Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
MaineCare Services
Policy Division
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 624-4050; Fax: (207) 287-6106
TTY: Dial 711 (Maine Relay)

DATE: August 15, 2023

TO: Interested Parties

FROM: Michelle Probert, Director, MaineCare Services

SUBJECT: Proposed Rule: 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Chapter II, Section 29, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

PUBLIC HEARING: The Department will hold a combined in-person and remote (via Zoom) public hearing.

Date and Time: **September 11, 2023, 12:00 PM Eastern Time (US and Canada)**
Location: State Office Building, Conference Rooms A & B
109 Capitol Street, Augusta, ME

Zoom Meeting link: https://mainestate.zoom.us/j/88458657517
Meeting ID: 884 5865 7517

Some devices may require downloading a free app from Zoom prior to joining the public hearing event.

The Department requests that any interested party requiring special arrangements to attend the hearing in person contact the agency person listed below before Friday, September 8, 2023.

In addition to the public hearing, individuals may submit written comments to DHHS by the date listed in this notice.

COMMENT DEADLINE: Comments must be received by **11:59 PM on September 21, 2023**.

This Section 29 rule provides home and community-based services (HCBS) that are authorized by a federal Medicaid Section 1915(c) HCBS waiver that meets federal standards.

On December 18, 2020, The Centers for Medicare & Medicaid Services (CMS) approved the Department's request to renew the Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder waiver for a five-year period, with an effective date of January 1, 2021. On April 13, 2023, the Department gave public notice of proposed amendments to the CMS-approved Section 29 waiver, to add services and enhance service delivery. Following the receipt of public comment on the proposed amended waiver, the Department will seek and anticipates receiving CMS approval of the waiver amendment.

Through this rulemaking and in accordance with CMS approval of the renewed waiver, and the Department's proposed waiver amendment, the Department proposes to:

1) Align similar processes, service descriptions, and similar provisions with MaineCare's four other Section 1915(c) waivers (primarily the Section 21 waiver);

2) Make permanent certain flexibilities added under Appendix K authority during the Covid-19 Public Health Emergency (PHE), which will expire on November 11, 2023, including the additions of Individual Goods and Services, Self-Directed Services and tiered Community Support Services;

3) Strengthen safeguards for Members by enacting the Plan of Corrective Action and Request for Exceptions processes;

4) Incorporate the Department's proposed Global HCBS Rule (MBM Ch. I, Sec. 6- Global HCBS Waiver Person-Centered Planning and Settings Rule) by reference; and

5) Add the opportunity for Section 29 Members to receive Increased Level of Support if they receive Shared Living services and have extraordinary need for additional support with behavioral or medical issues.

The Department is concurrently undertaking major substantive rulemaking under the APA for MBM Ch. III, Sec. 29, to describe reimbursement procedures for the new and updated services described in this rulemaking, and is proposing retroactive application for rule provisions to November 12, 2023, pursuant to 22 M.R.S. § 42(8), following approval by the Legislature, and final adoption by the Department.

The Department proposes the following specific changes to this rule:

- Covered Services: updating, expansion or clarification of the descriptions for the following Covered Services:
  - Assistive Technology
  - Career Planning
  - Community Support
  - Employment Specialist Services
  - Home Accessibility Adaptations
  - Home Support – Quarter Hour
  - Home Support – Remote Support
  - Shared Living (Foster Care Adult)
  - Non-Medical Transportation Service
  - Work Support – Group
  - Work Support – Individual

- Revised Definitions: Updating the following definitions: Activities of Daily Living, Autism Spectrum Disorder, Intellectual Disability, Instrumental Activities of Daily Living, Person-Centered Service Plan and Shared Living.

- New Definitions: Addition of definitions for the following terms: Budget Authority, Community Inclusion, Competitive Integrated Employment, Community Mapping, Disability-Specific Setting, Employer Authority, Fiscal Intermediary, Home and Community Based Services, Personal Resources, Provider-Managed Service, Self-Direction, Service Implementation Plan, and Supports Broker.

- Self-Direction: Addition of Self-Direction Services, including Financial Management Services, Supports Brokerage Services, and Individual Goods and Services, to the list of covered services in Section 29 to expand opportunities for Members to manage and control certain services and service delivery methods. These changes make permanent new services temporarily offered under

- the Appendix K, Emergency Preparedness and Response amendment authority during the Covid-19 pandemic.

- Community Support: Separation of Community Support services into three tiers of service delivery: Community Only- Individual, Community Only- Group, and Center-Based, to support individualized needs of the participant population more broadly. The Department will seek CMS approval for this change.

- Exceptions from Caps on Services: Establishment of an exceptions process which provides that Section 29 Members, and Members applying to receive Section 29 benefits, may request services in excess of otherwise applicable Section 29 monetary and/or unit caps, where necessary to ensure that Section 29 Members receive adequate and appropriate services and supports in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). This rulemaking proposes the *Requests for Exceptions* provision (See Sec. 29.14, Requests for Exceptions).

- Global HCBS Rule: Incorporation of the requirements of the January 19, 2022, Global HCBS Rule: see Sec. 29.15-1 [Person Centered Service Planning Process] and Sec. 29.05-1 [Home and Community Based Services Settings]), implementing the federal requirements for Maine's Section 1915(c) home and community-based waiver programs as required by 42 C.F.R. Sec. 441.301(c). The HCBS Global Rule includes requirements for person-centered service planning and for settings in which HCBS waiver services are provided.

- 29.07-2 (Limits): Changing the limit from $58,168.50 to $84,689.28 for the combined annual cost of Home Support (Remote or Quarter-hour), Community Support, and Shared Living Services. The Department received CMS approval for this change.

- 29.08-3 (Termination from Participation as a MaineCare Provider): Clarification of this provision which establishes standards for providers who are disenrolling from participating as MaineCare providers. As revised, the provision expressly references the requirement in the MaineCare Benefits Manual, Ch. I, Sec. 1 that providers must give written notice to the Office of MaineCare Services of their intent to terminate participation in the MaineCare Program. In addition, this provision requires Section 29 providers to notify all Section 29 Members they serve of the provider's intent to terminate participation in the MaineCare program.

- 29.10 (Provider Qualifications): Clarification of Provider Qualifications and Requirements for Direct Support Professionals (DSPs) and for Career Planners, Job Coaches, and Employment Specialists delivering Career Planning, Work Support, and Employment Specialist Services, to state that provider agencies may hire DSPs who are seventeen (17) years of age. The minimum age requirement for Career Planners, Job Coaches, and Employment Specialists remains eighteen (18) years of age.

- 29.10-1 (DSP Qualifications): Requirement that all DSPs, regardless of capacity and prior to provision of services to a Member, receive training regarding the Global HCBS Rule. Moreover, within six (6) months of hire and annually thereafter, the proposed rule requires DSPs to comply with the Department's regulations: Reportable Events System (14-197 C.M.R. ch. 12) and the Adult Protective Services System (10-149 C.M.R. ch. 1).

- 29.10-9 (Electronic Visit Verification): Requirement that providers of Home Support-Quarter Hour services comply with Maine DHHS Electronic Visit Verification (EVV) system standards

- and requirements, in accordance with the 21st Century Cures Act (P.L. 114-255), Section 12006, as codified in 42 U.S.C. § 1396b(l).
- 29.10-11 (POCA): Authorization for the Office of Aging and Disability Services (OADS) to issue written notices of deficiencies in service delivery, and requirement for providers to submit and implement Plans of Corrective Action (POCA) as approved by the Department. Providers have the right to appeal written notices of deficiencies. This POCA process will provide increased protections for Members and ensure that providers are in compliance 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 Members.

- 29.11 (Member Appeals): Clarification that Members have the right to appeal decisions made regarding priority level and waitlist determinations.

- 29.16 (Appendix I-Shared Living Criteria for Increased Level of Support): Addition of a new appendix describing the criteria for an increased level of support if, due to extraordinary medical or behavioral needs, a Member requires Shared Living Services beyond the level of support defined in § 29.05-12.

- 29.19 (Appendix IV-Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living): Clarification of requirements and responsibilities of the Administrative Oversight Agency and the Shared Living Provider for Shared Living Services.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare website at http://www.maine.gov/dhhs/oms/rules/index.shtml or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or Maine Relay number 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process. Please address all comments to the agency contact person identified in the Notice of Agency Rulemaking Proposal.

Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Chapter III, Section 29, Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

PROPOSED RULE NUMBER:

CONCISE SUMMARY: The Department is proposing to make the following changes to this major substantive rule:

The Department is adding new services which will be reimbursed pursuant to this rule:

- Home Support - Quarter Hour (Self-Directed)
- Shared Living - One member, Increased level of support
- Shared Living - Two members, Increased level of support
- Community Support - Community Only - Individual
- Community Support - Community Only - Group
- Community Support - Community Only - Individual (Self-Directed)
- Home Accessibility Adaptations (Self-Directed)
- Home Accessibility Adaptations Repairs (Self-Directed)
- Assistive Technology - (Monitoring feature/device, stand alone or integrated, any type, includes all accessories,
  components and electronics, not otherwise classified) (Self-Directed)
- Financial Management Service
- Supports Brokerage
- Individual Goods and Services

Provision of these services was originally implemented through the Appendix K: Emergency Preparedness and Response authority in response to the COVID-19 Public Health Emergency, which was approved by CMS but was not added to the Ch. II, Sec. 29 rule at that time. Appendix K expires on November 11, 2023, and the Department is concurrently going through APA rulemaking for Ch. II, Section 29, to add these services to that rule. The Ch. II, Section 29 rule is a routine technical rule and is being proposed separately in anticipation of its being legally effective on or before November 12, 2023. The Department is proposing a retroactive application date of November 12, 2023, for the rates for the new services in this Chapter III rulemaking, so that both the new services and their rates share the same legal effective date. This retroactive application is authorized by 22 M.R.S. 42(8), as having the retroactive rates for the new services will benefit, and does not harm MaineCare members or providers.

In accordance with 22 M.R.S. §7402, the Department proposes to implement annual rate adjustments every January 1st. Specifically, Section 29 services that have standard unit rates and that did not receive a rate adjustment within the prior twelve months will receive an annual increase equal to the annual increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), for the Northeast Region, or its successor index, as published by the United States Department of Labor, Bureau of Labor Statistics or its successor agency. This increase will ensure that rates are sufficient to allow reimbursement for services provided by essential support workers to equal to at least 125% of the minimum wage established in 26 M.R.S. Section 664. 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. The Department proposes that this annual rate adjustment have a retroactive application date of January 1, 2024. This retroactive application is authorized by 22 M.R.S. Sec. 42(8), as this benefits, and does not harm, any MaineCare member or provider.

As authorized by 22 M.R.S. §3173-J, the Department proposes to remove reimbursement rates from the rule. The Department proposes that all Section 29 reimbursement rates will now be solely listed on the MaineCare Provider Fee Schedule, which is posted on the Department's website.

The Department intends to seek permanent approval from the Centers for Medicare & Medicaid Services (CMS) for the added services and for the increased reimbursement rates.

Pursuant to 5 M.R.S. Sections 8071 and 8072, the Department expects that the Commissioner will provisionally adopt this rule after the public hearing and responses to public comments, and then submit the rule to the Legislature for approval. This rule will have legal effect only after review by the Legislature followed by final adoption by the Commissioner.

See http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.

STATUTORY AUTHORITY: 22 M.R.S. §§ 42 and 42(8), 3173, 3173-J, and 7401 to 7404

DATE FILED WITH THE SECRETARY OF STATE'S OFFICE: August 15, 2023

PUBLIC HEARING: The Department will hold a combined in-person and remote (via Zoom) public hearing.

Date and Time:	**Sep 11, 2023, 12:00 PM Eastern Time (US and Canada)**
Location:	State Office Building, Conference Rooms A & B 109 Capitol Street, Augusta, ME
Zoom Meeting link:	https://mainestate.zoom.us/j/88458657517
Meeting ID:	884 5865 7517

Some devices may require downloading a free app from Zoom prior to joining the public hearing event.

The Department requests that any interested party requiring special arrangements to attend the hearing in person contact the agency person listed below before Friday, September 8, 2023.

In addition to the public hearing, individuals may submit written comments to DHHS by the date listed in this notice.

COMMENT DEADLINE: Comments must be received by **11:59 PM on September 21, 2023**.

AGENCY CONTACT PERSON:	Heather Bingelis, Comprehensive Health Planner II
AGENCY NAME:	MaineCare Services
ADDRESS:	109 Capitol Street, 11 State House Station Augusta, Maine 04333-0011
TELEPHONE:	207-624-6951 FAX: (207) 287-6106 TTY: 711 (Deaf or Hard of Hearing)
EMAIL:	heather.bingelis@maine.gov

IMPACT ON MUNICIPALITIES OR COUNTIES (if any): The Department anticipates that this rulemaking will not have any impact on municipalities or counties.

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

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29.01 INTRODUCTION

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

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

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

The Centers for Medicare & Medicaid Services (CMS) requires the Department of Health and Human Services (DHHS) to identify the total number of unduplicated Members that may receive the benefit during the period of July 1 to June 30. The Benefit is a limited one.~~The Benefit is a limited one. Each year the Department of Health and Human Services (DHHS) must identify the total number of unduplicated members it will provide the benefit to during that year.~~ If there is no funded opening available, ~~or if a member is not eligible for a funded opening based on priority,~~ the ~~member~~ Member is placed on a waiting list as described in this rule.

29.02 DEFINITIONS

29.02-1 **Abuse** is defined in 22 M.R.S. ~~MRSA~~ §3472 and means the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; financial exploitation; or the intentional, knowing or reckless deprivation of essential needs. "Abuse" includes acts and omissions.

29.02-2 **Activities of Daily Living (ADL~~s~~)** is a term used collectively to describe fundamental skills that are required to independently care for oneself including~~are~~:

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

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.02 DEFINITIONS (cont.)

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

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

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

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

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

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

29.02-3 Administrative Oversight Agency means a provider agency that**:**

~~a~~A. Is approved by DHHS's Office of Aging and Disability Services (OADS).
~~b~~B. Enters into a contractual agreement with the Shared Living Provider for oversight and monitoring services.
~~c~~C. Bills and receives MaineCare reimbursement; and
~~d~~D. Satisfies additional requirements set forth in this rule.~~See additional qualifications as described in in 29.10.4~~.

29.02-4 Autism Spectrum Disorder (ASD) means a diagnosis that meets diagnostic criteria set forth in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, (American Psychiatric Association), that manifested during the developmental period.~~means a diagnosis that falls within the category of Pervasive Developmental Disorders, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of autism codified in 34-B MRSA §6002 and accompanying rules.~~

~~**29.02-5 Agency Home Support** means a Provider Managed Service Location that routinely employs direct care staff to provide direct support services.~~

29.02-~~6~~5 Authorized Entity is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ESTABLISHED 1/1/08
~~Last Updated~~Legal Effective Date: ~~2/4/19~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.02 DEFINITIONS (cont.)

29.02-6 Budget Authority is the authority and responsibility to manage a Member-directed budget permitting the Member to make decisions about the acquisition of waiver goods and services that are authorized in the Person-Centered Service Plan (PCSP) and to manage the dollars included in a Member-directed budget.

29.02-7 **Case Manager** is a person responsible for assuring the timely convening of the service planning team, assisting the Member with developing the PCSP, monitoring the planned services received by the Member, and assuring that those services meet the requirements set forth in the Member's PC~~is a person who works in determining, coordinating, and arranging appropriate and available services for members and facilitating the development of the Personal Plan. This person may also be referred to as an Individual Support Coordinator~~.

~~**29.02-8 Clinical Review Team (CRT)** is a multi-disciplinary team of qualified professionals that have work experience with adults with Intellectual Disabilities and Autism Spectrum Disorder. The CRT will partner with the resource coordinators to review and approve Medical Add-On; all initial classifications to the waiver; and home support service requests. The CRT will also be responsible for systematic reviews to determine that members are authorized at an appropriate level of service in accordance with the member's personal plan.~~

29.02-8 Community Inclusion is the intentional process of empowering Members to be actively engaged within their broader community. This includes facilitating a Member's interactions with other people while in the community; identifying and securing generic, paid and natural supports; and supporting a Member to develop reciprocal relationships.

