. The scope can vary from a short timeframe to a full 5-year review. An annual work plan determines the services to be reviewed, in addition to complaints and other referrals received. Program Integrity uses a confidence interval 90% and +/- 5% for SVRS.

When the Program Integrity Unit does a review based on a statistically valid random sample (SVRS), it starts with a well-defined universe of claims and uses the RAT-Stats v. 2010 program to obtain the SVRS by claim line. A statistician developed an extrapolation tool for use by the Program Integrity Unit (implemented in 2016) which determines the overpayment amount using a 5% margin of error. All reviews in which the Program Integrity Unit uses a SVRS are done following this process.

The Program Integrity Unit (PIU) does not currently have the ability to run a report that captures the number of cases done based on a SVRS, but an estimate of the frequency would be approximately 20-35% of the time. For certain services, MaineCare needs to look at all Participants in a specific location in order to determine staff to client ratios, therefore a SVRS would not be appropriate.

In the event that the Department of Health and Human Services (DHHS) is aware that a new provider will be providing a service that has a high capacity for fraud and abuse (such as personal care services), Program Integrity will prioritize that agency. This may range from a desk-level review of claims data to a full review of provider records. Additionally, the Department (DHHS) conducts routine statistical analysis of provider claims data in order to identify billing outliers. The Department then further investigates these outliers. Finally, the Department has engaged in targeted reviews of certain Medicaid services, in response to concerns about potential widespread deficiencies across providers.

Outliers are determined based on a variety of factors, such as the number of services, amount paid, units per Participant, or services per Participant. Factors are reviewed across the same service type or provider type to compare providers against their peers, using a specified standard deviation above the mean. Some services may require a different factor to be

considered an outlier, such as an absence of care (e.g. DME prescribed with no prior relationship, or non-emergency transportation without a corresponding medical claim); where another service may require looking at factors to determine overutilization or upcoding, such as a percentage of what was billed (e.g. percentage of high-level office visits to total office visits). The frequency in which these analyses typically occur is annually, based on an annual work plan.

Provider types with high capacities for fraud and abuse are prioritized in Program Integrity's annual work plan. Program Integrity Unit (PIU) uses a data-driven approach, and the outcome helps determine the type of review. If the provider has also been the subject of complaints or other concerns, that may warrant a full review. If the provider's claims are homogenous, PIU would tend to use a SVRS. Otherwise, PIU would do a desk-level or full review. In some instances, PIU does not need to review records, such as for coding or limits issues, and that information can be used to strengthen claims edits processing. Program Integrity strives to make the most of PIU resources, including utilizing the Unified Program Integrity Contractor (for the State of Maine, this contractor is Safeguard Services, LLC) for reviews of high-risk provider types.

The State has not engaged in targeted reviews because of widespread deficiencies, but rather, has engaged in targeted reviews to look for such deficiencies. Some services that have been reviewed using this type of approach are Home and Community Based Services and Personal Care Services. Deficiencies noted (though not necessarily widespread) included lack of or untimely background checks on employees, staffing ratios not being met (HCBS services), overbilling units (PCS), and general documentation deficiencies. The actions taken to resolve these issues include recouping overpayments from providers, referrals to Licensing, and recommendations brought forth for policy and system enhancements.

On-site reviews are conducted. Typical reasons for conducting an on-site review include whether there are concerns of fraud, if the provider is not cooperating with record requests by mail, or there is a need to see where records are secured or to review a provider's electronic health record system.

Maine's Program Integrity Unit plans to use EVV during post-payment review/audits. Program Integrity staff will compare the information in the EVV to the records submitted by the provider and the claims paid by MaineCare.

Program Integrity will utilize the EVV reports to inform decision-making regarding providers that should be selected for post-payment review. Providers with a high number of exceptions per employee, per consumer, or agency-wide will be prioritized. The Program Integrity sampling approach will include using statistically valid random samples (confidence interval 90% and +/- 5%) of claims for some providers but may also include looking at specific claims based on exceptions for other providers.

Maine has specific reporting requirements outlined in our policies. Regardless of the source, all complaints received in Program Integrity are logged and triaged within 48 hours. The triage process identifies whether there are any Participant safety concerns, and if so, an immediate referral is made to Adult Protective Services or Child Protective Services. The complaint then may be passed on to an auditor for further review. Outliers are identified based on payment amounts and amount paid per recipient being one standard deviation above the mean. Identifying growth over time entails looking at all claims for a specific service over a 2–5-year period to determine if the units increased by 100% or more from one year to the next. Maine's Program Integrity Unit may choose to review providers that are relatively new to the program to check for compliance, or providers that have never been reviewed, even if their claims appear appropriate.

The state is not a provider of these waiver services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of claims with appropriate documentation that services were rendered, coded, and paid in accordance with the reimbursement methodology in the approved waiver. Numerator: Total number of claims with appropriate documentation of services rendered, coded, and paid in accordance with the reimbursement methodology in the approved waiver. Denominator: Total number of paid claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and Percent of rates consistent with approved rate methodology. Numerator: Number of rates consistent with approved rate methodology. Denominator: Total

number of rates.

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The current MMIS system limits all services provided under the waiver to what is permitted by the policy for each classification group. Claims are denied if improper rates are billed or units of service are billed in excess of the limits outlined in policy.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

If concerns are raised by a provider regarding claims, the provider contacts the provider relations specialist through the Medicaid agency. If additional policy issues are identified, OADS requests data from OMS to verify the information. OADS and OMS work together to develop a plan for making changes in policy, provider's billing process and/or the MMIS system.

