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**DATE:** January 12, 2024

**TO:** Interested Parties

**FROM:** Michelle Probert, Director, MaineCare Services 

**SUBJECT:** Adopted 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

This letter gives notice of adopted 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.

The Department is adopting comprehensive amendments of 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual (“MBM”), Chapter II, Section 29, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder.

This Section 29 rule implements and regulates a Section 1915(c) home and community-based services (HCBS) Medicaid waiver program. Under Section 29, the Department provides HCBS to support eligible adult MaineCare Members with an intellectual disability or autism living in the community. MBM Chapter II, Section 29 is a routine technical rule pursuant to 34-B M.R.S. § 5432(3).

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. The Department is seeking and anticipates receiving CMS approval of this waiver amendment.

On or about August 23, 2023, the Office of the Secretary of State gave notice of proposed amendments of MBM Chapter II, Section 29 to the Executive Director of the Legislative Council, published notice of the proposed rulemaking, and gave notice of the rulemaking to known interested parties. The Department then held a hybrid remote and in-person public hearing pursuant to 34-B M.R.S. § 5465(4) on September 11, 2023, conducted jointly with the public hearing on proposed amendments to MBM Chapter III, Section 29. The Department then accepted additional written public comment regarding the proposed rulemaking pursuant to 5 M.R.S. § 8057-A(3) until the close of business on September 21, 2023. A summary of public comments, the Department’s responses, and changes made to the rule after it was published for public comment will be filed with the Secretary of State in conjunction with this rulemaking.

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- Community Support - Community Only – Individual (Provider Managed)
- Community Support - Community Only – Group (Provider Managed)
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- Supports Brokerage (Self-Directed)
- Individual Goods and Services (Self-Directed)

The Department is seeking and anticipates approval from CMS for these newly added services with an effective date of March 1, 2024. These services will continue to be provided through February 29, 2024, under the Department’s Appendix K: Emergency Preparedness and Response authority in response to the COVID-19 Public Health Emergency, which was approved by the Centers for Medicare and Medicaid Services (CMS) but not added to MBM Chapter II, Section 29 at that time.

The Department is concurrently going through APA rulemaking for MBM Ch. III, Section 29, to identify the methodology(ies) for reimbursements for these services. MBM Chapter III, Section is a major substantive rule, will be provisionally adopted pending approval by the Legislature, and will propose a retroactive date of March 1, 2024, for the increased reimbursement rates.

The Department adopts the following specific changes to this rule:

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  - Work Support – Group
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- Revised Definitions: Updates the following definitions: Activities of Daily Living, Autism Spectrum Disorder, Intellectual Disability, Instrumental Activities of Daily Living, Person-Centered Service Plan and Shared Living, and Services Delivered for the Member (formerly, “On Behalf Of” Services).
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Direction, Representative, Self-Direction, Service Implementation Plan, and Supports Broker.

- Self-Direction: Adds 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.
- Global HCBS Rule: Incorporates the requirements of the January 19, 2022, Global HCBS Rule: *see* §§ 29.04 [Person-Centered Service Plan (PCSP)], 29.15-1 [Self-Directed Person-Centered Service Planning Process] and 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. § 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): Changes 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): Establishes and clarifies standards for providers who are disenrolling from participating as MaineCare providers. 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): Clarifies 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): Requires 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 adopted 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): Requires 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(1).
- 29.10-11 (POCA): Authorizes for the Office of Aging and Disability Services (OADS) to issue written notices of deficiencies in service delivery and requires 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

provides increased protections for Members and ensures that providers comply with service requirements, have sufficient clinical and administrative capability to carry out the intent of the service, and have taken steps to assure the safety, quality, and accessibility of the service for Members.

- 29.11 (Member Appeals): Clarifies that Members have the right to appeal decisions made regarding priority level and waitlist determinations.
- 29.14, Exceptions from Caps on Services: Establishes 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 services and supports in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA).
- 29.16 (Appendix I-Shared Living Criteria for Increased Level of Support): Adds 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.
- 29.16 Appendix III, Performance Measures: The Department eliminates Appendix III because the Department utilizes data available through the Department of Labor, Person Centered Service Plans, and authorization data as part of the Department's commitment to quality assurance and quality improvement system. Additionally, specific performance measures are either no longer relevant or necessary to measure the performance of specifically listed employment services or have been met.
- 29.19 (Appendix IV-Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living): Clarifies the requirements and responsibilities of the Administrative Oversight Agency and the Shared Living Provider for Shared Living Services.

In conformance with the January 1, 2021, CMS-approved, renewed waiver, and the Department's pending, proposed waiver amendments, this rule also aligns similar processes, service descriptions, and similar provisions with MaineCare's four other Section 1915(c) waivers (primarily the Section 21 waiver).

As a result of public comments and further review by the Department and the Office of the Attorney General, the adopted rule includes clarifying language for §29.02-12 (E), Services that Support Personal Well-being, §29.04, Person-Centered Service Plan, §29.05-4 Community Support, and §29.05-8, Home Support-Quarter Hour.