29.02-9 Competitive Integrated Employment means employment that occurs in one or more competitive integrated setting(s), which meets the specific requirements set forth in 34 C.F.R. §361.5 including:

A. ensuring compensation is the higher of the federal, state or locally established minimum wage for the location where the Member works and includes eligibility for the level of benefits provided to other employees in similar positions at that location;

B. occurring in one or more location(s) typically found in the community that are not disability-specific settings;

C. enabling the Member to interact with co-workers and customers to the same extent as a person without a disability filling a similar position;

D. for wage employment, ensuring the employer of record is the business or organization ultimately benefitting from the work done by the Member;

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.02 DEFINITIONS (cont.)

E. offering the Member an individualized position in which the Member does not work side-by-side with one or more other individuals with disabilities on the same schedule; and
F. presenting, as appropriate, opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

29.02-10 Community Mapping is a discovery-based approach in which a provider learns with the Member about their community and the places, activities, events, businesses, associations, and clubs that are in it. The provider uses information gathered during community mapping to find opportunities for the Member to share interests, personal gifts, join a group, or learn something new.

29.02-~~9~~11 Correspondent is a person designated by the Maine Developmental Services Oversight and Advisory Board to act as a next friend of a person with Intellectual Disabilities or Autism Spectrum Disorder.

~~**29.02-10 Designated Representative** means the DHHS staff or Authorized Entity authorized by DHHS to perform specified functions.~~

29.02-~~11~~12 Direct Supports are a range of services that contribute to the health and well-being of the ~~member~~ Member and enhance ~~his or her~~their ability to live in or be part of the community. Direct support services may include personal assistance or services that support personal development, or services that support personal well-being. The emphasis and purpose of the direct support provided may vary depending on the type of service.

Direct supports include the following:

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

B. Self-Care includes assistance a provider delivers with eating, bathing, dressing, mobility, personal hygiene, and other services of daily living; assistance with light housework, laundry, meal preparation, transportation, grocery shopping, and assistance with health and nutrition maintenance, including assessing well-being and identifying need for medical assistance; complying with nutritional requirements as specified in the ~~Personal Plan~~PCSP; administration of non-prescription medication that are ordinarily self-administered; and administration of prescription

29.02 DEFINITIONS (cont.)

medication, when provided by a person legally authorized to assist with the administration of medication.

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

D. Activities that Support Personal Development include teaching or modeling for a ~~member~~ Member's self-care and self-management skills, physical fitness, behavior management; sensory, motor and psychological needs; interpersonal skills to cultivate supportive personal, family, work and community relationships; resources and opportunities for participation in services to promote social and community engagement; participation in spiritual services of the ~~member's~~ Member's choice; motivating the pursuit of personal development and opportunities; teaching or modeling informed choice by gathering information and practicing decision making; and learning to exercise; and supporting to the fullest extent opportunities for individuals to exercise personal initiative, achieve personal autonomy and independently make life choices including choices about daily schedules and activities, choices related to the physical environments where they spend time and choices about with whom to interact and for what purposes.

E. Services that Support Personal Well-being include directly or indirectly intervening to promote the health and well-being of the ~~member~~Member. This may include identifying risks such as risk of abuse, neglect or exploitation; participating in a ~~member's~~ Member's risk assessment, identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an intervention plan, including, if necessary, seeking emergency medical or safety assistance and complying with applicable reporting requirements. In the absence of a plan, intervention must be consistent with DHHS's Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine~~rule governing emergency intervention and behavioral treatment for persons with~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.02 DEFINITIONS (cont.)

~~intellectual disabilities~~ (14-197 C.M.R. ~~Chapter~~ ch. 5). ~~It may also be necessary to seek emergency medical or safety assistance when needed and comply with reporting requirements.~~

29.02-13 Disability-Specific Setting means a non-residential HCBS setting that exclusively or primarily serves persons with a disability and that is not open to the general public.

29.02-14 Employer Authority is the Member's ability, with provider support as detailed in this Section, to recruit, hire, supervise and direct the workers who deliver services. Along with the Fiscal Employer Agent (Fiscal Intermediary), the Member or the Member's Representative is the employer. The Department is not the employer.

29.02-~~12~~15 Employment Setting ~~for either Work Support Individual or Work Support Group means~~ is a work setting that is integrated with non-disabled employees in accordance with 29.05-15 and 29.05-16 of this rule for Members receiving Work Support Services (Individual or Group).~~in a variety of ways. The job must be one that is available to a non-disabled employee with the same expectations for the member's job performance and attendance. The member works under similar work conditions as others without disabilities in similar positions; including access to lunchrooms, restrooms, and breaks. The member performs work duties with ongoing interaction with other workers without disabilities, and has contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations. The member cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities. Staff providing Work Support or Employment Support Services at the worksite are not considered non-disabled employees in determining the level of integration. For those agencies that currently operate under an award from AbilityOne (http://www.AbilityOne.org), the federal workforce guidelines associated with this funding source will apply to the services funded by the NISH contract. The member can be on the employer's payroll. Members may receive additional employment supports from a provider agency. A member must be supervised in a manner identical to other employees. It is permissible, on a case-by-case basis to have the support provider offer and provide this supervision as long as the above conditions are met.~~

29.02-~~13~~16 Exploitation means the illegal or improper use of an incapacitated or dependent ~~member~~ Member or that ~~member's~~ Member's resources for another's profit or advantage as defined in 22 M.R.S. §3472.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.02 DEFINITIONS (cont.)

29.02-17 Fiscal Intermediary (FI) is the individual or entity that delivers Financial Management Services (FMS) in accordance with 29.05-6 of this rule to a Member electing to access Self-Directed Services.

29.02-~~14~~18 Habilitation is a service that is provided in order to assist a ~~member~~ Member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental and social functioning of a ~~member~~Member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.

29.02-19 Home and Community Based Services ("HCBS") provide opportunities for MaineCare beneficiaries eligible to receive services in their own home or community rather than in institutions. These waiver programs may make HCBS available to a variety of targeted population groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

29.02-~~15~~20 Instrumental Activities of Daily Living (IADL) are activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of medical eligibility~~include only the following: main meal preparation; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility~~.

29.02-~~16~~21 Intellectual Disability (ID**)** means a ~~diagnosis~~ disorder as defined 34-B M.R.S. § 5001 and diagnosed in accordance with Diagnostic Criteria set forth in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association), that manifested during the developmental period~~, in accordance with the definition of Intellectual Disability codified in 34-B MRSA §5001~~.

29.02-~~17~~22 Medical Add On is ~~an increase in~~ the rate paid to address short or ~~long~~ long-term medical needs ~~and is approved by the CRT~~. Medical Add-On is a component of ~~Home Support,~~ Community Support, Employment Specialist Services, and Work Support-Individual. ~~and~~ The rate is included in the established authorization ~~(as described in Section 29.04-1)~~. It is not a separately billable activity. Billing may not exceed the ~~Home Support,~~ Community Support, Employment Specialist Services, and Work Support-Individual authorized units of service. Documentation must clearly identify, and support periods of such activity as described in this rule. ~~Refer to Appendix I for more information.~~

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.02 DEFINITIONS (cont.)

29.02-~~18~~23 Member is a person determined to be eligible for MaineCare benefits by the Office for Family Independence (OFI) in accordance with the eligibility standards published by the OFI in the *MaineCare Eligibility Manual*. Some ~~members~~ Members may have restrictions on the type and amount of services they are eligible to receive.

29.02-~~19~~24 Neglect means a threat to a ~~member's~~ Member's health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 ~~MRSA~~ M.R.S. §3472.

29.02-~~20~~25 On Behalf Of is a billable activity that is provided for the benefit of an individual ~~members~~ Member ~~and is~~ while not necessarily involving a direct face-to-face service. On Behalf Of is a component of Home Support, Community Support, Employment Specialist Services and Work Support. It is included in the established authorization and is not a separately billable activity. Documentation must clearly detail, identify and support periods of such service.

29.02-~~21~~26 ~~Personal~~ Person-Centered Service Plan (PCSP) is a ~~member's~~ Member's plan developed at least annually that identifies the services required under the waiver benefit. The ~~Personal Plan~~PCSP must also ~~include~~ document services and supports not covered by the waiver but identified by the ~~member~~Member. Only covered services included on the ~~Personal Plan~~PCSP are reimbursable. The PCSP may also be known as a Person-Centered Plan, a plan of care, or a service plan, as long as the requirements specified in this rule are met.~~The Personal Plan may also be known as a person centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 29.04 are met.~~

29.02-27 Personal Resources refers to anything that is considered a Member's personal property including but not limited to:

A. financial resources and assets such as cash, earnings from employment, credit and/or debit card(s), bank accounts and other vehicles for holding, saving, and/or investing financial resources (e.g. Certificates of Deposit, retirement accounts, investment accounts, etc.);

B. clothing, toiletries, food, or other personal items purchased by the Member and/or for the Member from a family member, a guardian, or other members of his/her natural support network; and

C. technology or media, including but not limited to cell phones, computers, or other electronic devices.

29.02-~~22~~28 Prior Authorization is the process of obtaining written prior approval by DHHS or its Authorized Entity~~the Department's Designated Representative~~ as to the medical necessity and eligibility for a service.

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.02 DEFINITIONS (cont.)

29.02-29 Provider-Managed Service is a waiver service for which a provider is responsible for directing and managing all aspects of service delivery to the Member and in accordance with the Member's PCSP.

29.02-~~23~~30 Qualified Intellectual Disability Professional (QIDP) is a person who has at least one year of experience working directly with persons with ~~intellectual~~ Intellectual ~~disabilities~~ Disabilities or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor's degree as specified in title 42 ~~*Code of Federal Regulations* (~~C.F.R.~~)~~ 483.430~~, paragraph (B)(5)~~.

29.02-~~24~~31 Qualified Vendor is a provider approved by DHHS to provide waiver services to eligible ~~members~~ Members receiving services under this Section, in accordance with the requirements of 29.10. ~~DHHS requires agencies to provide high quality services that, at a minimum, meet the expectations of the members who utilize those services. DHHS may authorize agencies to provide services under this Section after an application, along with supporting documentation, has been submitted to a Designated Representative for review and approval. The Designated Representative will authorize only agencies that meet DHHS expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, and quality management. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement.~~

29.02-32 Representative is an individual responsible for managing self-directed services on behalf of a Member accessing Self-Direction.

29.02-33 Self-Direction means a waiver service(s) directed by the Member using employer authority, budget authority or both. Self-Direction provides an opportunity for a Member to exercise choice and control in identifying, accessing, and managing services and other supports in accordance with their needs and personal preferences.

~~**29.02-25 Shared Living** (Foster Care adult) is a model in which services are provided to a member by a person who meets all of the requirements of a Direct Support Professional with whom that member shares a home. The home may belong to the provider or the member, but the provider must enter into a contractual relationship with an Administrative Oversight Agency in order to provide services under this model. Only one member may receive services in any one Shared Living arrangement at the same time, unless a relationship existed prior to the service arrangement and the arrangement is approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently. Please see 29.10-5 for additional qualifications.~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.02 DEFINITIONS (cont.)

29.02-34 Service Implementation Plan (SIP) is the plan for providers chosen by the Member and as specified in the PCSP documenting how the provider will meet the Member's assessed needs and identified goals for the requested service. The SIP must include strategies for implementing and supporting the Member to meet their identified goals that are specific, measurable, achievable, relevant to the participant's identified outcomes, and have clear proposed timelines for achievement.

29.02-~~26~~35 Shared Living Provider is a Direct Support Professional who has a contract with an Administrative Oversight Agency to deliver Shared Living. A Shared Living Provider shares a home with one or two Members that are authorized to receive Shared Living Services~~is a provider who subcontracts with an agency to provide direct support to a member, with whom they share a home. The Shared Living Provider must be a Certified Direct Support Professional (DSP) who has met all the requirements to provide this service. The Shared Living Provider must enter into a contractual relationship with the Administrative Oversight Agency in order to provide services to a member. The agency supports the provider in fulfilling the requirements and obligations agreed upon by the DHHS, the Administrative Oversight Agency, and the member's Personal Plan. See 29.10-5 for additional qualifications~~.

29.02-36 Supports Broker is an individual or entity who delivers the covered service of Supports Brokerage to the Member accessing Self-Direction. The Supports Broker is selected by, works on behalf of, and under the direction of the Member.

29.02-~~27~~37 Utilization Review is a formal assessment of the medical necessity, efficiency, and appropriateness of services on a prospective, concurrent or retrospective basis.

29.02-~~28~~38 Year: for the purposes of calculating limits, Year refers to a timeframe of 365 days (366 days in a leap year) in which covered services included in this Section are authorized, the starting point and ending point of which may vary for each Member~~services are authorized on the state fiscal year, July 1 through June 30~~.

29.03 DETERMINATION OF ELIGIBILITY

A Member is eligible~~Eligibility~~ services under this Section if~~for this benefit is based on meeting~~ all three of the following criteria are met~~;~~: 1) the ~~member~~ Member meets the General Eligibility Criteria in Subsection 29.03-2, ~~must require~~including requiring Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care as set forth ~~under~~ in the *MaineCare Benefits Manual*, Chapter II, Section 50~~.~~; 2) the ~~member~~ Member ~~must have eligibility~~is eligible for MaineCare as determined by the DHHS Office for Family Independence (OFI~~), ~~); and 3) a funded opening is available for the Member.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.03 DETERMINATION OF ELIGIBILITY (cont.)

29.03-1 Funded Opening~~:~~

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

29.03-2 General Eligibility Criteria

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

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

B. Has an Intellectual Disability or Autism Spectrum Disorder as defined in the Definitions Section above, or Rett Syndrome (for individuals diagnosed prior to 2013) as defined by the DSM;~~Has an Intellectual Disability or Autism Spectrum Disorder or Rett Syndrome; and~~

C. Meets the medical eligibility criteria for admission to an ICF/IID as set forth under the *MaineCare Benefits Manual*, Chapter II, Section 50; ~~and~~

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

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

F. The estimated annual cost of the ~~member's~~ Member's services under the waiver is equal to or less than fifty percent (50%) of the state-wide average annual cost of care for an individual in an ICF/IID, as determined by ~~the~~ DHHS or, where the cost of care exceeds that amount, DHHS has approved the higher amount through the Exceptions Process in Subsection 29.14.

A Member who is found to be medically eligible for Section 29 services nonetheless may not receive Section 29 services if the Member does not receive a funded offer of Section 29 services. Medically eligible members who have not received a funded offer are placed on a waiting list as described in § 29.03-6 if they choose to receive Section 29 services, and become eligible for the service upon receipt of a funded offer.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.03 DETERMINATION OF ELIGIBILITY (cont.)

29.03-3 ~~Establishing Medical Eligibility~~Documentation Requirements

~~In order to determine medical eligibility, the~~ The ~~member~~ Member and ~~case~~ Case ~~manager~~ Manager must provide to DHHS the following:

A. A completed copy of the assessment form (BMS99) or current functional assessment approved by the DHHS; ~~and~~

B. A copy of the Member's ~~Personal Plan~~PCSP approved and signed by the ~~member~~ Member or guardian and the ~~case~~ Case ~~manager~~ Manager within the preceding six months ~~of the effective plan date and~~ :

C. ~~any~~ Any other relevant material indicating the ~~member's~~ Member's service needs~~.~~ ;

D. DHHS Estimated Annual Cost Form, containing a detailed estimate of the annual cost for waiver services identified in the PCSP, including the specific services and the number of units for each service required to meet the applicant's needs; and

E. If applicable, DHHS Request for Exceptions Form.

29.03-4 Medical Eligibility Determination and Notification Requirements

Based on review of the Assessment Form, the ~~Personal Plan~~PCSP, and DHHS Estimated Annual Cost Form, a QIDP designated by DHHS will determine the ~~member's~~ Member's medical eligibility for services under this Section.

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

If the ~~member~~ Member is found to be ~~medically~~ eligible, DHHS must send the ~~member~~ Member or guardian written notice that the ~~member~~ Member can receive either ICF/IID services under Section 50, or services under this Section. The ~~member~~ Member or guardian must submit ~~to the case manager~~ a signed Choice letter to the Case Manager documenting the ~~member's~~ Member's choice to receive services under this ~~section~~Section.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.03 DETERMINATION OF ELIGIBILITY (cont.)

29.03-~~4~~5 Calculating the Estimated Annual Cost

After determination of medical eligibility and ~~Prior~~ prior to formal determination of eligibility for services under this ~~section~~Section, each applicant and their planning team must identify the required mix of services to meet the applicant's needs and to assure their health and welfare. The applicant and their planning team shall submit a detailed estimate of the annual cost for waiver services identified in the ~~Personal Plan~~PCSP, including the specific services and the number of units for each service.