If the State Medicaid Agency were to identify a problem with claims, they would be evaluated further by having a discussion with the agency submitting the claim. The provider would then need to correct the claim. If there was any indication that the provider knowingly submitted inaccurate claims, or appeared fraudulent in any way, the State's program integrity unit would be contacted. Program Integrity would pull provider records, claims information, participant records etc...to determine if there are errors between the service delivered, what's authorized, and how it is billed. Depending on the errors or descrepencies detected, program integrity could seek recoupment, terminate the provider agreement, or even refer the provider to the Health Care Crimes unit of the State's Attorney General's Office.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other***	☐ ***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
Specify:	
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *As needed.*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Office of MaineCare Services (OMS) of the Maine Department of Health and Human Services' (Department), in collaboration with the Office of Aging and Disability Services (OADS), is responsible for establishing provider payment rates for waiver services. Historically, the Department has established payment rates through a variety of mechanisms, including consideration of historic cost and budget data, comparisons to rates paid for similar services in other programs, and targeted rate studies. Rates for this waiver are subject to review and amendment by the State legislature. The Maine Administrative Procedure Act (APA) applies uniform requirements to state agencies with rulemaking power and sets minimum standards for agencies to follow in adopting and implementing changes to rule. All MaineCare policies are posted on the Department's website for access at any time. The provider fee schedule is published in the MaineCare Benefits Manual, Chapter III, Section 21. https://www.maine.gov/sos/cec/rules/10/ch101.htm. Additionally, please see section Main 6-I of this approved Waiver for more information on how the state solicits public input for waiver amendments and renewals.

Waiver services are reimbursed on a prospective, fee-for-service basis, with a few exceptions. All rates were last updated by the Department in January 2022, to accomplish two aims: (1) ensure compliance with the requirements of with P.L. 2021, ch. 398 section AAAA (as described below), and (2) provide the COLA authorized by P.L 2021, section AAAA (as described below).

Rates based on 2020 rate study:
Burns & Associates, Inc. completed a rate study in 2020 that included multiple ME.0159 services. These rates were subsequently published by the Department. The rate models used to establish the rates (below) were based on data from a number of different sources, including:

- *A provider survey conducted in 2019*
- *Maine-specific wage data from the Bureau of Labor Statistics' May 2019 dataset, inflated to January 2021 using Maine-specific historic wage growth data from the Bureau of Economic Analysis*
- *Employee benefits data from the Bureau of Labor Statistics' 2019 National Compensation Survey and health insurance cost data from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey; and*
- *The Internal Revenue Services' 2020 standard mileage rate*

The ME0159 rates that were revised and updated by the rate study included the services below. The services below are reimbursed based on a quarter hour, with the exception of Career Planning services, which are reimbursed hourly.

- *Community Supports Group (community)*
- *Community Supports Individual (community)*
- *Home Support-1/4 hour*
- *Home Support-Remote Support (based on the direct care rate for Home Support-1/4 hour)*
- *Employment Specialist Services*
- *Work Support-Individual*
- *Career Planning*

Services below have published rates that have been determined by the Department, rate-setting division, based on provider cost data. Prior to publication, these rates go through the State Medicaid Agency, Finance Division, Commissioner's office for oversight and approval. All rates are proposed by the Department and open to public comment.

- *Shared Living (Adult Foster Care, per diem)*
- *Home Support-Agency Per Diem*
- *Home Support-Family-Centered Support (per diem)*
- *Crisis Assessment (per encounter)*
- *Crisis Intervention (per quarter hour)*
- *Community Support-center based (per quarter hour)*
- *Work Support-Group (per quarter hour)*
- *Assistive Technology – Transmission*

Similarly, the services below have published rates that have been determined by the OMS rate-setting division. These rates are established in order to be consistent with similar services found within the state Medicaid program. Prior to publication, these rates go through the State Medicaid Agency, Finance Division, Commissioner's office for oversight and approval. All rates are proposed by the Department and open to public comment. These services are reimbursed per quarter hour.

- *Assistive Technology Assessment*
- *Consultative Services*

- *Non-Traditional Communication Services*
- *Occupational Therapy-Maintenance*
- *Physical Therapy-Maintenance*
- *Speech Therapy-Maintenance*

Services reimbursed per invoice, based on actual costs, subject to prior approval and up to the approved limit:

- *Communication aids-Assistive Devices*
- *Assistive Technology-Devices*
- *Specialized Medical Equipment and Supplies*
- *Home Accessibility Adaptations*

Non-Medical Transportation is reimbursed on a per-member per-month basis, according to a full risk capitation model. The rates were calculated by Deloitte Consulting LLP and are consistent with CMS requirements that the capitation rates be actuarially sound and appropriate. The database variables (by region) included paid amount, number of rides, rides per thousand, average cost per ride, miles, miles per ride, cost per ride, and base per member per month.
Additionally, rate changes have resulted from specific legislation, for example, retroactive rate and service cap increases that were effective January 1, 2021 resulted from the Maine Legislature's passage of P.L. 2019 ch. 616, An Act Making Supplemental Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2020 and June 30, 2021. The Act provided funding for rate adjustments for specific services, to reflect the rate models prepared for the Department by Burns & Associates, Inc.
Recent legislation will systematize rate setting on an ongoing basis. This will enhance the Department's ability to ensure that rates are regularly reviewed for economy, efficiency, and quality of care, and that rates are sufficient to enlist enough providers. PL 2021, ch. 639 was enacted in 2022 and took effect August 8, 2022. As passed, PL 2021, ch. 639 creates a new stand-alone section of Maine law (22 M.R.S.A. §3173-J) that codifies the processes and principles for the MaineCare Rate System. These processes and principles include setting a schedule for regular rate review and adjustment, to be reviewed annually in consultation with a Technical Advisory Panel (TAP); reviewing relevant state and national data to inform rate amounts and payment models, with an emphasis on models that promote high value services by connecting reimbursement to performance; and formalizing a clear and transparent process for rate determination that includes public notice and comment.
On an ongoing basis, the Department's rate-setting unit will regularly review and adjust rates in compliance with PL 2021, ch. 398, AAAA. The new law requires that, effective January 1, 2022, the labor components of MaineCare reimbursement rates for specified services delivered by essential support workers must equal at least 125% of the minimum wage established in Title 26, section 664, subsection 1. Essential support workers are individuals who by virtue of employment generally provide to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or have direct access to provide care and services to clients, patients or residents regardless of the setting. 22 M.R.S. 7401. In addition, Part AAAA states that the reimbursement rate must include an amount necessary to reimburse the provider for taxes and benefits related to the wages. 22 M.R.S. §7402(2). Section AAAA-2 of the Act specifies that the 125% of minimum wage requirement for essential support workers applies to ME.0159 services.
PL 2021, ch. 398, OOO authorizes the Department to implement cost of living increases (COLAs) for services provided under ME.0159. Each January 1, services will receive an annual COLA equal to the percentage increase in the state minimum wage as set by the Department of Labor consistent with 26 M.R.S. §664. Services that received an increase to their rate within the previous 12-month period will not receive the annual COLA increase effective the following January 1. Pursuant to 22 M.R.S. § 7402(2), the legislation requires annual January ME.0159 COLA updates to ensure that reimbursement rates continue to comply with 22 M.R.S. Chapter 1627 going forward.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers bill the Department directly through the MMIS system. Claims are processed and paid directly to each provider.