Additionally, as a result of public comment, the adopted rule adds a provision allowing providers of Assistive Technology-Assessments to conduct evaluations via telehealth so long as the provider ensures that the assessment via telehealth meets the requirements of the scope of the service.

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The Summary of Public Comments and Responses identifies more specifically all changes that were made to the final rule.

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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 adopted rule is provided in the Notice of Agency Rulemaking Adoption, 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 Adoption.

## Notice of Agency Rule-making Adoption

**AGENCY:** Department of Health and Human Services, MaineCare Services

**CHAPTER NUMBER AND TITLE:** 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

**PROPOSED RULE NUMBER:** 2023-P171

**CONCISE SUMMARY:** The Department is adopting comprehensive amendments of 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual (“MBM”), Chapter II, Section 29, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder.

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

**EFFECTIVE DATE:** January 24, 2024

**AGENCY CONTACT PERSON:** Heather Bingelis, Comprehensive Health Planner  
**AGENCY NAME:** Division of Policy  
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10-144 Chapter 101  
 MAINECARE BENEFITS MANUAL  
 CHAPTER II

SECTION 29	SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER	ESTABLISHED 1/1/08 Legal Effective Date: 1/24/24
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*The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.*

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**29.01 INTRODUCTION**

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

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

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

The 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. If there is no funded opening available, the 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. §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 (ADLs)** is a term used collectively to describe fundamental skills that are required to independently care for oneself including:

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

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**29.02 DEFINITIONS (cont.)**

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

**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.

**29.02-5 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.

**29.02-6 Budget Authority** is the authority and responsibility to manage a Self-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 Self-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 PCSP.

**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.



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**29.02 DEFINITIONS (cont.)**

**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 (c) (9) 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;
- E. offering the Member an individualized position in which the Member has the opportunity to interact with the public, and with other employees who are not individuals with disabilities, to the same extent as employees in comparable positions who are not individuals with disabilities; 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.

**29.02-11 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.

**29.02-12 Direct Supports** are a range of services that contribute to the health and well-being of the Member and enhance 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 a provider delivers to a Member in performing tasks the Member would normally perform if the Member did not

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**29.02 DEFINITIONS (cont.)**

- have 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 PCSP; administration of non-prescription medication that are ordinarily self-administered; and administration of prescription medication, when provided by a person legally authorized to assist with the administration of medication.
  - C. Self-Management** includes assistance a provider delivers with managing safe and responsible behavior; exercising judgment with respect to the Member's health and well-being; communication, including conveying information, interpreting information, and advocating in the Member's interests; managing money including paying bills, making choices on how to spend money, keeping receipts, and expending funds with the permission of a Member's Representative Payee or guardian as applicable. Self-management also includes teaching coping skills, giving emotional support, and guidance to access needed resources.
  - D. Activities that Support Personal Development** include teaching or modeling for a Member's self-care and self-management skills, physical fitness, behavior management; sensory, motor and psychological needs; interpersonal skills to cultivate supportive personal, family, work and community relationships; resources and opportunities for participation in services to promote social and community engagement; participation in spiritual services of the Member's choice; motivating the pursuit of personal development and opportunities; teaching or modeling informed choice by gathering information and practicing decision making; and learning to exercise; 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. This may include identifying risks such as risk of abuse, neglect or exploitation; participating in a Member's risk assessment, identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely

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**29.02 DEFINITIONS (cont.)**

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 rule governing emergency intervention and behavioral treatment for persons with intellectual disabilities (14-197 CMR Chapter 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.
  
- 29.02-15 Employment Setting** 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).
  
- 29.02-16 Exploitation** means the illegal or improper use of an incapacitated or dependent Member or that Member’s resources for another’s profit or advantage as defined in 22 M.R.S. §3472.
  
- 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.
  
- 29.02-18 Habilitation** is a service that is provided in order to assist a Member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental and social functioning of a Member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.
  
- 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.

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**29.02 DEFINITIONS (cont.)**

- 29.02-20 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.
- 29.02-21 Intellectual Disability (ID)** means a 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.
- 29.02-22 Medical Add On** is the rate paid to address short or long-term medical needs. Medical Add-On is a component of Community Support, Employment Specialist Services, and Work Support-Individual. The rate is included in the established authorization. It is not a separately billable activity. Billing may not exceed the 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.
- 29.02-23 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 may have restrictions on the type and amount of services they are eligible to receive.
- 29.02-24 Neglect** means a threat to a Member’s health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 M.R.S. §3472.
- 29.02-25 Services Delivered for the Member (formerly On Behalf Of)** is billable activity that is provided for the benefit of an individual Member while not necessarily involving a direct face-to-face service and is a component of Home Support, Community Support, Employment Specialist Services and Work Support.
- 29.02-26 Person-Centered Service Plan (PCSP)** is a Member’s plan developed at least annually that identifies the services required under the waiver benefit. The PCSP must also document services and supports not covered by the waiver but identified by the Member. Only covered services included on the PCSP are reimbursable. The PCSP may also be known as a Person-Centered Plan, a plan of care, or a service plan, as long as the requirements specified in this rule are met.