29.03-~~5~~6 Waiting List and Offers for Funded Openings

DHHS will maintain a waiting list of ~~eligible~~ MaineCare ~~members~~ Members who are medically eligible for ~~cannot get access to~~ Section 29 Services ~~because~~ but for whom a funded opening is not available. GHHS will serve Members who are on the waiting list ~~for the benefit services shall be served~~ chronologically based on the date ~~the Designated Representative~~DHHS or its Authorized Entity ~~determines~~ determined the Member's potential eligibility for the waiver. ~~At the time w~~When a ~~member~~ Member is offered a funded opening, the ~~member~~ Member will be removed from the waiting list.

~~A member has~~Within sixty days ~~from the receipt of~~of receiving ~~notification by DHHS of~~ a funded opening to respond, a Member must respond to DHHS ~~with~~ of their intent to accept waiver services. A Member must begin receiving services within six months of accepting a funded offer. DHHS will withdraw the funded offer if (1) The Member fails to respond with intent to accept the funded opening within 60 days of receipt of notification by DHHS, or (2) The Member fails to begin waiver services within 6 months after accepting the funded offer.~~A member has six months from the receipt of notification to start receipt of services. If the member fails to respond with intent to accept the funded opening within 60 days of this notice or fails to begin services within 6 months, the waiver offer will then be withdrawn.~~ A member may reapply ~~at any time~~ for waiver services at any time.

29.03-~~6~~7 Redetermination of Eligibility

Every twelve (12) months the Member's Case Manager will submit a current Person-Centered Service Plan and an updated assessment form (BMS 99 or current Department-approved assessment) to OADS.
~~When making a determination of continuing eligibility, every 12 months from the date of initial approval and every 12 months thereafter, the member's case manager will submit to OADS a current Personal Plan that is less than six (6) months old, and an updated Assessment Form (BMS 99) or current functional assessment approved by the Department.~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.03 DETERMINATION OF ELIGIBILITY (cont.)

The Department will deny reimbursement for services if OADS does not receive the updated Assessment Form and PCSP by the due date. The Department will resume reimbursement for services after OADS receives the Assessment Form and a signed PCSP.

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

29.04 PERSON-CENTERED SERVICE PLAN (PCSP)~~PERSONAL PLAN~~

~~Whenever significant changes occur that alter level of care, the case manager will submit an updated Assessment Form to DHHS. The case manager must complete and submit all waiver documents including the BMS 99, or current functional assessment approved by the Department and the updated Personal Plan to the Resource Coordinator thirty (30) days in advance of the annual redetermination date.~~

The Case Manager must submit a request for services to DHHS or its Authorized Entity ~~If~~ when the ~~member~~ Member or guardian ~~chooses~~ elects to receive services under this Section~~, the request for services must be submitted to DHHS or its Authorized Entity~~. As part of the planning process, the ~~member's~~ Member's needs are identified and documented in the ~~Personal Plan~~PCSP. The PCSP and the Person-Centered Service Planning Process must comply with the requirements of the Global HCBS Waiver Person-Centered Planning and Settings Rule ("Global HCBS Rule"). *MaineCare Benefits Manual*, Chapter I, Section 6.~~Except for residential services, other services shall be provided to the member within ninety (90) days.~~

29.04-1 Prior Authorization for Reimbursable Services

The PCSP must identify all ~~Medically necessary~~ services and units of services that are required to meet the Member's needs.~~must be identified in the Personal Plan.~~ In order for a Section 29 service to be reimbursed, the Case Manager must submit ~~Requests~~ a request ~~for services must be submitted~~ to DHHS or its Authorized ~~Agent~~ Entity for Prior Authorization ~~in order for the services to be reimbursed. Requests will be reviewed by DHHS or its Authorized Entity, and may be examined and evaluated by DHHS or its Authorized Entity, before units of service are authorized.~~for that service. DHHS or its Authorized Entity will review each service by type and amount to determine that it is medically necessary and appropriate. DHHS will not reimburse for any service for which a PA is not granted.

All Prior Authorizations are time-limited, and the length of the authorization may vary by ~~member~~ Member and service as documented in the ~~Personal Plan~~PCSP. Upon expiration of an authorization, the Case Manager must obtain a new

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.04 PERSON-CENTERED SERVICE PLAN (PCSP) (cont.)

authorization for continued reimbursement for that service~~must be obtained before reimbursement may be provided for the service~~.

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

29.04-2 Person-Centered Service Planning Process~~Personal Plan Requirements~~

The Person-Centered Service Planning process must meet the following requirements, in addition to the Global HCBS Rule provisions.

If the Member chooses to have provider staff as part of their planning team,~~The case manager will ensure that a Planning Team is convened to initiate development of the Personal Plan prior to services being initiated.~~ Case Managers must meet separately with the ~~member~~ Member prior to finalizing the PCSP~~absent of current providers~~ to ensure conflict free planning and informed choice. The planning process must reflect the Member's cultural ~~conventions of the member~~ preferences and provide information in plain language that is accessible to the Member and, when applicable, the legal guardian. ~~The planning process must be conducted by providing information in plain language and in a manner that is accessible to the member and when applicable, their legal representative.~~

In addition to the above, and according to 34-B M.R.S. § 5466, Members are entitled to have access to an advocate. Case Managers must ensure Members are aware of this entitlement prior to the planning meeting to allow for inclusion of an advocate if the Member so chooses.

29.04-3 Person-Centered Service Plan Requirements

Pursuant to the Global HCBS Rule, the PCSP must reflect the services and supports that are important for the Member to meet the needs identified through an assessment of functional need, as well as the Member's preferences for the delivery of services and supports. The plan's effective ~~plan~~ date must be ~~current and~~ less than six (6) months old at the time of the ~~member's~~ Member's eligibility determination or redetermination. The planning process must comply with the requirements described in the Global HCBS Rule.~~in 42 CFR §441.301 (c)(1), and 34-B M.R.S.A. §5470-B(2).~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.04 PERSON-CENTERED SERVICE PLAN (PCSP) (cont.)

The ~~Personal Plan~~PCSP must ~~contain at a minimum~~include the following:

A. All MaineCare Home and Community waiver benefit services determined medically necessary by the team including ~~all other~~MaineCare-covered services ~~that may~~ not ~~be~~ covered under this ~~section~~ Section ~~but~~ that the ~~member~~ Member identifies and that are consistent with the objectives of the PCSP~~may pursue~~;

B. The frequency of ~~provision of the~~ each service~~s~~, including transportation services;

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

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

E. The role~~s~~ and ~~responsibility~~ responsibilities of the ~~member's~~ Member's service providers in supporting the ~~member's~~ Member's goals, including goals for strengthening natural and supportive personal, family, community and professional relationships;

F. For Members who cho~~o~~se to receive Home Support- Remote Support~~, must have~~ a safety/risk plan, ~~which shall describe~~describing ~~the~~ any potential risks to the ~~member's~~ Member's health and welfare that may arise while the Member is receiving Home Support- Remote Support and the reasonable steps to alleviate those risks; and

G. Signatures of the planning members on the PCSP must at a minimum include: (1) the Member and guardian, as applicable, and (2) the Case Manager. The plan is not in effect and DHHS cannot approve until the PCSP is signed by the planning team members.~~In order for the Personal Plan to be approved, the Personal Plan must include signatures of~~

~~1. The member,~~

~~2. The guardian, if applicable,~~

~~3. The case manager, and~~

~~4. Per 34-B MRSA §5470-B and 42 CFR §441.301, the individuals and providers responsible for the implementation of the plan.~~

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ESTABLISHED 1/1/08
~~Last Updated~~Legal Effective Date: ~~2/4/19~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.04 PERSON-CENTERED SERVICE PLAN (PCSP) (cont.)

DHHS or its Authorized Entity will use the ~~The Personal Plan will be used by DHHS or its Authorized Entity~~ PCSP to identify the type and ~~units~~ amount of authorized services the ~~member~~ Member may receive under this Section. If more than one provider is reimbursed for the same ~~category of direct supports~~covered service, the Service Implementation Plan required under § 29.04-6 must specify the roles and responsibilities of each provider.

~~All p~~Providers must regularly provide the Members they serve with~~ensure that~~ notice of the Grievance process outlined in 14-197 C.M.R. ~~Chapter~~ ch. 8 (Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism).~~is regularly provided to members served by the provider.~~ Providing notice includes~~, at a minimum,~~ ensuring that written notice of the grievance process is provided to the ~~member~~ Member and/or their guardian at ~~any~~ the planning meetings.~~; posting notice of the grievance process in an appropriate common area of all facilities operated by the provider; and posting notice of the grievance process on any website maintained by the provider. In addition, the provider must ensure that all staff are trained in the grievance process.~~

29.04-~~3~~4 Planning Team Composition

Each ~~member~~ Member or guardian will determine the composition of the ~~Planning~~ planning ~~Team~~team. ~~Planning will occur in a manner that is respectful and reflective of the member's preference.~~ The ~~member~~ Member will lead and direct the Person-Centered Service Planning process~~person-centered planning process where~~ whenever possible, including leading the planning meeting if they desire. The ~~member's~~ Member's ~~representative~~ guardian should have a participatory role, ~~as needed and~~ as defined by the ~~member~~Member, unless State law confers decision-making authority ~~to~~ on the legal guardian.

The Case Manager or Case Management Supervisor will support the Member or legal guardian in scheduling PCSP meetings and any other meetings at times and locations convenient to the Member and the individuals the Member chooses to have attend~~The Case Manager is responsible for convening the planning team and facilitating the Person-Centered Planning process. The Case Manager or Case Management Supervisor has sole authority for scheduling and rescheduling the planning team at the request of the member or their legal representative~~.

In addition to the ~~Case Manager~~Member, ~~The~~ the planning team ~~must~~ may include the following members, ~~if applicable~~when invited by the Member:

A. The ~~member~~Case Manager;

B. The ~~member's~~ Member's guardian; ~~and~~

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ESTABLISHED 1/1/08
~~Last Updated~~Legal Effective Date: ~~2/4/19~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.04 PERSON-CENTERED SERVICE PLAN (PCSP) (cont.)

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

~~The planning team may include the following members, if applicable:~~

~~A~~D. The ~~member's~~ Member's advocate or friend or ~~any~~ additional individuals invited by the ~~member~~Member;

~~B~~E. Direct Support Professionals providing services to the ~~member~~Member;

~~C~~F. Staff from the member's providers; and

~~D~~G. ~~Any~~ Other professionals involved or likely to be involved with the ~~member's~~ Member's ~~Personal Plan~~PCSP.

29.04-~~4~~5 Updating the ~~Personal~~ Person-Centered Service Plan

The Case Manager must revise and update the PCSP~~member's Personal Plan must be revised and updated~~ at least annually, based on the plan's effective date or at the request of the ~~member~~ Member or guardian.~~, and in addition~~The Case Manager must also update the PCSP when ~~other~~ there are significant changes ~~occur relating to~~in the ~~member's~~ Member's physical, social, behavioral, medical, communication, or psychological needs, or the ~~member's~~ Member has made significant progress toward his or her goals. The Case Manager must ~~re~~convene the Planning Team to revise and update the ~~Personal Plan~~PCSP as service needs change, including the locations where the Member receives services ~~are received~~. Planning meetings must be held both thirty (30) days prior to ~~30 days~~ and thirty (30) days following ~~subsequent to the~~ a planned move of a ~~member~~ Member to a new service in order to coordinate and to evaluate the ~~member's~~ Member's satisfaction with the change.

29.04-6 Service Implementation Plan (SIP)

After the PCSP is finalized as outlined in this rule, providers selected by the Member to provide needed services must complete a SIP describing the waiver service(s) to be ~~d~~delivered consistent with the Member's goals outlined within the PCSP. ~~-~~For each relevant goal, the provider must detail service delivery strategies that are specific, measurable, achievable, and include clear timeframes (i.e. start and projected completion dates) and related needs and risk factors for the requested waiver service. SIPs are not required for services that are reimbursed through invoicing (e.g. Assistive Technology Devices).

SIPs are required for both Provider-Managed Services and Self-Directed Services.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.04 PERSON-CENTERED SERVICE PLAN (PCSP) (cont.)

A. For a self-directed service where a Member or their Representative would have employer authority, either the Member or their Representative shall write the SIP and the Supports Broker will enter it into the Department's client data system.
B. For a self-directed service where a Member or their Representative would not have employer authority, the Supports Broker shall write the SIP.

Providers shall use the Department-approved Service Implementation Plan Form and the completed SIP must be approved by the Member or their guardian, as applicable. Providers must review and update the SIP annually or upon Member or guardian request or more frequently based on changes in the Member's needs or circumstances.

29.05 COVERED SERVICES

29.05-1 Home and Community Based Services Settings

Each HCBS setting must comply with the requirements of the Global HCBS Rule.

The following additional services settings requirements apply to Community Support Services, and Work Support Group services:
A. Members are allowed to have visitors at these service settings, so long as the Member's PCSP provides for visitors, and so long as the visit is reasonable in duration and does not pose a health and safety risk to others in the setting.~~-~~ The PCSP must state that the Provider will not charge for additional reimbursement for the visitors.
B. Members may have visitors at the employment setting comparable to the standards related to visitors for any other employee employed in that employment setting.

29.05-~~1~~2 Assistive Technology (AT): ~~Technology~~ means a service that directly assists a Member in the selection, acquisition, or use of an~~Assistive technology~~ AT device. means ~~an~~ a Department-approved item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of ~~members~~the Member. ~~Assistive technology service means a service that directly assists a member in the selection, acquisition, or use of an assistive technology device.~~

~~If authorized, the Department expects that Home Support Remote Support Hours will be implemented within 90 days of assessment.~~

~~Assistive Technology~~AT Services include~~s~~;

~~(A)~~A. Assistive Technology-Assessment:

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The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

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

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

3. ~~The t~~Training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the ~~member~~Member; and

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

AT Assessment is a Provider-Managed Service. ~~Assistive Technology Assessment is subject to a combined limit per year. See Section 29.07 below.~~

~~(B)~~B. ~~Assistive Technology~~ **AT Devices:**

1. ~~The p~~Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for members; and

2. ~~The s~~Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

The provision of AT Devices can be a Provider-Managed Service or a Self-Directed Service. ~~Assistive Technology Devices is subject to a combined limit per year. See Section 29.07 below.~~

~~(C)~~C ~~Assistive Technology~~**AT-Transmission** ~~(Utility Services)~~;
1. Fee associated with the transmission of data required for ~~use of~~ the ~~Assistive Technology~~AT Device~~s via internet or cable utility~~. ~~Assistive Technology Transmission is subject to a combined limit per month. See Section 29.07 16.~~

29.05-~~2~~3 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 Member may

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

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 Member'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 Member to identify career interests, employment skills and abilities, and ultimately developing a Career Plan that supports the Member 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 Member's goals and that opportunities for Competitive Integrated Employment or self-employment will yield wages at or above the State's minimum wage and complies with criteria set forth in §29.02-9 of this rule.

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

~~is a person-centered, comprehensive direct support. Career Planning assists with identifying a career direction and developing a plan for achieving competitive, integrated, individual employment or self-employment at or above the State's minimum wage. Services assist in identifying skills, priorities, and capabilities determined through an individualized discovery process. A Department approved Career Planning curriculum may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, and development of experiential learning opportunities and career options consistent with the member's skills and interests. Career Planning may be used in preparation to gather information for a referral to Vocational Rehabilitation.~~

~~Career Planning is limited to 60 hours annually, to be delivered in a six-month period. No two six-month periods may be provided consecutively. In order to receive Career Planning services, the member's Personal Plan must identify the need to~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

~~explore work, identify career direction and describe how the Career Planning services will be used to achieve those goals.~~

~~The service requires submission of the Career Plan at 3 intervals to DHHS in order to ensure that the service is provided in a manner that will result in competitive, integrated employment or self-employment at or above the current minimum wage.~~

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

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

Career Planning is a Provider-Managed Service.

29.05-~~3~~4 Community Support is ~~provided by a Direct Support Professional employed by an OADS approved provider in order~~ a service that ~~to~~ increases or maintains a ~~member's~~ Member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on ~~community~~ Community ~~inclusion~~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.

The provider may deliver Community Support in a non-Disability Specific Setting or community places of the Member's choosing or in a Disability-Specific Setting that complies with the Global HCBS Rule.

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,

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

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 Member on a Path to Employment. The Case Manager must document all relevant Community Support activities and services related to career exploration and employment exploration in the Member's PCSP.