For Transportation Services, the Broker shall receive a monthly capitated per-member per month (PMPM) payment for each Participant whose eligibility for the current month has been confirmed by the Department regardless of the Participants NEMT service use. This is a full risk contract outside of the MMIS system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

A Participant is not eligible for waiver services until both financial and medical eligibility have been established. Claims would not be processed without establishing eligibility as well as classification for services.

Upon assessment of the Participant, the medical eligibility data is entered into the electronic database system. Start and end dates for services are entered also. These dates correspond to the dates in which a provider can submit claims. If an end date has been reached and the Participant has not been reassessed for continued medical eligibility and classified with a new set of start and end dates, claims for services provided to that Participant will not be paid. When service is recommended in the Participant's plan, authorization is given to the provider in advance of provision of services and authorization is electronically transferred to the claims system.

Additionally, effective January 1, 2021, Maine implemented Electronic Visit Verification (EVV) for 1915(c) Authority waiver programs delivering personal care services within the home. Maine contracted with its Fiscal Agent, Gainwell, for an EVV solution. Gainwell has subcontracted with Sandata for the following EVV solution components: mobile and telephony applications that allow providers to create EVV records, a "3rd party aggregator" that allows providers with other EVV systems to submit data into Sandata, a portal to allow provider staff to manage accounts and records, and claims editing within the MMIS to match claims for PCS services with EVV records. The system requires that all visit records include member ID, caretaker ID, date of service, start and end times of the service, location, and CPT or HCPCS code.

The Maine EVV system includes a pre-payment validation process as well as post-payment review process. Pre-payment validation includes a 30-day pend process such that claims for services subject to EVV will pend for up to 30 days while the system searches for a matching EVV record and deny when no verified EVV record is found. The post-payment process includes ongoing monitoring and surveillance of claims data as described below.

Ongoing monitoring is conducted by the operating agency and includes on-site visits to monitor compliance with the waiver document, regulations and contract performance. If, at any time, the services provided do not conform, OADS will notify the Medicaid agency which will then audit claims for wrongful payment.

Payment for services provided is a multistep process. This is specifically outlined in the Maine MaineCare Benefits Manual, Chapter I- Section 1 General Administrative Policies and Procedures, Chapter II-Specific Policies by Service, and Chapter III- Allowances for Services describes in detail the reimbursement , payment process , and audit oversight including utilization review. Chapter I of the MaineCare Benefits Manual, Section 1.17, Utilization Review, states the following:

The Department or its Authorized Agent is responsible for carrying out a series of safeguarding measures. These measures safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assessing the quality of such services available under MaineCare. The Department may use consultants and peer reviewers with expertise appropriate to the medical care or services to be reviewed.
The Department has the authority to request medical records and other records as necessary to support utilization review, utilization management, concurrent review, or other service review activities. Providers must respond to requests in a timely manner and at no charge to the Department.

Chapter I of the MaineCare Benefits Manual, Section 1.18, Program Integrity, states the following:
The Program Integrity Unit, Division of Audit and /or the Department's Authorized Agent are responsible for surveillance and referral activities that may include, but are not limited to:
A. A continuous sampling review of the utilization of care and services for which payment is claimed;
B. An on-going sample evaluation of the necessity, quality, quantity and timeliness of the services provided to Participants;
C. An extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare;
D. A post-payment review that may consist of Participant utilization profiles, provider services profiles, claims, all pertinent professional and financial records, and information received from other sources;
E. The implementation of the Restriction Plans;
F. Referral to appropriate licensing boards or registries; and
G. Referral to the Maine Attorney General's Office, Healthcare Crimes Unit, for those cases in which fraudulent activity is suspected.

The Department and its professional advisors regard the maintenance of adequate clinical and other required financial

and product-related records as essential for the delivery of quality care. In addition, providers should be aware that comprehensive records, including but not limited to: treatment/service plans, progress notes, product and/or service order forms, invoices, and documentation of delivery of services and /or products provided are key documents for post-payment reviews. In the absence of proper and comprehensive records, no payment will be made and/or payments previously made may be recouped.
Once an overpayment has been identified and is finally determined, a Notice of Debt is sent over to the Maine Department of Health and Human Services' Service Center for collection. The Service Center will arrange for the repayment of the debt with the provider. The Service Center recoups in a variety of ways including: lump sum payment, installment payment plans, or offsetting against future Medicaid reimbursement.