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**29.02 DEFINITIONS (cont.)**

- 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.
- 29.02-28 Prior Authorization** is the process of obtaining written prior approval by DHHS or its Authorized Entity as to the medical necessity and eligibility for a service.
- 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.
- 29.02-30 Qualified Intellectual Disability Professional (QIDP)** is a person who has at least one year of experience working directly with persons with Intellectual Disabilities or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor's degree as specified in title 42 C.F.R. 483.430.
- 29.02-31 Qualified Vendor** is a provider approved by DHHS to provide waiver services to eligible Members receiving services under this Section, in accordance with the requirements of 29.10.
- 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.
- 29.02-34 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

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**29.02 DEFINITIONS (cont.)**

that are specific, measurable, achievable, relevant to the Member’s identified outcomes, and have clear proposed timelines for achievement.

**29.02-35 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.

**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.

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

**29.02-38 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.

**29.03 DETERMINATION OF ELIGIBILITY**

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

**29.03-1 Funded Opening**  
The number of MaineCare members 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;

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

- 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;
- C. Meets the medical eligibility criteria for admission to an ICF/IID as set forth under the *MaineCare Benefits Manual*, Chapter II, Section 50;
- D. Does not receive services under any other federally approved MaineCare home and community-based waiver program;
- E. Meets all MaineCare eligibility requirements as set forth in the *MaineCare Eligibility Manual*; and
- F. The estimated annual cost of the Member's services under the waiver is equal to or less than fifty percent (50%) of the state-wide average annual cost of care for an individual in an ICF/IID, as determined by 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.

**29.03-3 Documentation Requirements**

The Member and Case Manager must provide to DHHS the following:

- A. A completed copy of the assessment form (BMS99) or current functional assessment approved by the DHHS;
- B. A copy of the Member's PCSP approved and signed by the Member or guardian and the Case Manager within the preceding six months;
- C. Any other relevant material indicating the 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 PCSP, and DHHS Estimated Annual Cost Form, a QIDP designated by DHHS will determine the Member's medical eligibility for services under this Section.

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

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

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

**29.03-5 Calculating the Estimated Annual Cost**

After determination of medical eligibility and prior to formal determination of eligibility for services under this 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 PCSP, including the specific services and the number of units for each service.

**29.03-6 Waiting List and Offers for Funded Openings**

DHHS will maintain a waiting list of MaineCare Members who are medically eligible for Section 29 Services but for whom a funded opening is not available. GHHS will serve Members who are on the waiting list chronologically based on the date DHHS or its Authorized Entity determined the Member’s potential eligibility for the waiver. When a Member is offered a funded opening, the Member will be removed from the waiting list.

Within sixty days of receiving a funded opening to respond, a Member must respond to DHHS 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 may reapply for waiver services at any time.

**29.03-7 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.

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



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

reimbursement for services after OADS receives the Assessment Form and a signed PCSP.

The Case Manager must submit a request for services to DHHS or its Authorized Entity when the Member or guardian elects to receive services under this Section. As part of the planning process, the Member's needs and unmet needs are identified and documented in the 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.

**29.04-1 Prior Authorization for Reimbursable Services**

The PCSP must identify all services and units of services that are required to meet the Member's needs. In order for a Section 29 service to be reimbursed, the Case Manager must submit a request to DHHS or its Authorized Entity for Prior Authorization 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 and service as documented in the PCSP. Upon expiration of an authorization, the Case Manager must obtain a new authorization for continued reimbursement for that 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 upon finding that the Member no longer satisfies the eligibility standards for the service or level of service authorized.

**29.04-2 Person-Centered Service Planning Process**

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, Case Managers must meet separately with the Member prior to finalizing the PCSP to ensure conflict free planning and informed choice. The planning process must reflect the Member's cultural preferences and provide information in plain language that is accessible to the Member and, when applicable, the legal guardian.

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

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

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 date must be less than six (6) months old at the time of the Member's eligibility determination or redetermination. The planning process must comply with the requirements described in the Global HCBS Rule. The PCSP must include the following:

- A. All MaineCare Home and Community waiver benefit services determined medically necessary by the team including MaineCare-covered services not covered under this Section that the Member identifies and that are consistent with the objectives of the PCSP;
- B. The frequency of each service, including transportation services;
- C. How services contribute to the Member's health and well-being and the Member's ability to reside in a community setting;
- D. The Member's goals for strengthening and cultivating personal, community, family, and professional relationships;
- E. The roles and responsibilities of the Member's service providers in supporting the Member's goals, including goals for strengthening natural and supportive personal, family, community and professional relationships;
- F. For Members who choose to receive Home Support- Remote Support, a safety/risk plan, describing any potential risks to the 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.