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

Community Support is separated into three tiers of service delivery: Community Only-Individual, Community Only-Group, and Center-Based, to support individualized needs of the Member. The Community Only tiers (individual and group) are delivered outside of a Member's home or facility setting. The Center-Based tier is delivered from a facility setting but must ensure community integration and Community~~Community Support is intended to be flexible, responsive and provided to members as defined by the member's choice and needs as documented in the member's personal plan. The location of the service and staffing level may vary, allowing for a mix of individualized and group services.~~

~~Community Support allows for opportunities for career exploration and the facilitation of discussions about the benefits of working. Activities and discussions related to work should be relevant to identifying a member's employment interests, their individual strengths as related to employment, employment goals and the conditions necessary for the member to achieve and maintain successful employment.~~

~~The average staff to member ratio for Community Support for each program location must not exceed 1:3.~~

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The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.05 COVERED SERVICES (cont.)

Nothing in this rule prohibits one-to-one (1:1) service delivery. Community Support may be provided one Member to one Direct Support Professional (DSP) ratio (1:1) but shall not exceed a three Member to one DSP ratio (3:1) in any setting.

"On Behalf of", as defined in this rule, ~~is a component of Community Support; and~~ 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 29.16.

Medical Add-On, as defined in this rule and 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 29.17.~~A member may not receive Community Support while enrolled in high school. A member may not receive Community Support at his or her place of employment.~~

The cost of transportation related to the provision of Community Support is a component of the rate paid for the service and is not separately billable. ~~For specific limits of this service see 29.07.~~

Community Only-Individual can be a Provider-Managed Service or a Self-Directed Service. Community Only- Group and Community Center-Based are Provider-Managed services.

Payment for Provider-Managed, Community Only-Individual services is not made directly, or indirectly, to Members of the Member's immediate family. Payment for Self-Directed Community Only- Individual Services, may be made to friends or family members of the Member, including their spouse or the legal guardian.

If a Member requires or has selected a Representative to direct services on their behalf, the Representative may not also be paid to deliver Direct Support to the Member. When the guardian is acting as the Representative on behalf of the Member, the guardian may not also deliver paid Direct Support to the Member. In either case, the Financial Management Services provider is responsible for ensuring that payment made for the delivery of services under the Self-Directed Services option is appropriate.

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

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.05 COVERED SERVICES (cont.)

29.05-~~4~~5 Employment Specialist Services include services necessary to support a ~~member~~ Member in maintaining ~~Employment~~employment. Services include: (1) periodic interventions on the job site to identify a ~~member's~~ Member's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when a ~~member's~~ Member's goal for a type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job; (3) Employment Specialist Services for job development, if Vocational Rehabilitation denies services under the *Rehabilitation Act*, or the services are not available to the Member. ~~and the member is unable to benefit from Vocational Rehabilitation.~~ 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 ~~is required~~.

~~Employment Specialist Services are provided by an Employment Specialist who may work either independently or under the auspices of a Supported Employment provider but must have completed the approved Employment Specialist training as outlined by DHHS in order to provide Employment Specialist Services.~~ The PCSP must document the need for continued Employment Services ~~must be documented in a member's Personal Plan as necessary~~ to maintain employment over time.

Employment Specialist Services are ~~provided~~ delivered at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. The Employment Specialist must ensure that opportunities for Competitive Integrated Employment comply with the criteria set forth in §29.02-9 of this rule. Employment Specialist Services ~~may be utilized to~~ assist a ~~member~~ Member to establish and or sustain a business venture that is income producing. MaineCare funds may not be used to defray the expenses associated with the start up or operating a business.

"On Behalf of", as defined in this rule, ~~will continue as a component~~is included in the established authorization for ~~of~~ Employment Specialist Service~~s;~~ ~~and is included in the established authorization~~ and is not a separately billable service. For details related to covered and non-covered "On Behalf Of" activities see 29.16.

Medical Add-On, as defined in this rule and 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 29.17.

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

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The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

Employment Specialist Services are Provider-Managed services.

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

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

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

29.05-6 Financial Management Services are a critical support for self-direction, and encompass making payments through a FI that performs financial transactions (paying for goods and services or processing payroll for Members' workers included in the Member's service plan) on behalf of the Member.

This service includes:

A. Explanation of program rules and requirements including providing skills training for the Member or Representative on their responsibilities in exercising both employer and budget authority consistent with authorized services;

B. Enrolling Employer/Employer of Record and employees in the payroll processing system;

C. Payroll processing for employees addressing federal, state and local employment tax, labor and workers' compensation insurance rules, required background checks, and other requirements that apply on behalf of the Member functioning as the employer of workers;

D. Tracking spending and approving expenditures that align with the Department-approved Spending Plan Tool, including changes or additions to the list of Goods and Services;

E. Making financial transactions on behalf of the Member within the scope of select services for self-direction;

F. Providing a monthly financial- report to the Member which includes projected and actual spending to ensure the Member stays within the individual budget based on approved service authorizations;

G. Assisting Member with resolving employee questions and complaints and remediating as appropriate; and

H. Informing the Member 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.

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~~Last Updated~~Legal Effective Date: ~~2/4/19~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.05 COVERED SERVICES (cont.)

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

29.05-~~5~~7 Home Accessibility Adaptations are ~~those~~ physical adaptations to the private residence of the ~~member~~ Member or the ~~member's~~ Member's family, ~~required by the member's Personal Plan~~as documented in the PCSP, ~~that are~~and necessary to ensure the health, welfare and safety of the ~~member~~ Member or that enable the ~~member~~ Member 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.

~~Adaptations must not be covered under state plan services, including Section 60, Medical Supplies and Durable Medical Equipment of the *MaineCare Benefits Manual* and must be determined medically necessary as documented by a licensed physician and approved by DHHS Office of Aging and Disability Services (OADS).~~ Common ~~Adaptations~~ adaptations ~~commonly~~ 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).

Items not included above but which have been recommended in a Personal Plan are subject to approval by the DHHS for reimbursement.

~~Excluded are those~~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 ~~member~~Member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating is not allowable. General household repairs are not included in this service. All services shall be provided in accordance with applicable local, state or federal~~State or local~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

building codes. All providers must be appropriately licensed or certified in order to perform this service. 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 the paid provider, this service is not available.~~This service applies to member-owned or a member's family-owned home only. Provision of this service in a property owned, rented or leased by an agency is acceptable as long as the adaptation is portable and is the property of the member.~~

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

Home Accessibility Adaptations may be a Provider-Managed or a Self-Directed Service.

29.05-~~6~~8Home Support-Quarter Hour is an individually tailored Direct Support that assists Members with acquisition, retention, or improvement in skills related to living in their own home or with others (either owned or leased) within 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 Member.

Home Support-Quarter Hour may include assisting the Member 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 Member'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 Member to develop skills necessary to reduce or eliminate episodes in which the Member becomes a danger to self or others; and
D. Explore and engage in prevocational and/or work-related activities.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

In addition to the above, the PCSP must document the Member'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.

"On Behalf of", as defined in this rule, is included in the established authorization for Home Support-Quarter Hour Services and is not a separately billable service. For details related to covered and non-covered "On Behalf Of" activities see 29.16.

Home Support-Quarter Hour may be a Provider-Managed or a Self-Directed Service.

For Provider-Managed Home Support-Quarter Hour, payment is not made directly, or indirectly, to members of the Member's immediate family. For Self-Directed Home Support-Quarter Hour, payment may be made to friends or family members of the Member, including their spouse or the legal guardian. If a Member has a Representative to direct services on their behalf, the Representative may not also be paid to provide care to the Member. When the guardian is also acting as the Representative on behalf of the Member, the guardian may not also deliver direct support to the Member. ~~is direct support (billed per unit) provided in the member's home, by a Direct Support Professional to improve and maintain a member's ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with ADLs and/or IADLs, development and personal well-being.~~

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

~~Home Support cannot be provided at a Member's employment site.~~

~~On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.~~

~~There is no overlap between Assistive Technology and Home Support Remote Support. Assistive Technology provides for the assessment, the equipment and the~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

~~cost of the monthly transmission. Home Support-Remote Support provides the staff who are monitoring the member.~~

29.05-~~7~~9 Home Support-Remote Support: This service provides real time, remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, doors, temperature, smoke, CO, etc.), video cameras, microphones and speakers, as wells as health monitoring equipment. This assistive technology links each ~~member's~~ Member's residence to the Remote Support provider.

~~The Remote Support provider has staff available 24 hours per day 7 days per week to deliver direct 1:1 care when needed.~~ If a ~~member~~ Member chooses this service, the ~~member's Personal Plan~~PCSP must include a safety/risk plan ~~that identifies~~identifying ~~at least two levels of~~the emergency back-up arrangements.

The use of this service is based upon the Member's needs as identified by the assessment of functional need completed during the PCSP planning process. ~~member's assessed needs and the resulting Personal Plan.~~ The ~~Personal Plan~~PCSP reflects the ~~member's~~ Member'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.~~An Assistive Technology Assessment must be completed by a qualified consultant prior to the finalization of the Personal Plan by the case manager and the member with the assistance of the Planning Team to ensure the appropriateness of 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 Member in 1-to-1 direct support through the use of the Assistive Technology Device. Monitor Only is when Assistive Technology equipment is being used to monitor the Member without interacting. ~~All Remote Support Services must be provided in real time.~~
All electronic systems must have back-up power connections to insure functionality in case of loss of electric power. Providers must comply with all federal, state and local regulations that apply to its business including but not limited to the "*Electronic Communications Privacy Act of 1986*". Any services that use networked services must comply with HIPAA requirements.

There is no overlap between Assistive Technology and Home Support Remote Support. As set forth in §29.05-~~1~~2, Assistive Technology may be used to provide for assessments, equipment, and the cost of the ~~monthly~~ data transmission ~~utility~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

necessary to facilitate Home Support-Remote Support services. Home Support-Remote Support provides the staff to monitor the ~~member~~Member.

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

29.05-10 Individual Goods and Services include services, equipment, or supplies not otherwise provided through this benefit or through State Plan that address a self-directing Member's needs in the PCSP. Individual Goods and Services are available only to Members who have chosen to Self-Direct their services pursuant to § 29.15 and only to the extent the goods and services comply with and are not prohibited under that subsection, and do not cause the Member to exceed their Budget Authority or the annual cap on Individual Goods and Services. Services, equipment, and/or supplies should promote autonomy and independence, improve or ensure access to Competitive Integrated Employment, improve or maintain a Member's opportunities for full community integration and community membership, or improve or maintain access to non-emergency transportation.

Additionally, the service, equipment, or supplies must meet one or more of the following requirements:

A. Decrease the need for other Medicaid services;
B. Promote Community Inclusion; and/or
C. Increase the Member's safety within the home environment.

The Member must use personal funds to purchase services, equipment, or supplies when available. When the Member does not have personal funds or funding through another source, the Member may access funds available in the Member-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 Member must develop a spending plan that details all service-related costs according to the Member's authorized budget limits and calculates any remaining funds available for identified Individual Goods and Services documented within the PCSP.

With support and assistance from the Support Broker, the Member will use the Department-approved Spending Plan Tool to list the allowable Individual 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 Member and Support Broker must review the spending plan at regular intervals to

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

meet the Member's budgeting needs or when the Member needs additional or alternate Individual Goods and Services listed in the Spending Plan Tool. The Support Broker will ensure the Member seeks approval of the spending plan, including updates and changes to the same, from the FI.

29.05-~~8~~11 Respite Services are provided to ~~members~~ Members unable to care for themselves ~~that are~~and furnished on a short-term basis because of the absence of or need for relief ~~of those persons~~to individuals who normally provide care for the ~~member~~Member. Respite may be provided in the ~~member's~~ Member's home, provider's home or other location as approved by ~~a respite agency or~~ DHHS (for example, a motel in the case of an emergency).

29.05-~~9~~12 Shared Living ~~(Foster Care, Adult)~~ is Direct Support that is individually tailored to meet the 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) needs of the Member as identified in the PCSP. These Direct Supports assist the Member 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 Member's full access to the greater community, including opportunities to seek employment and work in competitive, integrated settings; engage in community life, control personal resources, and receive services in the community like individuals without disabilities. Services are delivered according to the Member's PCSP.

The Shared Living Provider delivers services to the Member with whom they share a home. Only one Shared Living Provider may deliver Shared Living in a home, either to one or two Members. 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 Member's Planning Team as documented in the Member's PCSP. See 29.19, Appendix IV for additional requirements.

The Department may approve an Increased Level of Support for Members receiving Shared Living Services based on the Member's increased medical, behavioral, and/or individual safety needs. The PCSP must accurately document the need and reason for, as well as the 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. See 29.16, Appendix I for additional requirements and application process.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

Shared Living is a Provider-Managed service.
~~direct support billed per diem and includes; personal care, protective oversight and supervision and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law)) provided in a private home by a principal care provider who lives in the home and is a Direct Support Professional. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports and social and leisure skill development that assist the member to reside in the most integrated setting appropriate to the member's needs.~~

~~For this Service, respite is a component of the rate paid to the Administrative Oversight Agency and therefore is not a separate billable service. The record must accurately reflect the member's location during the receipt of respite.~~

~~Only one member may receive services in any one Shared Living arrangement at the same time, unless a relationship existed prior to the service arrangement and the arrangement has been approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently.~~

29.05-13 Supports Brokerage is the delivery of support and information to ensure that Members understand the responsibilities involved with Self-Direction. Duties of the Supports Broker include, but are not limited to, coaching, and advising the Member about the responsibilities of being an employer, managing their personal budget, or implementation of their PCSP. The PSCP must specify the extent of the assistance the Supports Broker furnishes to the Member or Representative. This service must 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 Members or Representatives to recruit, hire, train, and manage employees independently.
B. Supporting Members in person-centered service planning for Self-Directed Services).
C. Supporting Members 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 Member'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.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

F. Supporting and monitoring Members 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 Members.
H. In conjunction with the FI, supporting the Member to monitor spending using the Department-approved Spending Plan Tool.
I. Supporting the Member to request adjustments to the PCSP as needed and ensuring those authorized adjustments are reflected in the updated Spending Plan Tool.
J. Supporting the Member 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.

29.05-~~10~~14 Non-Emergency Transportation Services (NET) under Chapter II, Section 113 ~~is offered in order to~~ enables ~~members~~ Members to gain access to Section 29 services, activities and resources, and other community services specified and documented within the PCSP.~~as specified by the Personal Plan. Transportation services for Section 29 services are provided under the *MaineCare Benefits Manual*, Section 113 (Non-Emergency Medical Transportation Services).~~

Whenever possible, a Member may access transportation from family, neighbors, friends, or community agencies~~, which can provide this service without charge, are utilized~~.

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 NET Broker~~provider~~ may ~~only be~~ reimburse~~d~~ a provider for providing transportation services only when the cost of transportation is not a component of a rate paid for another service and the transportation is delivered in accordance with Section 113 of the MBM. Where transportation is a component of the rate paid to a provider for a service, the provider shall provide the Member with transportation and the Member may not access NET.

29.05-~~11~~15 Work Support-Group is Direct Support delivered at the Member's place of employment~~provided~~ to improve a ~~member's~~ Member'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 ~~members~~Members. Mobile work crews, and business based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

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 ~~be demonstrably structured and provided in a manner that~~ promote~~s~~ ~~the~~ integration into the workplace ~~and~~, interaction between ~~members~~ Members 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 Employment Specialist must ensure that opportunities for Competitive Integrated Employment comply with criteria set forth in § 29.02-9, and that the Member's position is available to and includes the same duties and expectations for job performance and attendance as any other employee at the worksite before providing assistance to the Member in this workplace. The Member must be able to work under conditions similar to employees without disabilities in similar positions, including access to lunchrooms, restrooms, breaks and company-wide events.

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

A Provider agency delivering Medicaid-funded HCBS to Members 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 Member if such a relationship exists. In these circumstances, the provider must supervise the Member in a manner identical to other employees. The Department may approve the provider agency to supervise the Member when the appropriate conflict-of-interest safeguards are in place.

To receive this service, a ~~member~~ Member must have received an assessment and services under the *Americans with Disabilities Act*, and Section 504 of the *Rehabilitation Act*, and the need for on-going support must have been determined and documented in the ~~Personal Plan~~PCSP. The outcome of this service must be sustained paid employment and work experience leading to further career development and individually integrated ~~community~~ community-based employment for which the ~~member~~ Member is compensated at or above the minimum wage, and

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.05 COVERED SERVICES (cont.)

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.