**2 Due to Character limit - see Main - Additional Needed Information for remainder of this section.*

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a. Transportation is reimbursed through a 1915b Me.19 Maine Non-emergency Transportation Waiver capitated system with contracted brokers outside the MMIS system. b. The process for making the payments is through contracted services, the entity that processes these payments is the Department of Administration and Finance. c. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker submits encounter claims data. A review of the encounter data for each transportation broker is completed regularly. Transportation Service reimbursement is capitated and paid to the broker through the monthly invoice submitted to the Department by the Broker. The monthly invoice is paid through the State's accounting system and subject to the internal controls established by the Office of the State Controller. An audit trail of payments is based on the Maine Medicaid chart of accounts. A detailed explanation of transportation services is described in greater detail in the transportation waiver. The appropriation and unit / Object codes for entry onto line 19A of the CMS64 report are as follows:
Appropriation: 0147-
Unit for waivered services: 3618

Object codes: 6772; 6778; and 6786;
Cash draws for the federal portion of the Payment Management System are completed regularly through the Batch Interface claims processing system; and accounted for through the accounting appropriation 0147 for Medicaid. The unit for waivered services is 3618 using object codes 6772 ; 6778; and 6786. d. The basis of the draw is through the Maine Medicaid chart of accounts. The appropriation and unit / Object codes for entry onto line 19A of the CMS64 report are as follows (and previously noted):
Appropriation: 0147-
Unit for waivered services: 3618 Object codes: 6772; 6778; and 6786;
Cash draws for the federal portion of the Payment Management System are completed regularly through the Batch Interface claims processing system; and accounted for through the accounting appropriation 0147 for Medicaid. The unit for waivered services is 3618 using object codes 6772 ; 6778; and 6786.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For Transportation Services- The limited fiscal agent is selected through an RFP process. The waiver services that the fiscal agent will make payment for are Transportation Services. The fiscal agent pays through a capitated system. Chapter I of the MaineCare Benefits Manual authorizes audits for Services. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data. The broker for transportation is one of 3 contracted entities for the 8 regions depending upon the region in the state. Regions 3 and 4 are served by Penquis Community Action Program, Regions 1, 2, 6, 7 & 8 are served by LogistiCare Solutions, LLC, and Region 5 is served by Mid Coast Connector.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of***

the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the*

non-federal share of computable waiver costs. Select at least one:

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The rate structure for services delivered in residential settings is based solely on the cost of delivering the service and does not include room and board costs. Cost of room and board is paid for separately by a combination of participant funds (e.g. SSI) and other state contracted funds. Any payments made to room and board does not process through the MMIS claim system and is therefore not included with the cost.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when***

the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	28861.22	15014.00	43875.22	222644.00	8566.00	231210.00	187334.78
2	17836.89	15465.00	33301.89	229324.00	8823.00	238147.00	204845.11
3	39583.49	15928.00	55511.49	236203.00	9088.00	245291.00	189779.51
4	41560.98	16406.00	57966.98	243289.00	9360.00	252649.00	194682.02
5	43637.57	16899.00	60536.57	250588.00	9641.00	260229.00	199692.43

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who*

will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*
		Level of Care:
		ICF/IID
Year 1	*3215*	*3215*
Year 2	*3575*	*3575*
Year 3	*3755*	*3755*
Year 4	*3755*	*3755*
Year 5	*3755*	*3755*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average ALOS equals 277 days which applies for Waiver Years 1-5. This number equals the amount taken directly from the most recent 372 Waiver reporting that was submitted, which is for FY 2018 (01/01/2018 - 12/31/2018). Please note that the average ALOS was 320 days for Waiver Years (FYs) 2016 & 2017 which was derived from applicable 372 Waiver Reports. It was decided to use the most recent average ALOS as the participant counts have increased in the past few years.

Per IRAI 12.15.20: The participant count was based on a legislatively appropriated budget amount. As a result, participant counts are budgeted at 3600. The ALOS was predicated on historical usage from the 372 report. Because past historical data from the 372 report is a strong indicator of a future projected ALOS, reliance was placed on the 372 report for the ALOS.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

For Waiver Years 1-5:

The D Calculation was reviewed (for guidance) for service utilization within the waiver from the most recent 372 report for Waiver Year (WY) (01/01/2018 - 12/31/2018. However, queries were from the MaineCare Claims processing system for the most recent utilization data (CYs 2019 & 2020) as well as case managers' estimates, as well as estimates from staff of the Office of Aging and Disability Services (OADS) of future utilization for new services for future utilization for services (service components in the waiver). Historical utilization was used as a predictor of future utilization during the renewal period. Rates for the renewal were changed to represent recently approved rate increases. Utilization for the renewal period was assigned to each of the services, and the participant usage was multiplied by the expected units of service as well as by the unit rate. This calculation gave us the total cost for the program for the renewal years. The year to year totals for the renewal period were not given a percentage increase (or decrease) due to the uncertainty of new participant enrollment and future budget constraints.

Adjustments (utilization from WY 2020 was distributed to the new waiver participant group of 400 participants (2,635 and 3,035 participants)

January 1, 2021 Rate increase: WY1- WY5 -
The following rate increases were entered:
Work Support-Individual: $8.46 to $12.00
Career Planning: $34.29 to $58.25
Home Support-Quarter hour: $7.75 to $9.49
Employment Specialist: $9.09 to $13.73

participant Count Increase: The participant counts were increased WYs 1-5 proportionally by 15% based on the increase in participant count from 2,635 to 3,035.
Note: Per CMS IRAI 12/9/2020 no changes made MJF-Financial Analyst

August 30, 2021 Edits:
Based on recent budget approvals OADS able to offer the following enrollment increases:
WY1= 180 to 3215
WY2= 360 to 3575
WY3= 180 to 3755
WY4 = 3755
WY5 = 3755
Enrollments allocated proportionally based on percentage increases.

July 1, 2022 Rate increase (entered June 27, 2022): WY2- WY5 -

WY2: half year rate increase;
WYs 3-WY5-full annual increases for all procedure codes legislatively approved updates

Rate increases from 6% to 97% procedure specific.

Amendement: WY4 and WY5 rates were trended up at 5% to account for inflation.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

For Year 1 of the renewal period, the amount (13,740) was taken directly from the WY 2018 (01/01/2018 - 12/31/2018) 372 Waiver report. Based on historical 3% increase, the amount was trended to $14,577 (to CY 2020 or $14,577). The $14,577 was trended 3% to $15,014 as the base for CY 2021.