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

Providers must regularly provide the Members they serve with notice of the Grievance process outlined in 14-197 C.M.R. ch. 8 (Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism). Providing notice includes ensuring that written notice of the grievance process is provided to the Member and/or their guardian at the planning meetings.

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*The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.*

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

**29.04-4 Planning Team Composition**

Each Member or guardian will determine the composition of the planning team. The Member will lead and direct the Person-Centered Service Planning process whenever possible, including leading the planning meeting if they desire. The Member's guardian should have a participatory role, as defined by the Member, unless State law confers decision-making authority 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.

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

- A. The Case Manager;
- B. The Member's guardian;
- C. An approved Correspondent through the Maine Developmental Services Oversight and Advisory Board;
- D. The Member's advocate or friend or additional individuals invited by the Member;
- E. Direct Support Professionals providing services to the Member;
- F. Staff from the member's providers; and
- G. Other professionals involved or likely to be involved with the Member's PCSP.

**29.04-5 Updating the Person-Centered Service Plan**

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

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

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.

- 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.

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

AT Services include;

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**29.05 COVERED SERVICES(cont.)**

**A. AT-Assessment:**

1. 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.  
Evaluation of the assistive technology needs of a Member may be delivered via telehealth when the provider ensures that the assessment via telehealth meets the requirements of the scope of the service;
2. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
3. Training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the Member; and
4. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of Members.

**B. AT Devices:**

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

**C. AT-Transmission;**

1. Fee associated with the transmission of data required for the AT Devices.

The provision of AT Devices can be a Provider-Managed Service or a Self-Directed Service. AT Assessment is a Provider-Managed Service.

**The Department is seeking and anticipates approval from CMS for the newly added AT- Devices (Self-Directed) and AT Transmission (Self-Directed) services with an effective date of March 1, 2024.**

**29.05-3 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 obtain, maintain, or advance in achieving Competitive Integrated Employment or self-employment. Additionally, in order to receive Career Planning services, the

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**29.05 COVERED SERVICES (cont.)**

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.

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.

**29.05-4 Community Support** is a service that increases or maintains a Member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on Community Inclusion, personal development, and support in areas of daily living skills if necessary.

Community Support is intended to be flexible, responsive and delivered according to the Member's choice and needs as documented in the Member's PCSP.

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**29.05 COVERED SERVICES (cont.)**

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, 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

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**29.05 COVERED SERVICES (cont.)**

and Community Inclusion to the greatest extent possible as documented in the Member's PCSP.

The community support tiers are as follows:

1. Community Only-Individual – services provided by one staff to one Member at a time (1:1) within community settings.
2. Community Only-Group – services provided by one staff to two Members at a time (1:2) within community settings
3. Community Center-Based – services provided by no fewer than one staff to three Members within or from a facility/center.

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.

“Services Delivered for the Member” (formerly “On Behalf of”), as defined in this rule, is included in the established authorization for Community Support Services. For details related to covered and non-covered “Services Delivered for the Member” (formerly “On Behalf of”) activities see § 29.18.

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.

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.

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.



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**29.05 COVERED SERVICES** (cont.)

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.

**The Department is seeking and anticipates approval from CMS for newly added Community-Only Individual, Community Only-Group, and Community Only-Individual (Self-Directed) services with an effective date of March 1, 2024.**

**29.05-5 Employment Specialist Services** include services necessary to support a Member in maintaining employment. Services include: (1) periodic interventions on the job site to identify a Member’s opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when a Member’s goal for 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. If Employment Specialist Services are used for job development, a provider must submit, and retain in the Member’s record, current documentation of the lack of service availability or ineligibility from Vocational Rehabilitation.

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

Employment Specialist Services are delivered at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. 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 assist a Member to establish and or sustain a business venture that is income producing. MaineCare funds may not be used to defray the expenses associated with the start up or operating a business.

“Services Delivered for the Member” (formerly “On Behalf of”), as defined in this rule, is included in the established authorization for Employment Specialist Services. For details related to covered and non-covered “Services Delivered for the Member” (formerly “On Behalf of”) activities see 29.18.

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.

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**29.05 COVERED SERVICES** (cont.)

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

Employment Specialist Services are Provider-Managed services.

**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.

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.

**The Department is seeking and anticipates approval from CMS for the newly added FMS service with an effective date of March 1, 2024.**

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**29.05 COVERED SERVICES (cont.)**

**29.05-7 Home Accessibility Adaptations** are physical adaptations to the private residence of the Member or the Member’s family, as documented in the PCSP, and necessary to ensure the health, welfare and safety of the Member or that enable the Member to function with greater independence in the home. These include adaptations that are not covered under other sections of the *MaineCare Benefits Manual*, determined medically necessary as documented by a licensed physician or other medical professional, and approved by DHHS.