~~Work Support-Group may be used to support a member in a job that pays less than the minimum wage only if the employer complies with section 14(c) of the *Fair Labor Standards Act* (29 U.S.C. §214(c)) and 26 M.R.S. §666.~~

The provider must maintain ~~Documentation~~ documentation ~~must be maintained~~ in the Member's file of each member receiving this service that the service is not available under a program funded under section 110 of the *Rehabilitation Act of 1973* or the Individuals with *Disabilities Education Act* (20 U.S.C. §§1401, *et seq*.).

Work Support-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) ~~members~~ Members at one time may be supervised by a Direct Support Professional delivering Work Support-Group services. The appropriate group rate must be billed.

~~The provider will submit a group work site schedule to the OADS Resource Coordinator listing members, work sites, units of service and staff. The provider will submit schedules quarterly thereafter to the Resource Coordinator.~~

The provider must inform each ~~Information must be provided to the member~~ Member at least yearly that career planning and individual employment are available to ~~them~~ support the Member in ~~order to make~~ making an informed decision regarding the services the Member receives.

Work Support-Group is a Provider-Managed Service.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.05 COVERED SERVICES (cont.)

29.05-12 **Work Support-Individual** is Direct Support delivered to the Member~~provided~~ to improve a ~~member's~~ Member'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 ~~provided~~ delivered in a ~~member's~~ Member's place of employment but may be ~~provided~~ delivered in a ~~member's~~ Member's ~~home~~ residence in preparation for work if it does not duplicate ~~services already reimbursed as~~ Home Support, Community Support or Employment Specialist Services.

Work Support-Individual services must be ~~provided~~ delivered ~~to the member~~ in an integrated employment setting in the general workforce. ~~and the~~The ~~member~~ Member 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 Members 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 Employment Specialist must ensure that opportunities for Competitive Integrated Employment comply with criteria set forth in § 29.02-9, and that the Member's position is available to and include the same duties and expectations for job performance and attendance as any other employee at the worksite. The Member must be able to work under conditions similar to employees without disabilities in similar positions, including access to lunchrooms, restrooms, and breaks and company-wide events.

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

The Member may access Work Support-Individual Services under this Section when the Member ~~This service is provided after a 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~~Personal Plan~~.

Work Support-Individual may be ~~provided~~ delivered to self-employed ~~members~~ Members ~~where the member requires support~~ in operating ~~his or her~~their own business.

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ESTABLISHED 1/1/08
~~Last Updated~~Legal Effective Date: ~~2/4/19~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.05 COVERED SERVICES (cont.)

Work Support may be used ~~for Customized~~to customize employment for ~~members~~ Members with severe disabilities ~~to include~~including long term support to successfully maintain a job due to the ongoing nature of the ~~member's~~ Member's support needs, changes in life situation, or evolving and changing job responsibilities. ~~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 does not include volunteer work.

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

The provider must maintain ~~Documentation~~ documentation ~~must be maintained~~ in the Member's file ~~of each member receiving this service~~ that the service is not available under a program funded under ~~section~~ 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 ~~an individual's~~a Member's supported employment program.

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

Work Support-Individual is a Provider-Managed Service.

29.06 NON COVERED SERVICES

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

29.06-1 **Duplicative Services:** A Member receiving Section 29 services may not receive comparable or duplicative MaineCare services at the same time under any other Sections of the MaineCare Benefits Manual, including:

A. Section 2, Adult Family Care Services;
B. Section 18, Home and Community-Based Services for Adults with Brain Injury;
C. Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities;

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.06 NON COVERED SERVICES (cont.)

D. Section 20, Home and Community-Based Services for Adults with Other Related Conditions;
E. Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations;
F. Section 21, Home and Community Benefits for Adults with Intellectual Disabilities or Autism Spectrum Disorder;
G. Section 45, Hospital Services;
H. Section 46, Psychiatric Facility Services;
I. Section 50, ICF/IID Services;
J. Section 67, Nursing Facility Services, and
K. Section 97, Private Non-Medical Institution Services, when the Member is receiving personal care services.

29.06-~~1~~2 Services not identified by the ~~Personal Plan~~PCSP;

29.06-~~2~~3 Services to any MaineCare ~~member~~ Member ~~who receives~~receiving services under any other federally approved MaineCare Home and Community ~~based~~ Based waiver program;

29.06-~~3~~4 Services delivered in Nursing Facilities, Institutions for Mental Disease (IMDs), Intermediate Care Facilities (ICF/IIDs), and Hospitals~~Services to any member who is a nursing facility resident, or ICF/IID resident, psychiatric hospital resident, or hospital resident~~;

29.06-~~4~~5 Services that are reimbursable under any other ~~sections~~ Sections of the *MaineCare Benefits Manual*;

29.06-~~5~~6 Any service otherwise reimbursable under the *Rehabilitation Act of 1973* or the Individuals with *Disabilities Education Act*, including but not limited to job development and vocational assessment or evaluations;

29.06-~~6~~7 Room and board is not reimbursed by MaineCare.~~;~~ The term "room" means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals a day; or any other full nutritional regimen. Board does not include the provision of a meal or snacks at an adult day health or similar facility outside the ~~member's~~ Member's home. Board also does not include the delivery of ~~a single~~ meal(s) to a ~~member~~ Member at ~~his/her~~their own home through a meals-on-wheels service;

29.06-7 Work Support-Individual or Work Support-Group or Employment Specialist Services when the ~~member~~ Member is not engaged in employment;

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~~Last Updated~~Legal Effective Date: ~~2/4/19~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.06 NON COVERED SERVICES (cont.)

29.06-~~8~~9 Home Accessibility Adaptations unless the service has been determined non-reimbursable under Medical Supplies and Durable Equipment, Section 60 or other ~~sections~~ Sections of the *MaineCare Benefits Manual*;

29.06-~~9~~10 When a member is offered a supported employment opportunity with a provider agency, the provider may not pay the Member's wages from any MaineCare reimbursement claimed by the provider for the delivery of supported employment~~A member may not have wages from employment paid for with MaineCare reimbursement~~; ~~and~~

29.06-~~10~~11 Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the ~~member's~~ Member's parent, sibling or other biological family member. This rule will not be avoided by adult adoption. For Self-Directed Services, the guardian may deliver services to a Member, regardless of the familial relationship to the Member;

29.06-12 Services delivered in any setting that is located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment and any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution;

29.06-13 Services delivered in any other setting, as determined by the state, that has the effect of isolating individuals receiving Section 29 services from the broader community of individuals not receiving Medicaid HCBS and does not fully remediate the isolating qualities, as determined by the state, and to the extent additional determination is required under federal law, as determined by the Secretary of the US Department of Health and Human Services; and

29.06-14 Services delivered in settings, after March 17, 2023, that are determined by the state not to be fully compliant with Global HCBS Rule standards applicable to the setting.

29.07 LIMITS

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

~~Effective 2/4/19~~

29.07-2 The ~~combined~~ annual limit for ~~members~~ Members who receive any combination of Home Support (Remote or ¼ hour), Community Support, or Shared Living Services, is $84,689.28 ~~$58,168.50~~. ~~This cap will be retroactive to July 1, 2018.~~

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.07 LIMITS (cont.)

29.07-3 **Employment Specialist Services** are provided on an intermittent basis with a maximum of ten (10) hours (forty (40) quarter hour units) each month, and may not be delivered at the same time as Work Support-Group or Work Support-Individual.~~.~~

29.07-4 **Home Accessibility Adaptations** are limited to ~~ten thousand dollars (~~$~~10,000~~10,494.00~~)~~ in a five (5) year period with an additional annual allowance up to ~~three hundred dollars (~~$~~300~~314.82~~)~~ for repairs and replacement per year. General household repairs are not included in this service. All items in excess of ~~five hundred (~~$~~500~~524.70~~)~~ ~~dollars~~ require documentation from a physician or another appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the ~~member's~~ Member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit ~~can~~ may be reimbursed under this ~~section~~Section.

29.07-5 **Transportation:** A provider may only be reimbursed for providing transportation services when the cost of transportation is not a component of a rate paid for another service.

29.07-6 **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 Member 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.~~Respite Services are limited to $1,224.60.00) per year. This respite cap will be effective retroactive to July 1, 2018. Additionally, the quarter hour (1/4) billing for Respite shall not exceed the per diem limit of $110.21 for each date of service. Reimbursement for Respite is a quarter (1/4) hour billing code. After thirty-three (33) quarter hour units of consecutive Respite Services, the provider must bill using the per diem billing code.~~

~~Effective 2/4/19~~

~~The quarter hour (1/4) Respite amount billed any single day cannot exceed the Respite per diem rate of $110.21.~~

~~**29.07-7** Services reimbursed under this section are not available to members who reside in an ICF/IID, nursing facility or are inpatients of a psychiatric hospital or hospital.~~

~~**29.07-8** **Duplicative Services.** A member may not receive services that are comparable or duplicative under another Section of the *MaineCare Benefits Manual* at the same time as services provided under this waiver benefit. Such comparable or duplicative services include, but are not limited to services covered under the *MaineCare Benefits Manual*, Section 2, Adult Family Care Services; Section 18, Home and~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.07 LIMITS (cont.)

~~Community Based Services for Adults with Brain Injury; Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities; Section 20, Home and Community Based Services for Adults with Other Related Conditions; Section 21, Home and Community Benefits for Person with Intellectual Disabilities or Autism Spectrum Disorder; Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations; Section 45, Hospital Services; Section 46, Psychiatric Facility Services; Section 50, ICF/IID Services; Section 67, Nursing Facility Services and Section 97, Private Non-Medical Institution Services.~~

29.07-~~9~~7 Enrollment in High School: A ~~member~~ Member may not receive Community Support while enrolled in high school. ~~A member may not receive Community Support at his or her place of employment.~~

29.07-~~10~~8 Place of Employment: A Member may not receive Community Support or Home Support at their place of employment.
~~A member may not receive Employment Specialist Services while enrolled in high school.~~

29.07-~~11~~9 Work Support Individual Services are limited to one Direct Support Professional per ~~member~~ Member at a time.

29.07-~~12~~10 Annual MaineCare Expenditures for services under this waiver for an individual Member ~~The total amount of Services authorized~~ may not exceed 50% of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department, except for expenditures on service enhancements authorized as an Exception under § 29.14 or other modification granted under the Americans with Disabilities Act.

29.07-~~13~~11 Nursing Facility or Hospital: If a ~~current waiver recipient enters~~Member is admitted to a nursing facility or a hospital, the Department will temporarily suspend payment under Section 29 for the period of the Member's admission~~the waiver will be temporarily suspended~~. If the ~~waiver recipient~~Member remains in the nursing facility or hospital for more than thirty (30) consecutive days without a discharge plan back to the community, enrollment in this ~~waiver~~ benefit will be terminated unless the Department approves a written request~~unless there is a written request to the Department~~ to continue holding the funded opening.

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.07 LIMITS (cont.)

29.07-~~14~~12 Assistive Technology ~~services~~ Services are not covered under this rule if they are available under another MaineCare rule.

Assistive Technology services are subject to the following limits:

A. Assistive Technology-Assessments ~~is~~ are subject to a combined limit of 32 units (8 hours) per year.

B. Assistive Technology-Devices, including the selecting, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices, ~~is~~ are subject to a combined limit of $6,815.22 ~~6,000~~ per year.

C. Assistive Technology-Transmission ~~(Utility Services)~~ is ~~subject to a combined~~ limited of $~~50~~ 54.12 per month.

29.07-~~15~~13 Career Planning is limited to 60 hours to be delivered in a six-month period. No two six-month periods may be provided consecutively. Career Planning furnished under this benefit 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) and (17).

29.07-16 Out of State Services: 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 Members 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.

29.07-15 Volunteering cannot involve volunteering for the provider of the service, other entities owned or operated by the provider, relatives of the provider or situations where a Member must be paid under existing state and federal labor laws.

29.08 DURATION OF CARE

~~Each member receiving services under this Section is eligible for as many covered services as are authorized by DHHS in the member's personal plan. Services are authorized to meet the needs~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.08 DURATION OF CARE (cont.)

~~identified in the member's most recent assessment, subject to limits on covered service components specified elsewhere in this Section.~~

29.08-1 Voluntary Termination of Services: A ~~member~~ Member who currently receives the ~~benefit~~ services under this Section, but no longer wants to receive the ~~benefit~~services, will be terminated~~,~~ after DHHS receives written notice from the ~~member~~ Member that ~~he or she~~they no longer want~~s~~ the benefit.

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

A. The ~~member~~ Member is determined to be financially or medically ineligible for this benefit or MaineCare;

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

C. The ~~member~~ Member is determined to be receiving MaineCare services from another Home and Community Based Waiver benefit;

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

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

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

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

3. There is no approved ~~Personal Plan~~PCSP.

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

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.08 DURATION OF CARE (cont.)

G. The annual cost of the ~~member's~~ Member's services under this waiver exceeds fifty percent (50%) of the state-wide average annual cost of care for an individual in an ICF/IID, as determined by ~~the~~ DHHS, unless the Member is authorized to exceed this limit pursuant to the Exceptions process in this rule or an Americans with Disabilities Act (ADA) modification approved by DHHS.

29.08-3 **Termination from Participation as a MaineCare Provider:** Pursuant to Chapter I of the *MaineCare Benefits Manual*, the provider must notify the Department in writing of the intent to terminate its participation (disenroll) in the MaineCare program, at least thirty (30) days prior to the effective date of termination for non-emergency terminations and seven (7) days prior to the effective date for emergency terminations.

Additionally, providers shall notify all Members receiving Section 29 services from the provider in writing of the provider's intent to disenroll from the MaineCare program as a provider of Section 29 services following the same timeline for non-emergency and emergency terminations noted above. ~~**Provider Termination** from the MaineCare program: The provider must provide the member and DHHS thirty (30) days written notice prior to the effective date of termination.~~

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

~~A. The reason a waiver service was not provided,~~

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

29.09 MEMBER RECORDS

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

In addition, the ~~member's~~ Member's records must contain:

A. The ~~member's~~ Member's name, address, birth date, MaineCare identification number, guardian contacts and emergency contacts;

B. The ~~member's~~ Member's social and medical history, including allergies and diagnoses;

C. The ~~member's~~ Member's ~~Personal Plan~~PCSP; and

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.09 MEMBER RECORDS (cont.)

D. Written progress notes signed by the staff performing the service that identify any actions related to progress towards the achievement of the Member's goals~~,~~ related to the services and needs established by the ~~member's Personal Plan signed by the staff performing the service~~PCSP.

All providers must document ~~-~~each service provided, the date of each service, the type of service, the activity, need or goal to which the service relates, the length of time of the service, and the signature of the individual performing the service. If services are provided by two (2) or more staff working different shifts, then each shift must be documented separately.

The provider must also document the setting where each service is provided, selecting one or more of the following: (1) non-disability-specific integrated community setting; (2) provider owned or controlled setting; (3) disability-specific setting that is not provider-owned or controlled.

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

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS

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

To provide services under this ~~section~~ Section a provider must be a ~~qualified~~ Qualified ~~vendor~~ Vendor as approved by ~~DHHS~~ OADS and enrolled by the MaineCare program. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement. A Qualified Vendor must meet all HCBS Settings requirements and provide notice to the Department upon the need for agency closure or termination of services to Members as outlined in this rule.
Once a provider has been authorized to provide services, the provider cannot terminate the ~~member's~~ Member's services without written authorization from ~~DHHS~~OADS.

Providers must ensure staff are trained in identifying risks, such as risk of abuse, neglect or exploitation; participating in a ~~member's~~ Member's risk assessment; identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an intervention plan. Any ~~plan,~~ intervention must be consistent with the DHHS's rule governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism (14-197 C.M.R. ch. 5). ~~emergency intervention and behavioral treatment for persons with intellectual disabilities (14-197 CMR Chapter 5).~~ It may also be necessary to seek emergency

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

medical or safety assistance when needed and comply with ~~Reportable Events and Adult Protective~~ reporting requirements outlined in DHHS's Reportable Events System (14-197 C.M.R. ch. 12) and/or Adult Protective Services System (10-149 C.M.R. ch. 1).