The trend factor was based on a budgeted increases of 3%.

Beginning with the Year 1 renewal period, and ending with the Year 5 renewal period, a 3% projected increase was used based on projected budget increases for the time period.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

For Year 1 of the renewal period, the amount (203,751) was taken directly from the WY 2018 (01/01/2018 - 12/31/2018) 372 Waiver report. Based on historical 3% increase, the amount was trended to $216,159 (to CY 2020 or $216,159). The $216,159 was trended 3% to $222,644 as the base for CY 2021.

The trend factor was based on a budgeted increases of 3%.

Beginning with the Year 1 renewal period, and ending with the Year 5 renewal period, a 3% projected increase was used based on projected budget increases for the time period.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

For Year 1 of the renewal period, the amount (7,839) was taken directly from the WY 2018 (01/01/2018 - 12/31/2018) 372 Waiver report. Based on historical 3% increase, the amount was trended to $8,316 (to CY 2020 or $8,316). The $8,316 was trended 3% to $8,316 as the base for CY 2021.

The trend factor was based on a budgeted increases of 3%.

Beginning with the Year 1 renewal period, and ending with the Year 5 renewal period, a 3% projected increase was used based on projected budget increases for the time period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Community Support	
Home Support-1/4 hour	
Respite	
Work Support- Group	
Financial Management Services	
Individual Goods and Services	
Supports Brokerage	
Assistive Technology	
Career Planning	
Employment Specialist Services	
Home Accessibility Adaptations	
Home Support-Remote Support	
Non-Medical Transportation	

Waiver Services	
Shared Living Services	
Work Support-Individual	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support Total:							**35615113.86**
Community Support-Center Based	☐	per 1/4 hour	1182	2519.00	5.17	**15393457.86**	
Community Support-Group	☐	per 1/4 hour	788	1400.00	7.13	**7865816.00**	
Community Support-Individual	☐	per 1/4 hour	788	1400.00	11.20	**12355840.00**	
Home Support-1/4 hour Total:							**10871184.09**
Home Support-1/4 hour	☐	per 1/4 hour	907	1263.00	9.49	**10871184.09**	
Respite Total:							**4938.00**
Respite	☐	per diem	10	4.00	110.21	**4408.40**	
Respite Services-1/4 Hour	☐	per 1/4 hour	1	160.00	3.31	**529.60**	
Work Support-Group Total:							**15985.20**
Work Support-Group-Four Participants	☐	per 1/4 hour	2	385.00	2.12	**1632.40**	
Work Support-Group-Three Participants	☐	per 1/4 hour	2	385.00	2.82	**2171.40**	
Work Support-Group-Five Participants	☐	per 1/4 hour	2	385.00	1.69	**1301.30**	

GRAND TOTAL:	**92788825.33**
Total: Services included in capitation:	11712502.20
Total: Services not included in capitation:	81076323.13
Total Estimated Unduplicated Participants:	**3215**
Factor D (Divide total by number of participants):	**28861.22**
Services included in capitation:	3643.08
Services not included in capitation:	25218.14
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Work Support-Group-Six Participants	☐	per 1/4 hour	2	385.00	1.41	1085.70	
Work Support-Group-Two Participants	☐	per 1/4 hour	6	385.00	4.24	9794.40	
Financial Management Services Total:							1.00
Financial Management Services	☐	1	1	1.00	1.00	1.00	
Individual Goods and Services Total:							1.00
Individual Goods and Services	☐	1	1	1.00	1.00	1.00	
Supports Brokerage Total:							1.00
Supports Brokerage	☐	1	1	1.00	1.00	1.00	
Assistive Technology Total:							205676.16
Assistive Technology-Device	☐	per device	30	1.00	6000.00	180000.00	
Assistive Technology-Monthly Transmission	☐	per month	22	12.00	50.00	13200.00	
Assistive Technology-Assessment	☐	per 1/4 hour	54	16.00	14.44	12476.16	
Career Planning Total:							30290.00
Career Planning	☐	per hour	26	20.00	58.25	30290.00	
Employment Specialist Services Total:							29519.50
Employment Specialist Services	☐	per 1/4 hour	43	50.00	13.73	29519.50	
Home Accessibility Adaptations Total:							40000.00
Home Accessibility Adaptations	☐	per adaptation	2	4.00	5000.00	40000.00	
Home Support-Remote Support							6756.00

GRAND TOTAL:	**92788825.33**
Total: Services included in capitation:	11712502.20
Total: Services not included in capitation:	81076323.13
Total Estimated Unduplicated Participants:	**3215**
Factor D (Divide total by number of participants):	**28861.22**
Services included in capitation:	3643.08
Services not included in capitation:	25218.14
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Monitor only	☐	per 1/4 hour	30	1.00	2.00	**60.00**	
Interactive Support	☐	per 1/4 hour	54	16.00	7.75	**6696.00**	
Non-Medical Transportation Total:							**11712502.20**
Non-Medical Transportation - PMPM	☒	PMPM	3215	12.00	303.59	**11712502.20**	
Shared Living Services Total:							**32427337.32**
Shared Living - One Participant	☐	per diem	1	365.00	78.02	**28477.30**	
Shared Living - One Participant ILS	☐	per diem	569	365.00	156.00	**32398860.00**	
Shared Living - Two Participant	☐	per diem	1	1.00	0.01	**0.01**	
Shared Living - Two Participant ILS	☐	per diem	1	1.00	0.01	**0.01**	
Work Support-Individual Total:							**1829520.00**
Work Support-Individual	☐	per 1/4 hour	396	385.00	12.00	**1829520.00**	

GRAND TOTAL:	**92788825.33**
Total: Services included in capitation:	11712502.20
Total: Services not included in capitation:	81076323.13
Total Estimated Unduplicated Participants:	**3215**
Factor D (Divide total by number of participants):	**28861.22**
Services included in capitation:	3643.08
Services not included in capitation:	25218.14
Average Length of Stay on the Waiver:	277