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

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

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

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

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

**The Department is seeking and anticipates approval from CMS for Home Accessibility Adaptations-Self-Directed services with an effective date of March 1, 2024.**

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**29.05 COVERED SERVICES (cont.)**

**29.05-8 Home 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 as outlined in the Member’s PCSP.

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.

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.

“Services Delivered for the Member” (formerly “On Behalf of”), as defined in this rule, is included in the established authorization for Home Support-Quarter Hour Services. For details related to covered and non-covered “Services Delivered for the Member” (formerly “On Behalf of”) activities see 29.18.

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

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**29.05 COVERED SERVICES (cont.)**

Representative on behalf of the Member, the guardian may not also deliver direct support to the Member.

**The Department is seeking and anticipates approval from CMS for the newly added Home Support-Quarter-Hour (Self-Directed) service with an effective date of March 1, 2024.**

**29.05-9 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 well as health monitoring equipment. This assistive technology links each Member's residence to the Remote Support provider.

If a Member chooses this service, the PCSP must include a safety/risk plan identifying 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. The PCSP reflects the 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.

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 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 §29.05-2, Assistive Technology may be used to provide for assessments, equipment, and the cost of the data transmission necessary to facilitate Home Support-Remote Support services. Home Support-Remote Support provides the staff to monitor the Member.

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

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**29.05 COVERED SERVICES (cont.)**

**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 Self-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 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.

**The Department is seeking and anticipates approval from CMS for the newly added Individual Goods and Services service with an effective date of March 1, 2024.**

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**29.05 COVERED SERVICES (cont.)**

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

**29.05-12 Shared Living** 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.

Shared Living is a Provider-Managed service.

**The Department is seeking and anticipates approval from CMS for the newly added Shared Living – Two Members served, Shared Living - One Member, Increased level of support and the Shared Living - Two Members, Increased level of support services with an effective date of March 1, 2024.**

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*The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.*

**29.05 COVERED SERVICES (cont.)**

**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 PCSP 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.
- 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.

**The Department is seeking and anticipates approval from CMS for the newly added Supports Brokerage service with an effective date of March 1, 2024.**



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**29.05 COVERED SERVICES (cont.)**

**29.05-14 Non-Emergency Transportation Services (NET)** under Chapter II, Section 113 enables Members to gain access to Section 29 services, activities and resources, and other community services specified and documented within the PCSP.

Whenever possible, a Member may access transportation from family, neighbors, friends, or community agencies.

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

A NET Broker may reimburse 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.

**29.05-15 Work Support-Group** is Direct Support delivered at the Member's place of employment to improve a 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. Mobile work crews, and business based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed. Regardless of the model, the primary focus of service delivery is job related including adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

Work Support-Group must promote integration into the workplace, interaction between 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.

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**29.05 COVERED SERVICES (cont.)**

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.

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 must have received an assessment and services under the *Americans with Disabilities Act*, and Section 504 of the *Rehabilitation Act*, and the need for on-going support must have been determined and documented in the PCSP. The outcome of this service must be sustained paid employment and work experience leading to further career development and individually integrated community-based employment for which the Member is compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Work Support-Group does not include vocational services provided in a facility-based work setting in specialized facilities that are not part of the general workforce.

The provider must maintain documentation 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.

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**29.05 COVERED SERVICES (cont.)**

No more than six (6) 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 must inform each Member at least yearly that career planning and individual employment are available to support the Member in making an informed decision regarding the services the Member receives.

Work Support-Group is a Provider-Managed Service.

**29.05-16 Work Support-Individual** is Direct Support delivered to the Member to improve a 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 delivered in a Member's place of employment but may be delivered in a Member's residence in preparation for work if it does not duplicate Home Support, Community Support or Employment Specialist Services.

Work Support-Individual services must be delivered in an integrated employment setting in the general workforce. The 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.

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**29.05 COVERED SERVICES (cont.)**

The Member may access Work Support-Individual Services under this Section when the Member has received an assessment and services under the *Americans with Disabilities Act* and Section 504 of the *Rehabilitation Act* and need for on-going support has been determined and documented in the PCSP, along with the Member’s health and safety needs within the workplace.

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

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

Work Support-Individual does not include volunteer work.

The provider must maintain documentation in the Member’s file that the service is not available under a program funded under Section 110 of the *Rehabilitation Act* of 1973 or the *Individuals with Disabilities Education Act* (20 U.S.C. §1401, *et seq.*).

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

“Services Delivered for the Member” (formerly “On Behalf of”), as defined in this rule, is included in the established authorization for Work Support-Individual Services. For details related to covered and non-covered “Services Delivered for the Member” (formerly “On Behalf of”) activities see 29.18.