~~All staff, regardless of length of employment, must have Behavioral Regulations (14-197 CMR, Chapter 5), Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Mental Retardation and Autism (14-197, ch. 12), and Rights of Persons with Intellectual Disabilities or Autism Training (Title 34-B §5605). These trainings are required every thirty-six (36) months. Documentation of training must be maintained in provider personnel files.~~

~~Additional information regarding provider requirements can be found in APPENDIX IV-Additional Requirements for Section 29 Providers Community Support Services and Employment Specialist Services.~~

29.10-1 Direct Support Professional (DSP)

The following requirements apply to DSPs:

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

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

1. Introduction to Developmental Disabilities;
2. Professionalism;
3. Individual Rights and Choice and
4. Maltreatment.

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

~~C~~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:

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

1. Reportable Events (14-197, Ch. 12) Reportable Events System (14-197 C.M.R. ch. 12) and Adult Protective Services System (10-149 C.M.R. ch. 1);

2. ~~Adult Protective Services (10-149, Ch. 1)~~Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5);

3. ~~Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)~~Rights and Basic Protections of a Person with an Intellectual Disability or Autism (~~Title~~ 34-B M.R.S. §5605);

4. ~~Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)~~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;

~~Effective 2/4/19~~

5. ~~Grievance Training (14-197, ch. 8)~~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 Rule.

~~D~~C. DSPs must ~~have~~ pass a background check completed consistent with §~~Section~~ 29.10-6.

~~E~~D. DSPs must have an adult protective and child protective record check consistent with §29.10-8;~~.~~

~~F~~E. ~~DSPs must be at least eighteen (18) years of age.~~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. This provision does not apply to 29.10-2 - Job Coaches, 29.10-3 - Career Planners, or 29.10-4 - Employment Specialists delivering supported employment services;

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

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

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

~~I~~H. A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN), or otherwise has been trained to administer medications through a training program specifically for Shared Living model homes and authorized, certified, or approved by DHHS~~.~~;

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

~~K. A DSP who also provides Career Planning must have completed the additional employment modules in the Maine College of Direct Support and an additional twelve (12) hours of Career Planning and Discovery training provided through Maine's Workforce Development System.~~

~~L~~I. All new staff or subcontractors must complete the Maine College of Direct Support within six (6) months of actual employment calculated from their date of hire. Evidence of date of hire and enrollment in the training must be documented in writing in the employee's personnel file or a file for the subcontractor. Services provided during this time are reimbursable as long as the documentation exists in the personnel file~~.~~;

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

~~N. Only a DSP who is certified as a Certified Nursing Assistant-Medications (CNA-M), a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN) may administer medications to a member.~~

~~O~~K. A DSP may supervise another DSP.

29.10-2 Job Coach (Work Support-Individual and/or Work Support-Group) is a person who provides support to Members to gain skills related to performing specific job tasks in order to maintain employment. A Job Coach may help the Member with building supports on the job and other employment related needs.

The following requirements apply to Job Coaches:

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

A. 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 hold a Job Coach certificate from Maine's *College of Employment Services*.

B. Job Coaches must be eighteen years of age or older, must be graduated from high school or hold a GED, and 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.

29.10-3 Career Planner is a person who provides Career Planning Services to a waiver Member to explore their employment interest, abilities and learn about businesses. The Career Planner will assist in the application to Bureau of Rehabilitation Services and Benefit Counseling for supports to become employed in Competitive Integrated Employment. The Career Planner will develop the Career Plan that is then used to develop employment that matches the Member's skills, interests and abilities.

The following requirements apply to Career Planners:

A. 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).

B. Career Planners must receive six (6) hours of continuing education in employment annually to maintain Career Planning certification.

C. Career Planners must be eighteen years of age or older and must have graduated from high school or hold a GED or equivalent.

29.10-4 Employment Specialist is a person who provides Employment Specialist Services or Work Support. When providing Employment Specialist Services the Employment Specialist can assist the Member with building connections on the job to support inclusion, and job development in specific situations such as transferring to a similar job. An Employment Specialist may work independently or under the auspices of a Supported Employment provider, but must have completed the approved Employment Specialist training.

In addition to the requirements outlined for Direct Support Professionals, Employment Specialists must meet the following requirements:

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

A. Successful completion of 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;
B. Supervision by a Certified Employment Specialist during the first six months of employment;
C. Employment Specialists must be eighteen years of age or older and must be graduated from high school or hold a GED or equivalent;
D. Completion of a background check consistent with Section 21.10-08; and
E. Have worked a minimum of one (1) year with a person or persons having an Intellectual Disability or Autism Spectrum Disorder in a work setting.
F. 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.

~~is a person who provides Employment Specialist Services or Work Support. The following requirements apply to Employment Specialists:~~

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

~~B. Employment specialists must be supervised during the first six months of hire by a Certified Employment Specialist in order to provide services.~~

~~C. Employment Specialists must have graduated from high school or acquired a GED.~~

~~D. Staff can either be certified as an Employment Specialist or complete the Approved Direct Support Curriculum along with additional modules specific to employment.~~

~~E. Employment Specialists must have satisfied a background check consistent with Section 29.10-6.~~

~~F. Employment Specialists 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.~~

~~G. 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 (six) hours of Department approved continued education every twelve (12) months.~~

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The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

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

29.10-~~4~~6 Electronic Visit Verification (EVV)

~~Effective 2/4/19~~

~~**The Department is seeking and anticipates receiving approval from CMS for this section. Pending approval, the change will be effective.**~~

~~Effective January 1, 2020, every provider~~Providers of Home Support-Quarter Hour services must comply with Maine DHHS Electronic Visit Verification ("EVV") system ~~for~~ standards and requirements. In compliance with Section 12006 of the 21st Century CURES Act (P.L. 114-255), as codified in 42 U.S.C. § 1396b(l)(1), ~~Visits~~ visits conducted as part of such services must be electronically verified with respect to: the type of service performed; the individual receiving the service; the date of the service; the location of the service delivery; the individual providing the service; and the time the service begins and ends. Providers may utilize the Maine DHHS EVV system at no cost, or may procure and utilize their own EVV system, so long as data from the provider-owned EVV system can be accepted and integrated with the Maine DHHS EVV system ~~and otherwise is compatible~~.

29.10-~~5~~7 Shared Living ~~(Foster Care, Adult)~~

The Shared Living Provider must be a Certified Direct Support Professional (DSP) who has met all the requirements to provide this service. The Shared Living Provider must enter into a contractual relationship with the Administrative Oversight Agency in order to provide services to a Member. See 29.19, Appendix IV, for additional requirements.

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

~~The Shared Living Home Provider is required to:~~

~~A.~~ ~~Maintain a clean and healthy living environment addressing any necessary member-specific environmental or safety standards (see Appendix IV).~~

~~B.~~ ~~Attend to the member's physical health and emotional well-being.~~

~~C.~~A. ~~Participate as a part of the member's Person-Centered Planning Team and maintain open communication with the Case Manager, Administrative Oversight Agency, guardian and Person-Centered Planning Team.~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

~~D. Assist in transition, admission, or discharge plans.~~
~~E. Include the member in family and community life, assisting the member to develop healthy relationships and increased community independence.~~
~~F. Provide community access to services and activities desired by the member, including but not limited to religious affiliation (if desired), physical activities, shopping, volunteering, etc.~~
~~G. Maintain professional daily documentation in accordance with MaineCare requirements.~~
~~H. Maintain daily documentation of all medication administered to the member or taken by self-administration.~~
~~I. Report any unusual incidents to the member's team (Case Manager, Administrative Oversight Agency and guardian) and, when required, through the Reportable Events Reporting System.~~
~~J. Report to the member's team all changes in household members or legal status of household members.~~
~~K. Maintain current homeowner's or renter's insurance at all times.~~
~~L. Provide the transportation to appointments and activities.~~
~~M. Maintain a valid Maine driver's license and a properly registered, inspected, insured and maintained vehicle.~~
~~N. Enter into a contract for professional support with the Administrative Oversight Agency.~~

29.10-~~6~~8 Background Check Criteria: The provider must conduct criminal history background checks and adult and child protective background checks every two years on all employees~~, persons contracted or hired~~ contracted individuals, consultants, volunteers, students, and other persons who may provide services under this Section. The provider is accountable for any fees associated with the background checks.

A criminal history background check is required for any adult who may be providing direct or indirect services where the ~~member~~ Member receives Shared Living. Background checks are required for any adult, other than the Member, residing in a Shared Living Home. ~~Background checks must be completed before a hire is finalized and prior to the employee working with members.~~ Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. For Members choosing Self-Direction, the FI facilitates a criminal background check on behalf of the Member or Representative for all prospective employees. The FI also conducts background checks on Representatives when the self-directing Member requires or chooses a Representative.

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The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

The provider shall not hire or retain in any capacity any person who may directly provide services to a ~~member~~ Member under this Section if that person has a record of:

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

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

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

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

E. a habitual offender status under 29-A M.R.S. §2551-A.~~any criminal conviction within Title 29-A, chapter 23, subchapter 2, article 1, or Title 29-A, chapter 23, subchapter 5.~~

Additionally, the provider must contact the State's child and adult protective services units (within the Offices of Child and Family Services (OCFS) and OADS, respectively) to obtain any records substantiating allegations of abuse, neglect or exploitation against prospective employees before hiring the same. In such cases where the background check reveals a substantiated finding of abuse, neglect or exploitation by a prospective employee, the provider is responsible for deciding whether to move forward with hiring the prospective employee, while acting in accordance with licensing standards.~~The provider shall contact child and adult protective services (including OADS and the Office of Child and Family Services) units within State government to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child or adult protective services investigation substantiating abuse, neglect or exploitation by an employee of the provider, it is the provider's responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards. Within 60 days of the effective date of this rule, all staff and all adults residing with a member must have all background checks completed. All background checks must be completed every twenty-four (24) months thereafter. Costs for background checks are the responsibility of the provider.~~

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

29.10-~~7~~9 Informed Consent Policy

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

29.10-~~8~~10 Rights, Reportable Events, and Behavioral Support Training~~Reportable Events & Behavioral Treatment~~

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

A. Reportable Events System (14-197 C.M.R. ch. 12); and
B. Adult Protective Services System (10-149 C.M.R. ch. 1); and
C. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5); and
D. Rights and Basic Protections of a Person with an Intellectual Disability, Autism, or an Acquired Brain Injury (34-B M.R.S. § 5605).

Providers must ensure that staff members receive Department-sponsored training regarding all the regulations listed above (items a. through d.) within six (6) months of being hired and every thirty-six (36) months thereafter. Providers will maintain documentation of all training within individual personnel files, regardless of the staff member's length of employment.

~~Providers shall comply with all terms and conditions of DHHS' Reportable Events System and Adult Protective Services System as described in 14-197 CMR, chapter 12 and 10-149 CMR, chapter 1. All staff must receive training in mandatory reporting/ reportable events and Behavioral Regulations either before they begin work with members or, at the latest, six (6) months of being hired and every thirty six (36) months thereafter. All staff must receive the following Department sponsored training:~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

~~Reportable Events System (14-197, Ch. 12)~~

~~Adult Protective Services System (10-149, Ch. 1)~~

~~Regulations Governing Behavioral Support, Modification, and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5); and~~

~~Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)~~

~~Completion of trainings should occur before staff begin work with members or within six (6) months of the date of hire and every thirty six (36) months thereafter. All staff, regardless of length of employment, must have documentation of training completion in their personnel file.~~

29.10-11 Plan of Corrective Action (POCA)

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

B. Plan of Corrective Action (POCA): Within 30 days after receiving notification of any deficiency, including a deficiency with respect to the requirements of Appendix IV, a provider must submit a Plan of Corrective Action (POCA) for approval by the Department. The Department will approve, reject, or suggest changes to, the POCA, in writing. If the Department rejects a POCA, the written notice of rejection will explain the reason(s) why the POCA is being rejected, and may suggest changes to the POCA. If the Department does not respond to POCA within 30 days of receipt, the Notice of Deficiency shall be withdrawn.

C. The POCA must meet the following requirements:

1. The POCA must be a specific plan which describes how the deficient circumstance(s) (event, incident, or risk) will be corrected, including the actions which will be taken to bring about correction.
2. The POCA must address correction of the specific deficient circumstance(s) cited. In those instances where the deficiency resulted from a previously missed time frame, the plan must include an immediate correction of the deficient circumstance(s) even though the required time frame has been missed.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

3. The POCA must address all identified areas where the correction of all related deficient circumstances would be implemented as specific deficiencies cited may not represent all instances within the site/service where the practice is deficient. It is, therefore, the provider's responsibility to identify and correct the deficiency throughout the site/service.
4. The POCA must identify actions steps to prevent the deficient circumstance(s) from recurring/occurring. When monitoring systems are to be implemented, the plan will include the type of monitoring, detail for implementation, as well as the responsible party/entity.
5. The POCA must clearly delineate the frequency each element of the plan is to occur. Such terms as "frequently," "periodically," "as needed" and "ongoing" lack the necessary specificity to be acceptable.
6. The POCA must identify by title the individual(s) responsible for the implementation and monitoring of the plan. The individuals identified must be employed by the provider.
7. The POCA must provide date(s), to run from the date of Department approval of the POCA, by which all components of the plan will be implemented, and the corrections completed. The length of time to correct the deficiency specified by the POCA must be as soon as possible.
8. The POCA should not duplicate or closely parallel a previously submitted failed plan.

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

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

29.11 MEMBER APPEALS

In accordance with Chapter I of the *MaineCare Benefits Manual*, ~~members~~ Members have the right to appeal in writing or verbally any decision made by DHHS to reduce, deny or terminate services provided under this benefit. In addition, Members have the right to appeal decisions made regarding priority level and waitlist determinations. The right to appeal does not extend to changes in law or policy adversely affecting some or all recipients. The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling Local: 207-287-6598, Toll Free: 1-800-606-0215 or TTY:711.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.11 MEMBER APPEALS (cont.)

Office of Aging and Disability Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

29.12 REIMBURSEMENT

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

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

C. Providers of Community Support-Center Based and Work Support-Group services will not be reimbursed for any times the Member is away from a Provider's setting, and a Provider staff member is not continuing to deliver support. The Provider must keep detailed and accurate accounting (by 15-minute increments) of when the Member is receiving the service from staff.

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

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

29.13 BILLING INSTRUCTIONS

Providers must bill in accordance with DHHS billing instructions.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.14 REQUESTS FOR EXCEPTIONS

29.14-1 General

Members who receive services through this Benefit and Members applying to receive services through this Benefit may submit a Request for Exceptions. The purpose of submitting a Request for Exceptions is to ensure that Members receive adequate and appropriate services and supports in the most integrated setting appropriate to their needs, consistent with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134, and consistent with Section 29 health and safety requirements. To achieve that outcome, Members may submit a Request for Exceptions to seek services in excess of otherwise-applicable Section 29 waiver monetary and/or unit caps. Members or their guardian may seek Exceptions by submitting a written request.

Filing a Request for Exceptions is neither a waiver of nor a substitute for the Member's right to an administrative hearing on an appeal under Chapter I, Section 1; to file a grievance under 14-197 C.M.R. ch. 8; or to file a complaint pursuant to 34-B M.R.S. § 5611.

29.14-2 Applications

A. Requests for Exceptions must be submitted in writing on a form provided by the Department by the Member, the Member's guardian (as applicable), or the Member's Case Manager.

B. For those Members seeking an Exception when applying to receive Section 29 services, the Member, the Member's guardian (as applicable), or the Member's Case Manager shall submit the Request for Exceptions with the materials required under the Section 29 regulation for a determination of the Member's medical eligibility for Section 29 services. A Member must satisfy all Section 29 eligibility requirements and obtain a funded offer of Section 29 services prior to the Department's consideration of a Request for Exceptions.

C. For those Members who have received a funded offer of Section 29 services or are already receiving Section 29 Services, Requests for Exceptions shall be submitted to the Department via email to HCBSwaiverexceptions.DHHS@maine.gov, or via US Mail to the Office of Aging and Disability Services, 11 State House Station, Augusta ME 04333. The Department will acknowledge receipt of a Request for Exceptions from a Section 29 Member within five (5) business days.

D. The Member bears the burden of establishing that the Member needs an Exception to: (i) ensure the Member receives adequate and appropriate services and supports in the most integrated setting appropriate to their needs and to avoid an undue risk of segregation in an institution; and (ii) that natural supports are not available to meet the needs the Exceptions are intended to address.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.14 REQUESTS FOR EXCEPTIONS (cont.)

E. A Request for Exceptions shall include the following information when known to the Member:
   1. The name, address, telephone number, email address, and MaineCare number of the Member and the name, address, telephone number, and email address, of the person who submitted the Request for the Member, if applicable;
   2. The specific provision(s) in MBM Chapters II or III, Section 29 from which an Exception is requested;
   3. The specific Exception(s) requested, the proposed level of service that would result from approval of the Request for Exceptions, and the anticipated duration of the proposed Exception(s);
   4. Any relevant facts;
   5. A history of the Department's action on the issue including prior communications with the Department on this issue, if applicable;
   6. The name, address, and telephone number of any person inside or outside the Department with knowledge of the matter with respect to which the Exception is requested; and
   7. Signed releases of information authorizing persons with relevant knowledge or records to furnish the Department with information pertaining to the request, if desired.