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support Total:							**15230534.00**
Community Support-Center Based	☐	per 1/4 hour	1315	1000.00	6.53	**8586950.00**	
Community Support-Group	☐	per 1/4 hour	876	400.00	7.37	**2582448.00**	
Community Support-Individual	☐	per 1/4 hour	876	400.00	11.59	**4061136.00**	
Home Support-1/4 hour Total:							**5024880.00**
Home Support-1/4 hour	☐	per 1/4 hour	1008	500.00	9.97	**5024880.00**	
Respite Total:							**9701.52**
Respite	☐	per diem	11	4.00	198.78	**8746.32**	
Respite Services-1/4 Hour	☐	per 1/4 hour	1	160.00	5.97	**955.20**	
Work Support-Group Total:							**22922.90**
Work Support-Group-Four Participants	☐	per 1/4 hour	2	385.00	2.97	**2286.90**	
Work Support-Group-Three Participants	☐	per 1/4 hour	2	385.00	3.75	**2887.50**	
Work Support-Group-Five Participants	☐	per 1/4 hour	2	385.00	2.51	**1932.70**	
Work Support-Group-Six Participants	☐	per 1/4 hour	2	385.00	2.20	**1694.00**	
Work Support-Group-Two Participants	☐	per 1/4 hour	7	385.00	5.24	**14121.80**	
Financial Management Services Total:							**1.00**
Financial Management Services	☐	1	1	1.00	1.00	**1.00**	
Individual Goods and Services Total:							**1.00**
Individual Goods and Services	☐	1	1	1.00	1.00	**1.00**	
Supports Brokerage Total:							**1.00**

GRAND TOTAL:	**63766891.12**
Total: Services included in capitation:	*13024011.00*
Total: Services not included in capitation:	*50742880.12*
Total Estimated Unduplicated Participants:	**3575**
Factor D (Divide total by number of participants):	**17836.89**
Services included in capitation:	*3643.00*
Services not included in capitation:	*14193.81*
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports Brokerage	☐	1	1	1.00	1.00	1.00	
Assistive Technology Total:							236989.20
Assistive Technology-Device	☐	per device	33	1.00	6296.40	207781.20	
Assistive Technology-Monthly Transmission	☐	per month	25	12.00	50.00	15000.00	
Assistive Technology-Assessment	☐	per 1/4 hour	60	16.00	14.80	14208.00	
Career Planning Total:							34620.20
Career Planning	☐	per hour	29	20.00	59.69	34620.20	
Employment Specialist Services Total:							33768.00
Employment Specialist Services	☐	per 1/4 hour	48	50.00	14.07	33768.00	
Home Accessibility Adaptations Total:							40000.00
Home Accessibility Adaptations	☐	per adaptation	2	4.00	5000.00	40000.00	
Home Support-Remote Support Total:							8817.51
Monitor only	☐	per 1/4 hour	33	1.00	2.47	81.51	
Interactive Support	☐	per 1/4 hour	60	16.00	9.10	8736.00	
Non-Medical Transportation Total:							13024011.00
Non-Medical Transportation - PMPM	☒	PMPM	3575	12.00	303.59	13024011.00	
Shared Living Services Total:							28063223.79
Shared Living - One Participant	☐	per diem	1	277.00	119.89	33209.53	
Shared Living - One Participant	☐	per diem	633	277.00	159.86	28030012.26	

GRAND TOTAL:	63766891.12
Total: Services included in capitation:	13024011.00
Total: Services not included in capitation:	50742880.12
Total Estimated Unduplicated Participants:	3575
Factor D (Divide total by number of participants):	17836.89
Services included in capitation:	3643.00
Services not included in capitation:	14193.81
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ILS							
Shared Living - Two Participant	☐	per diem	1	1.00	1.00	1.00	
Shared Living - Two Participant ILS	☐	per diem	1	1.00	1.00	1.00	
Work Support-Individual Total:							2037420.00
Work Support-Individual	☐	per 1/4 hour	441	385.00	12.00	2037420.00	

GRAND TOTAL:	63766891.12
Total: Services included in capitation:	13024011.00
Total: Services not included in capitation:	50742880.12
Total Estimated Unduplicated Participants:	3575
Factor D (Divide total by number of participants):	17836.89
Services included in capitation:	3643.00
Services not included in capitation:	14193.81
Average Length of Stay on the Waiver:	277

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support Total:							17573750.00
Community Support-Center Based	☐	per 1/4 hour	1381	1000.00	7.07	9763670.00	
Community Support-Group	☐	per 1/4 hour	921	400.00	8.24	3035616.00	
Community Support-Individual	☐	per 1/4 hour	921	400.00	12.96	4774464.00	
Home Support-1/4 hour Total:							5988645.00
Home Support-1/4	☐	per 1/4 hour				5988645.00	

GRAND TOTAL:	148635988.30
Total: Services included in capitation:	13679765.40
Total: Services not included in capitation:	134956222.90
Total Estimated Unduplicated Participants:	3755
Factor D (Divide total by number of participants):	39583.49
Services included in capitation:	3643.08
Services not included in capitation:	35940.41
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
hour			1059	500.00	11.31		
Respite Total:							**15179.72**
Respite	☐	per diem	11	4.00	311.03	**13685.32**	
Respite Services-1/4 Hour	☐	per 1/4 hour	1	160.00	9.34	**1494.40**	
Work Support-Group Total:							**30507.40**
Work Support-Group-Four Participants	☐	per 1/4 hour	2	385.00	4.13	**3180.10**	
Work Support-Group-Three Participants	☐	per 1/4 hour	2	385.00	5.07	**3903.90**	
Work Support-Group-Five Participants	☐	per 1/4 hour	2	385.00	3.60	**2772.00**	
Work Support-Group-Six Participants	☐	per 1/4 hour	2	385.00	3.23	**2487.10**	
Work Support-Group-Two Participants	☐	per 1/4 hour	7	385.00	6.74	**18164.30**	
Financial Management Services Total:							**225000.00**
Financial Management Services	☐	per month	150	12.00	125.00	**225000.00**	
Individual Goods and Services Total:							**472230.00**
Individual Goods and Services	☐	per invoice	75	12.00	524.70	**472230.00**	
Supports Brokerage Total:							**510000.00**
Supports Brokerage	☐	per 1/4 hour	150	200.00	17.00	**510000.00**	
Assistive Technology Total:							**271974.30**
Assistive Technology-Device	☐	per device	35	1.00	6815.22	**238532.70**	
Assistive Technology-Monthly Transmission	☐	per month	26	12.00	54.20	**16910.40**	
Assistive Technology-	☐	per 1/4 hour	63	16.00	16.40	**16531.20**	