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:

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**29.06 NON COVERED SERVICES (cont.)**

- 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;
  - 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.
- 29.06-2** Services not identified by the PCSP;
- 29.06-3** Services to any MaineCare Member receiving services under any other federally approved MaineCare Home and Community Based waiver program;
- 29.06-4** Services delivered in Nursing Facilities, Institutions for Mental Disease (IMDs), Intermediate Care Facilities (ICF/IIDs), and Hospitals;
- 29.06-5** Services that are reimbursable under any other Sections of the *MaineCare Benefits Manual*;
- 29.06-6** Any service otherwise reimbursable under the *Rehabilitation Act of 1973* or the Individuals with *Disabilities Education Act*, including but not limited to job development and vocational assessment or evaluations;
- 29.06-7** Room and board is not reimbursed by MaineCare. The term “room” means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day; or any other full nutritional regimen. Board does not include the provision of a meal or snacks at an adult day health or similar facility outside the Member’s home. Board also does not include the delivery of meal(s) to a Member at their own home through a meals-on-wheels service;

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**29.06 NON COVERED SERVICES (cont.)**

- 29.06-8** Work Support-Individual or Work Support-Group or Employment Specialist Services when the Member is not engaged in employment;
  
- 29.06-9** Home Accessibility Adaptations unless the service has been determined non-reimbursable under Medical Supplies and Durable Equipment, Section 60 or other Sections of the *MaineCare Benefits Manual*;
  
- 29.06-10** 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;
  
- 29.06-11** Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the Member's parent, sibling or other biological family member. This rule will not be avoided by adult adoption. 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 can receive services under only one Home and Community Waiver Benefit at any one time.
  
- 29.07-2** The annual limit for Members who receive any combination of Home Support (Remote or ¼ hour), Community Support, or Shared Living Services, is \$84,689.28.

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**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 \$10,494.00 in a five (5) year period with an additional annual allowance up to \$314.82 for repairs and replacement per year. General household repairs are not included in this service. All items in excess of \$524.70 require documentation from a physician or another appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the Member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this Section.
  
- 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.
  
- 29.07-7**     **Enrollment in High School:** A Member may not receive Community Support while enrolled in high school.
  
- 29.07-8**     **Place of Employment:** A Member may not receive Community Support or Home Support at their place of employment.
  
- 29.07-9**     **Work Support Individual Services** are limited to one Direct Support Professional per Member at a time.
  
- 29.07-10**    **Annual MaineCare Expenditures** for services under this waiver for an individual Member 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.
  
- 29.07-11**    **Nursing Facility or Hospital:** If a Member is admitted to a nursing facility or a hospital, the Department will temporarily suspend payment under Section 29 for the

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**29.07 LIMITS (cont.)**

period of the Member's admission. If the 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 benefit will be terminated unless the Department approves a written request to continue holding the funded opening.

**29.07-12 Assistive Technology 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 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, are subject to a combined limit of \$6,815.22 per year.
- C. Assistive Technology-Transmission is limited of \$54.12 per month.

**29.07-13 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)).

**29.07-14 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**

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



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

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

- A. The Member is determined to be financially or medically ineligible for this benefit or MaineCare;
- B. The Member is determined to be a nursing facility resident, psychiatric hospital patient, hospital patient, or ICF/IID resident for six months;
- C. The Member is determined to be receiving MaineCare services from another Home and Community Based Waiver benefit;
- D. The Member is no longer a resident of the State of Maine;
- E. The health and welfare of the Member can no longer be assured because:
  - 1. The Member or immediate family, guardian or caregiver refuses to abide by the PCSP or other benefit policies;
  - 2. The home or home environment of the Member becomes unsafe to the extent that benefit services cannot be provided without risk of harm or injury to the Member or to individuals providing covered services to the Member; or
  - 3. There is no approved PCSP.
- F. The Member has not received at least one waiver service in a thirty (30) day period; or
- G. The annual cost of the Member's services under this waiver exceeds fifty percent (50%) of the state-wide average annual cost of care for an individual in an ICF/IID, as determined by 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.

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**29.09 MEMBER RECORDS**

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

In addition, the Member's records must contain:

- A. The Member's name, address, birth date, MaineCare identification number, guardian contacts and emergency contacts;
- B. The Member's social and medical history, including allergies and diagnoses;
- C. The Member's PCSP; and
- 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 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 records to substantiate service delivery and units of authorization.

**29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS**

To provide services under this Section a provider must be a Qualified Vendor as approved by OADS and enrolled by the MaineCare program. 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 services without written authorization from OADS.

Providers must ensure staff are trained in identifying risks, such as risk of abuse, neglect or exploitation; participating in a Member's risk assessment; identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an

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

intervention plan. Any intervention must be consistent with the DHHS’s rule governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism (14-197 C.M.R. ch. 5). It may also be necessary to seek emergency medical or safety assistance when needed and comply with reporting requirements outlined in DHHS’s Reportable Events System (14-197 C.M.R. ch. 12) and/or Adult Protective Services System (10-149 C.M.R. ch. 1).