29.14-3 Department Review And Decision

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

B. The Department shall apply some or all of the Criteria set forth below in § 29.14-4 and issue a written decision ("Decision") on the Request for Exceptions within sixty (60) days of receipt of all materials submitted by the Member or requested by the Department.

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

D. The Department's Decision shall state:
   1. The name of the Member on whose behalf the Request for Exceptions was made, and the Exceptions sought;

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.14 REQUESTS FOR EXCEPTIONS (cont.)

2. A list of documents reviewed, and a summary of other information obtained to review the Request for Exceptions;
3. Whether the Department has granted, granted in part, or denied the Request for Exceptions;
4. Alternative services or Exceptions offered to the Member;
5. The nature of any Exceptions granted to the Member, their duration, any conditions, and the reasons for the imposition of any limits on the duration of or conditions for the Exceptions;
6. The reasons for the Department's Decision; and
7. Notice of the Member's appeal rights.

E. All Exceptions are subject to Utilization Review.

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

29.14-4 Criteria for Decisions

A. The Department, or its Authorized Entity, can only approve a Request for Exceptions if the Member has demonstrated all of the below criteria:
1. The requested service is a Covered Service;
2. The Member reasonably requires the Exception to receive services in the community, or failure to grant the Exception will place the Member at serious risk of institutionalization or segregation;
3. The Member lacks natural supports to meet the needs that the requested Exception is intended to address;
4. The need for Exception could not be met with other services or combination of services available in the MaineCare Benefits Manual; and
5. The Exception will ensure the Member's needs will be met in the most integrated setting appropriate to their needs.

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

29.14-5 Duration; Re-Assessment

A. The Member's Case Manager, the Member, or the Member's guardian (as applicable) shall note approved Exception(s) and their duration in the Member's

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.14 REQUESTS FOR EXCEPTIONS (cont.)

Person-Centered Service Plan.

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

C. At least sixty (60) days prior to the expiration of an Exception, if the Member wishes to renew the Exception, the Member, the Member's guardian (as applicable), or the Member's Case Manager shall submit a request to renew the Exception in conformance with § 29.14-2. The Department will evaluate the request to renew
the Exception applying the criteria set forth in § 29.14-4.

29.14-6 Appeals

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

29.15 SELF-DIRECTION

For Self-Directed Services, a Member, or their Representatives if applicable, has decision-making authority over certain services and takes direct responsibility to manage those services with the assistance of a system of available supports.

Self-Direction promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered. The Member may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports as well as to terminate an employee who is not performing in a satisfactory manner.

During the planning phase of PCSP development, 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.

Providers must supply information on Self-Direction on a timely basis to support a Member's ability to make an informed decision, allowing sufficient time for the Member to weigh the pros and cons and obtain additional information as necessary before electing or rejecting this option.

Members who wish to participate in Self-Direction, but who are unable or unwilling to exercise the Employer Authority, may delegate related responsibilities to a

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.15 SELF-DIRECTION (cont.)

Representative. The Representative assumes all responsibilities as the employer on behalf of the Member but cannot be employed as a direct worker.

29.15-1 Self-Directed Person Centered Service Planning Process

For Members choosing Self-Direction, the process for developing the PCSP will not be different from that of traditional waiver services and must comply with the Global HCBS Rule.

The Member'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, as noted above, 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 Member and guardian about available opportunities for the same.

The Member or their Representative, in coordination with the Support Broker, must develop a Service Implementation Plan in accordance with the provisions outlined in this rule.

29.15-2 Self-Directed Budget

The Member has full Budget Authority to manage and allocate funds according to defined parameters set forth in the Member's individual budget, either fixed or flexible, and as determined and documented within the Member's PCSP.

A fixed budget includes direct vendor-purchased services for which the Member, or Representative as applicable, has Employer Authority but does not have Budget Authority. The Fiscal Intermediary pays a vendor directly who procures or delivers the service up to the monetary value of the authorized service. There is no discretion in how the fixed budget is spent outside of the prior authorized amount.

A flexible budget includes services for which the Member, or Representative as applicable, has both Employer Authority and Budget Authority. Only those services labeled as part of a flexible budget allow the Member to exercise control over how their budget is spent on services and supports needed to live in the community. The Member can determine the wages of their staff as well as select allowable Individual Goods and Services.

The process for developing the overall budget for the Member who has chosen Self-Direction does not differ from the budget development process as described in this

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.15 SELF-DIRECTION (cont.)

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 Member's annual budget is calculated by converting the units of service to a total dollar amount. The Case Manager submits the Member'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 Member'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 Member 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 Member 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.

29.15-3 Self-Directed Services

At a minimum, a Member who wishes to self-direct must receive:

1) Financial Management Services; and
2) Supports Brokerage

Members may choose from the following optional Self-Directed Services:

1) Individual Goods and Services
2) Home Support- Quarter Hour
3) Community Only-Individual Support
4) Assistive Technology- Devices
5) Assistive Technology- Transmission
6) Home Accessibility Adaptations

29.15-4 Staffing

In order to fulfill their employer responsibilities, the Member and/or Representative, must successfully complete skills training. The FI will train the Member and/or Representative, in advance of conducting employer functions, on the skills and tools related to the hiring process and essential to the employer role. This includes training

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.15 SELF-DIRECTION (cont.)

on the use of any phone and/or web-based tools, the required employee paperwork and support regarding any questions related to the employment paperwork.

In coordination with the FI and with skills training support from the Supports Broker, the Member or Representative will recruit and hire prospective staff once the FI has verified that the employee is eligible for hire.

At a minimum, all employees must receive training in the following:
Reportable Events System (14-197 C.M.R. ch. 12); and
Adult Protective Services System (10-149 C.M.R. ch. 1); and
Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5); and
Rights and Basic Protections of a Person with an Intellectual Disability, Autism, or an Acquired Brain Injury (34-B M.R.S. § 5605; 14-197 C.M.R. ch. 1).

The FMS will inform the employee about the aforementioned department-sponsored, no-cost trainings as part of the orientation process.

The Member and/or Representative must maintain employee records for every staff member hired including orientation and other trainings such as CPR and First Aid certification and other disability-related trainings.

Employees/staff hired by the Member may be friends or family members of the Member, including their spouse or the legal guardian. If a Member requires or has selected a Representative to direct services on their behalf, the Representative may not also be paid to deliver paid Direct Support to the Member. When the guardian is acting as the Representative on behalf of the Member, the guardian may not also deliver paid Direct Support to the Member.

The Member sets the worker's rate of pay which 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. 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 and a spending plan is developed for each Member. The FI will create an account solely for the Member's allocated funds for Individual Goods and Services.

The Member, with the assistance of a Support Broker, will have the ability to hire eligible staff to meet their needs as identified in the PCSP, 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 Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.15 SELF-DIRECTION (cont.)

29.15-5 Denial of Self-Directed Services

The Department may deny or terminate a Member's ability to utilize Self-Direction, if it determines that the Member, or the Member'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 Member;
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 must cease;
E. Demonstrates any other action having a direct bearing on the Member'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 Member; or
F. Demonstrates any other action which may affect the effective and efficient administration of the program.

Prior to, and as part of denying or terminating the Member's ability to elect Self-Direction, the Case Manager will support the Member to transition to another Representative or to Provider-Managed services, as appropriate.

Pursuant to Chapter I, Section 1 of the MBM, the Department will provide written notice of the denial or termination including the Member's right to appeal the denial or termination.

29.15-6 Limits and Safeguards

A. Individual Goods and Services that are non-allowable:

1. Cash Payments;
2. Gifts or loans for Member-directed workers, family, or friends;
3. Food, beverages, or nutritional supplements;
4. Entertainment equipment or downloadable files/applications or supplies;
4. Air conditioners, heaters, fans, generators, and similar items;
6. Illegal drugs, alcoholic beverages, tobacco products, or vaping devices;
7. Costs incurred by the employee associated with travel such as airfare, lodging, meals, etc. for vacations or entertainment;
8. Utility costs, rental costs, or mortgage payments;
9. Clothing, shoes, or other apparel;

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.15 SELF-DIRECTION (cont.)

10. Household linens, towels, or drapes;
11. Paint and related supplies;
12. Cleaning for other household members or areas of a home that are not used as part of the Member's personal care;
13. Medications, vitamins/herbal supplements;
14. Experimental or prohibited treatments/procedures;
15. Household cleaning supplies;
16. 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);
17. Landscape and yard work;
18. Pet care;
19. Massages, manicures, pedicures or any cosmetic service or supply or; and
20. Any other item not specified which does not meet the scope of service.

B. A Member may not "cash out" their services for the sole purpose of using Individual Goods and Services.

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

D. Supports Brokerage Services are subject to annual maximum of 200 units. A Support Broker shall not be employed by the Member to deliver direct care services. Supports Brokerage is not considered a direct service. A family member or legal Representative shall not act as the Member's Support Broker to prevent conflict-of-interest.

E. A Member may not roll over unspent Individual Goods and Services funds across fiscal years.

F. A Member 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).

G. A Member may not exceed authorized individual budget limits unless the Member has received an approved Request for Exceptions or Americans with Disabilities Act (ADA) Accommodation.

H. A Member who overutilizes and schedules employees more hours than the authorized budget can cover, may receive a written warning from the

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.15 SELF-DIRECTION (cont.)

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.

I. A Member who is unable or unwilling to adhere to the budget requirements set forth in this rule may be required to appoint a new Representative to serve as the employer of record or be involuntarily disenrolled from Self-Direction.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.16 APPENDIX I-Shared Living Criteria for Increased Level of Support

At times, a Member may require Shared Living Services beyond the level of support defined in § 29.05 due to intensive medical or behavioral needs. In these instances, DHHS may authorize an increased level of support, namely additional staff for the purposes of ensuring the Member's health and safety, for Members who have current and documented challenging behavioral issues or intensive medical needs. OADS will review all increased level of support requests using the following criteria to determine whether to approve such requests.

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

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

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

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

1. The specific illness or condition to be addressed that requires increased support;
~~1.~~2. The manner in which increased support will be utilized;

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.16 APPENDIX I-Shared Living Criteria for Increased Level of Support (cont.)

3. The expected duration of the increased support specifying if it is expected that the increased support is needed for an indefinite period of time;
4. The anticipated frequency of the increased support on a daily, weekly, or monthly basis; and
5. Whether the intended setting for service delivery is appropriate to carry out the physician's recommended treatment or intervention.

Increased level of support is not for respite or as a substitute for the Shared Living Provider, but in addition to the Shared Living Provider.

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

The Provider must complete and submit the Department-approved Home Support Frequency tool summarizing the Member's extraordinary need (described in A.1. and A.2 above), along with the physician's recommendation and other supporting documentation as requested to the Care Coordinator. The Care Coordinator will review and verify that the PCSP and any additional information is current and submit the request to OADS.

OADS will review the information submitted with the request including the PCSP, information in the electronic records (reportable events, crisis notes and case management notes), and any applicable assessments or evaluations of the Member.

OADS staff will issue a written decision within twenty (20) working days of receipt of all required documentation. If additional information is required, OADD will issue a written request to the Care Coordinator. Upon receipt of the additionally requested information, OADS staff will approve or deny the request in writing within ten (10) working days.

If the Member requires an Increased Level of Support for an extended or indefinite period of time, the Care Coordinator must submit the application and supporting documentation at least annually, or more frequently when needed, to OADS for review and continued approved.

The Home Support Frequency tool can be found at this website, https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism.

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.~~14~~17APPENDIX II-Guidelines for Approval of Medical Add-On in Maine Rate Setting

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

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

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

The following standards and practices must be demonstrated in order for the Department or its Authorized Entity~~CRT~~ to approve a Medical Add-On:

A. **Physician Order**

1. There must be a written physician or physician's assistant's order, less than three (3) months old for the ~~member~~Member. This order must specify:

   a. The specific illness or condition to be addressed;

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

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

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

   e. Where applicable and possible:

      i. The approximate length of time required for each episode of the treatment or intervention and

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.~~14~~17APPENDIX II-Guidelines for Approval of Medical Add-On in Maine Rate Setting (cont.)

ii. The degree of licensure or certification required for those who carry out the treatment, and those who provide training and oversight relative to its application.

B. **Planning Team**

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

a. To review and complete the request for Medical Add-On and any additional documentation required for submission to the Department or its Authorized Entity~~CRT~~.

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

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

2. All of these determinations and recommendations must be noted in the ~~Personal Plan~~PCSP.

C. **Provider Requirements**

1. The provider must be an enrolled MaineCare provider.

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

D. **Approval Process**

1. The Department or its Authorized Entity~~CRT~~ will review the information submitted with the request, the ~~Personal Plan,~~PCSP information in the electronic record such as reportable events, crisis notes, as well as any applicable assessments or evaluations in the ~~member's~~ Member's record.

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.~~14~~17APPENDIX II-Guidelines for Approval of Medical Add-On in Maine Rate Setting

2. The Department or its Authorized Entity~~CRT~~ will issue a written decision for the Medical Add-On, within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued. Upon receipt of the additional information the Department or its Authorized Entity~~CRT~~ will approve or deny the request within ten (10) working days.

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

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

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.~~15~~18APPENDIX II~~I~~ - "On Behalf Of" Covered Services

"On Behalf Of" Covered Services include the following:

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

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

C. Services and time that are directly related to a ~~member~~ Member that are associated with that ~~member's~~ Member's ~~personal plan~~PCSP, medical plan or behavioral plan including in-service training specific to a ~~member's~~ Member's ~~personal plan~~PCSP, consultations with supervisors, therapist, clinicians, ~~member's~~ Member's employer and or medical staff; services relating to a ~~member's~~ Member's parent, guardian or to a member of Maine's Developmental Services Oversight and Advisory Board (MDSOAB) ~~representative~~; documentation, reports and presentations to review committees.

D. Services and time that are directly related to a ~~member~~ Member that are associated with home visits, family events and or family reunification including transporting a ~~member~~ Member to their parent's, guardian's, or friend's home for visits, returning a ~~member~~ Member to their home, and any time spent during such a visit such as attending a family function with the ~~member~~Member.

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

"On Behalf Of" Non-Covered Services include the following:

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

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

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

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

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

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

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

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.~~15~~18APPENDIX II~~I~~ - "On Behalf Of" Covered Services (cont.)

~~The primary goal of Performance Measurement is to use data to determine the level of success a service is achieving in improving the health and well-being of members. Performance Goals and Performance Measures assist to monitor quality, inform and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on Performance Measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the DHHS and MaineCare providers.~~

~~**29.16-1 Performance Goals**~~

~~Members receiving this service will experience improved or preserved functional abilities while being able to live in a safe and stable setting within the community.~~

~~**29.16-2 Performance Measures**~~

~~a. 65% of members receiving Work Support-Individual services will have worked a total number of hours of paid employment during the quarter that is greater than the total number of Work Support-Individual support hours they received during the quarter.~~

~~b. 100% of members receiving Work Support Services-Group making less than minimum wage, will have a Personal Plan in place that identifies how Work Supports is being utilized to increase the member's productivity and ensure good job match in order to move toward an hourly wage that meets or exceeds the State of Maine minimum wage standard.~~

~~**29.16-3 Performance Measure Data Source**~~

~~Providers must electronically enter member level data into a DHHS defined web-based data collection system by the fifteenth of the month after the quarter ends.~~

~~**29.16-4 Performance Measurement Compliance**~~

~~DHHS may exercise the following steps to ensure compliance:~~

~~**Step 1**: DHHS will notify the provider in writing of any compliance and performance issues identified by DHHS staff. The notice will include the performance provision that is in noncompliance and a date by which the provider will correct or remedy the identified non-compliance/performance issue.~~

~~**Step 2**: If the compliance/performance issues described by DHHS in Step 1 have not been addressed by the specified dates, the provider and a representative of DHHS will~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.~~15~~18APPENDIX II~~I~~ - "On Behalf Of" Covered Services (cont.)