GRAND TOTAL:	**148635988.30**
Total: Services included in capitation:	13679765.40
Total: Services not included in capitation:	134956222.90
Total Estimated Unduplicated Participants:	**3755**
Factor D (Divide total by number of participants):	**39583.49**
Services included in capitation:	3643.08
Services not included in capitation:	35940.41
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment							
Career Planning Total:							**41025.40**
Career Planning	☐	per hour	31	20.00	66.17	**41025.40**	
Employment Specialist Services Total:							**39780.00**
Employment Specialist Services	☐	per 1/4 hour	51	50.00	15.60	**39780.00**	
Home Accessibility Adaptations Total:							**43280.00**
Home Accessibility Adaptations	☐	per adaptation	2	4.00	5410.00	**43280.00**	
Home Support-Remote Support Total:							**11511.43**
Monitor only	☐	per 1/4 hour	35	1.00	3.17	**110.95**	
Interactive Support	☐	per 1/4 hour	63	16.00	11.31	**11400.48**	
Non-Medical Transportation Total:							**13679765.40**
Non-Medical Transportation - PMPM	☒	PMPM	3755	12.00	303.59	**13679765.40**	
Shared Living Services Total:							**107303724.00**
Shared Living - One Participant	☐	per diem	1800	310.00	177.20	**98877600.00**	
Shared Living - One Participant ILS	☐	per diem	60	310.00	261.67	**4867062.00**	
Shared Living - Two Participant	☐	per diem	100	260.00	132.90	**3455400.00**	
Shared Living - Two Participant ILS	☐	per diem	2	260.00	199.35	**103662.00**	
Work Support-Individual Total:							**2429615.65**
Work Support-Individual	☐	per 1/4 hour	463	385.00	13.63	**2429615.65**	

GRAND TOTAL:	**148635988.30**
Total: Services included in capitation:	13679765.40
Total: Services not included in capitation:	134956222.90
Total Estimated Unduplicated Participants:	**3755**
Factor D (Divide total by number of participants):	**39583.49**
Services included in capitation:	3643.08
Services not included in capitation:	35940.41
Average Length of Stay on the Waiver:	277

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support Total:							**18443920.00**
Community Support-Center Based	☐	per 1/4 hour	1381	1000.00	7.42	**10247020.00**	
Community Support-Group	☐	per 1/4 hour	921	400.00	8.65	**3186660.00**	
Community Support-Individual	☐	per 1/4 hour	921	400.00	13.60	**5010240.00**	
Home Support-1/4 hour Total:							**6290460.00**
Home Support-1/4 hour	☐	per 1/4 hour	1059	500.00	11.88	**6290460.00**	
Respite Total:							**15939.12**
Respite	☐	per diem	11	4.00	326.58	**14369.52**	
Respite Services-1/4 Hour	☐	per 1/4 hour	1	160.00	9.81	**1569.60**	
Work Support-Group Total:							**32039.70**
Work Support-Group-Four Participants	☐	per 1/4 hour	2	385.00	4.34	**3341.80**	
Work Support-Group-Three Participants	☐	per 1/4 hour	2	385.00	5.32	**4096.40**	
Work Support-Group-Five Participants	☐	per 1/4 hour	2	385.00	3.78	**2910.60**	
Work Support-Group-Six Participants	☐	per 1/4 hour	2	385.00	3.39	**2610.30**	
Work Support-Group-Two	☐	per 1/4 hour	7	385.00	7.08	**19080.60**	

GRAND TOTAL:	***156061491.64***
Total: Services included in capitation:	*14363776.20*
Total: Services not included in capitation:	*141697715.44*
Total Estimated Unduplicated Participants:	***3755***
Factor D (Divide total by number of participants):	***41560.98***
Services included in capitation:	*3825.24*
Services not included in capitation:	*37735.74*
Average Length of Stay on the Waiver:	*277*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participants							
Financial Management Services Total:							**236250.00**
Financial Management Services	☐	per month	150	12.00	131.25	**236250.00**	
Individual Goods and Services Total:							**495846.00**
Individual Goods and Services	☐	per invoice	75	12.00	550.94	**495846.00**	
Supports Brokerage Total:							**535500.00**
Supports Brokerage	☐	per 1/4 hour	150	200.00	17.85	**535500.00**	
Assistive Technology Total:							**285572.98**
Assistive Technology-Device	☐	per device	35	1.00	7155.98	**250459.30**	
Assistive Technology-Monthly Transmission	☐	per month	26	12.00	56.91	**17755.92**	
Assistive Technology-Assessment	☐	per 1/4 hour	63	16.00	17.22	**17357.76**	
Career Planning Total:							**43077.60**
Career Planning	☐	per hour	31	20.00	69.48	**43077.60**	
Employment Specialist Services Total:							**41769.00**
Employment Specialist Services	☐	per 1/4 hour	51	50.00	16.38	**41769.00**	
Home Accessibility Adaptations Total:							**45444.00**
Home Accessibility Adaptations	☐	per adaptation	2	4.00	5680.50	**45444.00**	
Home Support-Remote Support Total:							**12091.59**
Monitor only	☐	per 1/4 hour	35	1.00	3.33	**116.55**	
Interactive	☐					**11975.04**	