**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.
  - a. Prior to providing services to a Member alone, a DSP must complete the following four modules from the College of Direct Support, including computer based and live sessions:
    - 1. Introduction to Developmental Disabilities;
    - 2. Professionalism;
    - 3. Individual Rights and Choice and
    - 4. Maltreatment.
  - b. Documentation of completion must be retained in the personnel record.
- B. DSPs must complete the following Department approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months:
  - 1. Reportable Events (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. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5);
  - 3. Rights and Basic Protections of a Person with an Intellectual Disability or Autism or an acquired brain injury (34-B M.R.S. §5605);
  - 4. DSPs, regardless of capacity and prior to provision of service to a Member, must be trained upon hire on the Rule Describing

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

Grievance Process for Persons with Intellectual Disabilities and Autism;

- 5. 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.
  
- C. DSPs must pass a background check completed consistent with § 29.10-6.
- D. DSPs must have an adult protective and child protective record check consistent with §29.10-8;
- E. 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 18<sup>th</sup> 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;
- F. 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;
- G. DSPs must have current CPR and First Aid Certification;
- H. A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN), or otherwise has been trained to administer medications through a training program specifically for Shared Living model homes and authorized, certified, or approved by DHHS;
- 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;
- 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;
- 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:

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**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 have 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.

**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:

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**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 29.10-08; 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.

**29.10-5 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. 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 PCSP.

**29.10-6 Electronic Visit Verification (EVV)** Providers of Home Support-Quarter Hour services must comply with Maine DHHS Electronic Visit Verification (“EVV”) system standards and requirements. In compliance with Section 12006 of the 21st Century CURES Act (P.L. 114-255), as codified in 42 U.S.C. § 1396b(1)(1), visits conducted as part of such services must be electronically verified with respect to: the type of service performed; the individual receiving the service; the date of the service; the location of the service delivery; the individual providing the service; and the time the service begins and ends. Providers may utilize the Maine DHHS EVV system at no cost, or may procure and utilize their own EVV system, so long as data from the provider-owned EVV system can be accepted and integrated with the Maine DHHS EVV system.

**29.10-7 Shared Living** 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.

**29.10-8 Background Check Criteria:** The provider must conduct criminal history background checks and adult and child protective background checks every two years on all employees contracted individuals, consultants, volunteers, students, and other

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

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 receives Shared Living. Background checks are required for any adult, other than the Member, residing in a Shared Living Home. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. 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.

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

- A. any criminal conviction that involves abuse, neglect or exploitation;
- B. any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;
- C. any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim;
- D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two (2) years; or
- E. a habitual offender status under 29-A M.R.S. §2551-A.

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.

**29.10-9 Informed Consent Policy**

Providers must put in place and implement an informed consent policy approved by DHHS. For the purposes of this requirement, informed consent means consent obtained in writing from a Member or the Member's legal guardian for a specific treatment, intervention or service, following disclosure of information adequate to

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

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, the policy must inform the Member and their guardians, where applicable, of the risks and benefits of services and the right to refuse or change services or providers.

**29.10-10 Rights, Reportable Events, and Behavioral Support Training**

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

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

**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



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

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.
  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.

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**29.11 MEMBER APPEALS**

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

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

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

**29.12 REIMBURSEMENT**

- A. Reimbursement methodology for covered services shall be 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 records to substantiate service delivery and units of authorization.

**29.13 BILLING INSTRUCTIONS**

Providers must bill in accordance with DHHS billing instructions.

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**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](mailto: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

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

- intended to address.
- E. A Request for Exceptions shall include the following information when known to the Member:
  - 1. The name, address, telephone number, email address, and MaineCare number of the Member and the name, address, telephone number, and email address, of the person who submitted the Request for the Member, if applicable;
  - 2. The specific provision(s) in MBM Chapters II or III, Section 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

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

- Exceptions was made, and the Exceptions sought;
  - 2. A list of documents reviewed, and a summary of other information obtained to review the Request for Exceptions;
  - 3. Whether the Department has granted, granted in part, or denied the Request for Exceptions;
  - 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.

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

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

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**29.15 SELF-DIRECTION (cont.)**

**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





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**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 FI 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.

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*The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.*

**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 Self-directed workers, family, or friends;
  - 3. Food, beverages, or nutritional supplements;
  - 4. Entertainment equipment or downloadable files/applications or supplies;
  - 5. Air conditioners, heaters, fans, generators, and similar items;
  - 6. Illegal drugs, alcoholic beverages, tobacco products, or vaping devices;

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**29.15 SELF-DIRECTION (cont.)**

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;
  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



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**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;
- 2. The manner in which increased support will be utilized;
- 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;



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

The purpose of this Appendix is to detail guidelines for Office of 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 Department or its Authorized Entity is responsible for review and approval, of all Medical Add-On rate increases for services under this 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 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. 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
    - 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.