~~meet, discuss, and document the compliance/performance issues. DHHS and the provider will develop a corrective action plan which must include:~~

~~1. A statement of the corrective actions required for compliance with the Performance Measures;~~

~~2. The date by which the provider will comply with the terms of the Performance Measures;~~

~~3. The consequences for non-compliance which may include the sanctions described in Chapter I of this manual or other consequences as determined by the DHHS; and~~

~~4. Signatures of the provider and DHHS representative.~~

~~**Step 3**: In accordance with Chapter I, if the provider fails to undertake the corrective actions in the corrective action plan, DHHS may impose sanctions, up to and including termination of the Provider Agreement in accordance with the procedures described in Chapter I, *General Administrative Policies and Procedures*, Section 1.03-4, "Termination of Participation by Provider or DHHS" and Section 1.19, "Sanctions/Recoupments".~~

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ESTABLISHED 1/1/08
~~Last Updated~~Legal Effective Date: ~~2/4/19~~

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living

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

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

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

A. Application Form. Initial applications shall be submitted using DHHS ~~forms to the OADS District Resource Coordinator~~. The initial application shall be signed and dated by the provider owner and the presiding officer of the Governing Body, if applicable.

B. The initial application shall be accompanied by documents described in this ~~section~~ Section of rule demonstrating compliance with requirements described in the following portions of these rules:

1. Organizational Structure

a. Ownership

i. **Authority**. The provider shall maintain documented evidence of its source(s) of authority to provide services. Such evidence will include articles of incorporation, corporate charter, or similar documents.

ii. Records. Corporations, partnerships, or associations shall maintain records of the contact information for officers, directors, charters, partnership agreements, constitutions, articles of association and/or by-laws, as applicable.

b. Capacity

i. **Professional Qualifications**. Provider shall have written job descriptions for all positions within the agency. The provider shall acquire and retain evidence to demonstrate that all persons engaged in the provision of services regulated by the State of Maine, other applicable government entities, professional associations or similar bodies are appropriately qualified, certified, and/or licensed.

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29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

1. The management shall have related experience demonstrating competency and experience in the health or human service setting and remain in good standing of licensure or certification

2. Supervisors of Services, Employment Specialist Services, or Community Support Services shall be required to meet all of the requirements of the DSP position.

3. **Copies of contracts or service agreements**. When the provider manages services delivered by another provider, a documented cooperative, affiliated service, or subcontracting agreement shall exist. This agreement shall be updated and renewed at least annually. The provider shall ensure that services provided through an affiliation agreement or subcontract complies with these rules and any contractual requirements.

c. **Organization Chart**

i. The provider will outline the business structure in an organizational chart, identify management, staff and other individuals compensated by the provider for assisting in the care of ~~member~~Member(s) and illustrating the supervisory responsibilities; include credentials as required for the service delivery.

2. Personnel Management

a. **General Orientation Program**. The provider shall have a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns, and volunteers. This orientation shall include, but not be limited to:

i. an overview of the service delivery system as a whole, including the availability of peer and family supports and other elements of services;

ii. the provider's mission, philosophy, clinical services, and therapeutic modalities, policies, and procedures

iii. ~~member's~~ Member's right to privacy and confidentiality; and

iv. safety and emergency procedures general to the provider~~;~~.

b. **Position Specific Orientation and Training**. The provider shall have personnel policies that includes a description of the education, experience, and training required for Direct Support Professionals, Supervisors, and Program Directors.

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER ~~Last Updated~~Legal Effective Date: ~~2/4/19~~ ESTABLISHED 1/1/08

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

The policy shall address any provider requirement for a valid driver's license, personal insurance limitations, computer proficiency, and any specific training specified by the provider and include a component specific to monitoring continued compliance.

The policy should note any requirement that the DSP will receive additional training specific to ~~member~~Member(s) needs as addressed in the ~~Personal Plan~~PCSP.

i. The provider shall provide to all employees, interns, and volunteers, orientation specific to the duties and responsibility for which they were retained or accepted, and ensure the appropriate certification and training requirements specified in this rule and applicable governing regulations which includes but is not limited to the following:

1. Person Centered Planning Process as outlined in 42 CFR §441.303
2. Medication Administration Training required for all DSPs who assist members with over-the-counter and prescribed medication
3. Cultural competence training relevant to the populations served, including: age, gender, race, religion, culture, and sexual orientation.
4. MaineCare Benefits Manual, Chapter I, Section 6, Global HCBS Waiver Person-Centered Planning and Settings Rule.

3. Operational Policies and Procedures

a. **General Policies**. The provider shall maintain policies governing essential elements of service provision. Policies include and are not limited to:

i. **Behavioral Regulations**. The provider shall comply and ensure that all staff and other individuals compensated for assisting in the care of ~~member~~Member(s) comply with the DHHS' Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine, (14-197 C.M.R. ~~Ch~~ch. 5.)

ii. **Rights and Protection**. The provider shall comply and ensure that all staff and other individuals compensated for assisting in the care of ~~member~~Member(s) comply with 34-B ~~MRSA~~ M.R.S. §5605, Rights and Basic Protections of a Person with an Intellectual Disability or Autism.

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The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

iii. **Reports of Abuse, Neglect or Exploitation**. The provider shall maintain a specific policy and procedure governing the reporting, recording, and review of allegations of abuse, neglect, or exploitation of persons receiving services, in accordance with applicable laws, rules, and regulations, including but not necessarily limited to the Adult Protective Statute. The provider shall comply and shall ensure that all staff and other individuals compensated by the provider for assisting in the care of ~~member~~Member(s) comply with DHHS' rule governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism (14-197 C.M.R. ~~Ch~~ch. 5), Reportable Events System (14-197 C.M.R. ~~Ch~~ch. 12), Adult Protective Services System (10-149, C.M.R. ~~Ch~~ch. 1) and state law on reportable events and reports of abuse, neglect, and exploitation (22 ~~MRSA~~ M.R.S. §3477, Persons Mandated to Report Suspected Abuse, Neglect or Exploitation; 34-B M.R.S. ~~MRSA~~ §5604-A, Duty to Report Incidents; Adult Protective Services Act and Rights Violations; and 22 M.R.S. ~~MRSA~~ §3740, *et seq*., *Adult Protective Services Act*).

~~Effective 2/4/19~~

iv. **Procedures.** The provider shall maintain written policies and procedures and have reporting forms available at each site where ~~members~~ Members are served to ensure compliance with the above-mentioned laws and regulations governing Reportable Events, Rights and Basic Protections and Reporting of Abuse, Neglect and Exploitation.

v. **Duration of Care**. The provider shall maintain policies that outline the admission process, discharge procedures for planned or unplanned termination of services, the referral of individuals deemed inappropriate or not qualified for a particular program to other programs to meet the individual's needs, and the mechanisms undertaken to eliminate wait lists or the justification for having no wait list.

vi. **Medication Management**. The provider shall maintain specific policies and procedures ensuring that any staff and other individuals compensated for assisting in the care of ~~member~~Member(s) receive appropriate training in and comply with medication administration protocol that is in accordance with DHHS expectations.

vii. **Notice Regarding Right to File a Grievance.** –Pursuant to 14-197 C.M.R. ch. 8, the provider is required to post information regarding the Member's right to file and the process for filing a grievance in an appropriate common area of all facilities operated by the provider; and post notice of the grievance process on any website maintained by the provider. In addition, the provider must ensure that all staff are trained in the grievance process.

b. **Service-Specific Policies for Shared Living Services**

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The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

i. **Shared Living Provider Requirements.** The Shared Living provider maintains a supportive home environment that promotes Community Inclusion with an appropriate level of support and supervision.

The Shared Living Provider is required to maintain a clean and healthy living environment addressing any Member-specific environmental or safety needs. Additionally, the Shared Living Provider shall:

1. Attend to the Member's physical health and emotional well-being;
2. Participate, when requested by the Member, as a part of the Member's Person-Centered Service Planning Team and maintain open communication with the Case Manager, Administrative Oversight Agency (AOA), and guardian.
3. Assist in transition, admission, or discharge plans;
4. Include the Member in family and community life, assisting the Member to develop healthy relationships and increased community independence;
5. Provide community access to services and activities chosen by the Member including, but not limited to; spiritual or religious affiliation, physical activities, shopping, volunteering, etc.;
6. Maintain professional daily documentation in accordance with MaineCare requirements;
7. Maintain daily documentation of all medication administered to the Member or by self-administration;
8. Report any unusual incidents to the Member's team (Case Manager, AOA and guardian) and, when required, through the Reportable Events Reporting System;
9. Report changes in household members or legal status of household members to the Member's team;
10. Maintain current homeowner's or renter's insurance at all times;
11. Provide the transportation to appointments and activities;
12. Maintain a valid Maine driver's license and a properly registered, inspected, insured, and maintained vehicle; and
13. Enter into a contract for professional support with the AOA.

ii. **AOA oversight responsibilities.** -In addition to ensuring that the Shared Living Provider meets requirements listed in 29.17 (3)(b)(i)(1 -13) above, the AOA assures that the Shared Living Provider:

1. Supports the Member commensurate with the Member's assessed level of need addressing any necessary environmental, health, or safety standards specific to that Member;
2. Demonstrates adherence to the Global HCBS Rule including documentation;
3. May not deliver or be reimbursed for community support, or employment services as an employee of an agency to an individual for whom they provide Shared Living;

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:*~~

29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

4. Resides in the home where Shared Living is delivered and that home shall be the Shared Living provider's primary, legal residence; and
5. Demonstrates the skills and ability to provide care for the Member as outlined in the PCSP.

iii. **AOA general requirements.** In addition to the oversight responsibilities listed in 29.17 (3)(b)(ii)(1 -5) above, the AOA:

1. Is approved by DHHS-Office of Aging and Disability Services (OADS);
2. Holds an Office of MaineCare Services Provider Agreement;
3. Enters into a contractual agreement with the Shared Living Provider for oversight and monitoring services;
4. Bills and receives MaineCare reimbursement;
5. Satisfies the Provider Qualifications and Requirements set forth in this rule;
6. Performs recruitment activities, including advertising, home inspections and reference/background checks. The AOA supports admission and discharge planning for the Member and ensures the shared living home meets the criteria to be shared living provider;
7. Develops a Service Implementation Plan in coordination and agreement with the Shared Living Provider and the Member prior to the delivery of Shared Living Services;
8. When the Shared Living Provider is not available, the AOA arranges alternate support ("Shared Living respite") when the Member agrees to receive Shared Living from an alternate provider. The AOA ensures the alternate provider is qualified to deliver services, meeting the requisite educational and background check criteria as described in this rule. Shared Living respite is a component of the Shared Living rate paid to the AOA for those dates of service and therefore is not a separately billable service. The Member's PCSP must accurately reflect the Member's location during the receipt of Shared Living respite, if different from the authorized service location;
9. Authors a contract which is signed by the AOA and the Shared Living Provider. The purpose of the contract is to clearly outline:
    a. The relationship of the parties including that the Shared Living Provider is a contractor and not an employee of the AOA.
    b. The scope and standards of practice for Shared Living Services.
    c. Contractor obligations for training, documentation, home environment, safety, mandated reporting, confidentiality and cooperation with the AOA, and other responsibilities as stated in this Manual.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

d. AOA obligations as stated in this Manual.
e. Terms for stipend payments as determined by the AOA.
f. Cause for termination of the contract;

10. Provides training to Shared Living Providers. The training is a component of the rate retained by the AOA. Training must ensure each Shared Living Provider meets the requirements to be a provider in accordance with the MaineCare Benefits Manual; and
11. Maintains and retains documentation of contractual arrangements for all Shared Living Providers, including those that have ended, in accordance with Ch I, Sec.1 of the MaineCare Benefits Manual.

iv. **Reimbursement requirements.**

1. A portion of the daily rate billed for the Shared Living Services is retained by the AOA. A minimum ceiling of 60 percent of the daily rate must be paid to the shared living provider. Shared living shall not be billed on the same day as respite.
2. The setting where Shared Living is delivered is a location where there is one Shared Living Provider delivering services to a group size of 1:1 or 1:2. The rate paid to the oversight agency of shared living shall reflect the group size:
   a. Payment for one individual shall use the procedure code and modifier for one person served; and
   b. Payment for a group size of two shall use the procedure code and modifier for two persons served.

4. **Quality Management**. The provider shall have written policies governing the development and maintenance of an effective quality management program to ensure quality service delivery consistent with federal and state laws and regulations, including MaineCare's Global HCBS Rule. The program shall:

a. ~~identify~~ Identify areas determined by the provider to be critical to quality service provision~~.~~:
b. ~~describe~~ Describe goals set by the provider to improve services or service delivery and shall describe indicators to measure achievement of the goals~~.~~:
c. ~~include~~ Include on-going, year-round, regular activities to measure goal achievement.; and
d. ~~include~~ Include a component describing the system to monitor compliance with federal and state laws and regulations.

i. **Evaluation**. The findings of the quality management process shall be reviewed at least annually by the provider.

The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.~~The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:~~

29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

ii. **Plan of Correction**. A finding of deficiency in violation of federal or state laws or regulations shall be reported to DHHS within a 30-day period and be accompanied by a Plan of Correction to be deemed acceptable by the DHHS.

5. **Financial Management**

a. The provider shall make available to DHHS upon request, a federal income tax return for the year in question, a statement of finances including income statement, balance sheet, cash flow statement, operations and program budget, and profit projection.

6. Environment

a. **Fire and Safety Inspections**. Upon receipt of the completed application, fire and safety inspections may be conducted by an authorized ~~representatives~~ individual of any organized fire departments~~,~~ in Maine, by the State Fire Marshall's office, and code enforcement officers.

i. Fire drills shall be conducted and documented at least four times per year.
ii. Emergency Management Plan shall address the event of loss of essential services such as electricity, water, and heat.

b. **Structures**. The provider shall meet current requirements of the *Americans with Disabilities Act of 1990*, the *Rehabilitation Act of 1973*, and the *Maine Human Rights Act*. New construction, renovation, remodeling or repair shall be in full compliance with the *Americans with Disabilities Act of 1990*, the *Rehabilitation Act of 1973*, and the *Maine Human Rights Act*. All structures used in the delivery of waiver services shall be maintained in good repair, free from danger to the ~~member's~~ Member's health or safety, and shall be appropriate to the services provided. The provider shall ensure that:

i. Member furnishings and equipment are appropriate to the Member's age and physical conditions. and for Shared Living settings where the provider(s) is not a related caregiver of the Member(s) receiving the Shared Living services, ensuring individual resident choice regarding how Members furnish and decorate their sleeping and/or living unit consistent with the terms of the lease or residency agreement they have with the provider.

ii. Lockable entrance door(s) and lockable door(s) to the private space of the individual within a shared living unit, ensuring only the individual and appropriate staff shall have keys to door(s).

~~furnishings and equipment are appropriate to the member's age and physical conditions,~~

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29.~~17~~19APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

iii. ~~rooms~~ Rooms and areas are clean, appropriately lit, and adequately heated and ventilated based on the needs of the ~~members~~Members~~,~~.
iv. ~~the~~ The square footage of rooms (i.e. bathrooms, bedroom, dining areas) are appropriate and adequate for the level of privacy, purpose of the space and to accommodate users~~,~~.
v. ~~utilities~~ Utilities are maintained in good repair and in a manner consistent with applicable codes~~,~~.
vi. ~~a~~ A storage area that shall provide secure space used for the proper storage of potentially harmful materials (i.e. chemicals, medications, and firearms).

c. **Integrated Settings**. The setting in which residential. community supports, and employment ~~specialist~~ services are ~~provided~~ delivered shall be integrated in and support full access to the greater community to the fullest extent ~~and~~including:

i. ~~be~~ Be one of choice and based on the needs of the individual as indicated in the member's Personal Plan~~;~~.
ii. ~~ensure~~ Ensure a ~~member's~~ Member's rights of privacy, dignity and respect and freedom from coercion and restraint~~;~~.
iii. ~~support~~ Support opportunities to seek employment in competitive integrated settings, engage in community life, control personal resources, optimize autonomy and choice in activities and schedules, facilitate choice of services and providers, and access to services in the community~~;~~.
iv. The providers may modify programs as needed to comply with MaineCare's Global HCBS Rule ~~HCB settings~~ requirements above or assist individuals to relocate to compliant settings of choice.

~~In the event that any provider fails to meet the requirements set forth in this Appendix, DHHS will notify the provider in writing of any remedies needed to bring the provider into full compliance. DHHS also will issue a plan of correction setting forth the timeframes within which the provider's compliance must be achieved. Failure to comply with the plan of correction within the stated timeframes may result in the provider's disenrollment for services and/or any other sanctions penalties allowed under the *MaineCare Benefits Manual* or other state or federal law.~~