GRAND TOTAL:	**156061491.64**
Total: Services included in capitation:	14363776.20
Total: Services not included in capitation:	141697715.44
Total Estimated Unduplicated Participants:	**3755**
Factor D (Divide total by number of participants):	**41560.98**
Services included in capitation:	3825.24
Services not included in capitation:	37735.74
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support		per 1/4 hour	63	16.00	11.88		
Non-Medical Transportation Total:							**14363776.20**
Non-Medical Transportation - PMPM	☒	PMPM	3755	12.00	318.77	**14363776.20**	
Shared Living Services Total:							**112668976.40**
Shared Living - One Participant	☐	per diem	1800	310.00	186.06	**103821480.00**	
Shared Living - One Participant ILS	☐	per diem	60	310.00	274.75	**5110350.00**	
Shared Living - Two Participant	☐	per diem	100	260.00	139.55	**3628300.00**	
Shared Living - Two Participant ILS	☐	per diem	2	260.00	209.32	**108846.40**	
Work Support-Individual Total:							**2550829.05**
Work Support-Individual	☐	per 1/4 hour	463	385.00	14.31	**2550829.05**	

GRAND TOTAL:	**156061491.64**
Total: Services included in capitation:	14363776.20
Total: Services not included in capitation:	141697715.44
Total Estimated Unduplicated Participants:	**3755**
Factor D (Divide total by number of participants):	**41560.98**
Services included in capitation:	3825.24
Services not included in capitation:	37735.74
Average Length of Stay on the Waiver:	277

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support Total:							**19363814.00**
Community Support-Center Based	☐	per 1/4 hour	1381	1000.00	7.79	**10757990.00**	
Community Support-Group	☐	per 1/4 hour	921	400.00	9.08	**3345072.00**	
Community Support-Individual	☐	per 1/4 hour	921	400.00	14.28	**5260752.00**	
Home Support-1/4 hour Total:							**6602865.00**
Home Support-1/4 hour	☐	per 1/4 hour	1059	500.00	12.47	**6602865.00**	
Respite Total:							**16736.04**
Respite	☐	per diem	11	4.00	342.91	**15088.04**	
Respite Services-1/4 Hour	☐	per 1/4 hour	1	160.00	10.30	**1648.00**	
Work Support-Group Total:							**33629.75**
Work Support-Group-Four Participants	☐	per 1/4 hour	2	385.00	4.55	**3503.50**	
Work Support-Group-Three Participants	☐	per 1/4 hour	2	385.00	5.59	**4304.30**	
Work Support-Group-Five Participants	☐	per 1/4 hour	2	385.00	3.97	**3056.90**	
Work Support-Group-Six Participants	☐	per 1/4 hour	2	385.00	3.56	**2741.20**	
Work Support-Group-Two Participants	☐	per 1/4 hour	7	385.00	7.43	**20023.85**	
Financial Management Services Total:							**248058.00**
Financial Management Services	☐	per month	150	12.00	137.81	**248058.00**	
Individual Goods and Services Total:							**520632.00**
Individual Goods and Services	☐	per invoice	75	12.00	578.48	**520632.00**	
Supports Brokerage Total:							**562200.00**

GRAND TOTAL:	**163859088.85**
Total: Services included in capitation:	15082032.60
Total: Services not included in capitation:	148777056.25
Total Estimated Unduplicated Participants:	**3755**
Factor D (Divide total by number of participants):	**43637.57**
Services included in capitation:	4016.52
Services not included in capitation:	39621.05
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports Brokerage	☐	per 1/4 hour	150	200.00	18.74	562200.00	
Assistive Technology Total:							299852.06
Assistive Technology-Device	☐	per device	35	1.00	7513.78	262982.30	
Assistive Technology-Monthly Transmission	☐	per month	26	12.00	59.76	18645.12	
Assistive Technology-Assessment	☐	per 1/4 hour	63	16.00	18.08	18224.64	
Career Planning Total:							45229.00
Career Planning	☐	per hour	31	20.00	72.95	45229.00	
Employment Specialist Services Total:							43860.00
Employment Specialist Services	☐	per 1/4 hour	51	50.00	17.20	43860.00	
Home Accessibility Adaptations Total:							47716.24
Home Accessibility Adaptations	☐	per adaptation	2	4.00	5964.53	47716.24	
Home Support-Remote Support Total:							12691.91
Monitor only	☐	per 1/4 hour	35	1.00	3.49	122.15	
Interactive Support	☐	per 1/4 hour	63	16.00	12.47	12569.76	
Non-Medical Transportation Total:							15082032.60
Non-Medical Transportation - PMPM	☒	PMPM	3755	12.00	334.71	15082032.60	
Shared Living Services Total:							118300599.60
Shared Living - One Participant	☐	per diem	1800	310.00	195.36	109010880.00	
Shared Living - One Participant	☐	per diem	60	310.00	288.49	5365914.00	

GRAND TOTAL:	**163859088.85**
Total: Services included in capitation:	15082032.60
Total: Services not included in capitation:	148777056.25
Total Estimated Unduplicated Participants:	**3755**
Factor D (Divide total by number of participants):	**43637.57**
Services included in capitation:	4016.52
Services not included in capitation:	39621.05
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ILS							
Shared Living - Two Participant	☐	per diem	100	260.00	146.52	**3809520.00**	
Shared Living - Two Participant ILS	☐	per diem	2	260.00	219.78	**114285.60**	
Work Support-Individual Total:							**2679172.65**
Work Support-Individual	☐	per 1/4 hour	463	385.00	15.03	**2679172.65**	

GRAND TOTAL:	**163859088.85**
Total: Services included in capitation:	15082032.60
Total: Services not included in capitation:	148777056.25
Total Estimated Unduplicated Participants:	**3755**
Factor D (Divide total by number of participants):	**43637.57**
Services included in capitation:	4016.52
Services not included in capitation:	39621.05
Average Length of Stay on the Waiver:	277