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

**B. Planning Team**

1. The team must meet or otherwise confer for the following purposes:
  - a. To review and complete the request for Medical Add-On and any additional documentation required for submission to the Department or its Authorized Entity.
  - b. To determine whether the setting where the Member is served is appropriate to carry out the physician's recommended treatment or intervention; and
  - c. To determine how the Member's needs shall be met and what the staffing requirements are.
2. All of these determinations and recommendations must be noted in the 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 will review the information submitted with the request, the PCSP information in the electronic record such as reportable events, crisis notes, as well as any applicable assessments or evaluations in the Member's record.
2. The Department or its Authorized Entity 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 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. Verification of this continued need must be provided to the Department or its Authorized Entity within a year of the original approval, in order for the Medical Add-On to continue.



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**29.18 APPENDIX III – Additional Guidance for Home Support, Community Support, Work Support, Career Planning, and Employment Specialist Covered Services that are Delivered Directly for the Member (formerly, “On Behalf Of” Covered Services)**

“Services Delivered for the Member” (formerly “On Behalf Of” ) Home Support, Community Support, Work Support, Career Planning, and Employment Specialist Services that are delivered directly for the Member when the Member is not present only if the activities and actions meet the scope of the service and when documented within the Member’s PCSP to meet a specific and identified need. These activities are included in the established authorization. Documentation must clearly detail, identify and support periods of such service.

These billable activities include the following:

- A. Member Services When the Member is in the Same Location But Not Present: activities and time offered whenever the staff and the Member are in the same physical environment (e.g. staff waiting for a member during a medical appointment or a home visit), for Work Support, Career Planning, or Employment Specialist, Home Support, or Community Support services.
- B. Professional Consultations for the Member: activities and time by Home Support providers for scheduling appointments and consulting with physicians, dentists, medical personnel, therapists, clinicians, or employers to meet a specified need within the Member’s PCSP, medical plan or behavioral plan (e.g. collaborating with a physician or therapist regarding a medication or treatment intervention).
- C. Employer & Related Collaboration: collaborating with an employer or business by Work Support, Career Planning, and Employment Specialist providers to assist the Member in obtaining or maintaining employment, including supporting the business to accommodate and support the Member to reduce reliance on paid supports and increase overall workplace inclusion as identified in the Member’s PCSP, or collaborating with other individuals on the Member’s treatment team regarding the Member’s medical needs or behavioral plans relating to the workplace setting and the Member’s overall success and integration within the workplace setting as documented in the PCSP.
- D. Home Visits & Family Reunification: activities and time spent by Home Support and Community Support providers for the purposes of, as specified in the Member’s PCSP, arranging Member’s home visits and participation in family events and or family reunification, including transporting a Member to their parent’s, guardian’s, or friend’s home for visits, returning a Member to their home, and any time spent during such visits with the Member.
- E. Community Integration: activities and time spent by Community Support providers to support Member’s Community Integration, such as outreach to and collaboration with places and people within the Member’s community of choice as identified within the PCSP, to ensure successful inclusion for the Member in their chosen place, group, club, or event.
- F. Habilitative Skill Building for Home and Work: activities and time spent by Work Support, Career Planning, Employment Specialist, Home Support, and Community Support providers that support the Member in practicing specific learned skills,



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**29.19 APPENDIX 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(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 to visit the Member and the Member’s home and program as often as DHHS deems necessary to assure quality services, including unscheduled visits.

The provider must submit the following to OADS:

- A. Application Form. Initial applications shall be submitted using DHHS. 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 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.
  - 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.

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

- 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(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 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.

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(s) needs as addressed in the PCSP.

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

- 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(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. 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(s) comply with 34-B M.R.S. §5605, Rights and Basic Protections of a Person with an Intellectual Disability or Autism.
  - 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(s) comply with DHHS' rule governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism (14-197 C.M.R. ch. 5), Reportable Events System (14-197 C.M.R. ch. 12), Adult Protective Services System (10-149, C.M.R. ch. 1) and state law on reportable events and reports of abuse, neglect, and exploitation (22 M.R.S. §3477, Persons Mandated to Report Suspected Abuse, Neglect or Exploitation; 34-B M.R.S. §5604-A, Duty to Report Incidents; Adult Protective Services Act and Rights Violations; and 22 M.R.S. §3740, *et seq.*, *Adult Protective Services Act*).



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

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.
  14. Attend all required trainings and provide proof of current trainings and certifications to the AOA as needed to ensure compliance with all applicable requirements to be a provider in accordance with this rule and Ch.I, Sec. 1 of the MaineCare Benefits Manual.
- 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;
  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;

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

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.
  - 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. Maintains and retains documentation of the Shared Living Provider’s training and certification requirements ensuring each Shared Living Provider meets all applicable requirements to be a Shared Living provider in accordance with this rule and Ch.I, Sec. 1 of 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.



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

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 areas determined by the provider to be critical to quality service provision;
- b. Describe goals set by the provider to improve services or service delivery and shall describe indicators to measure achievement of the goals;
- c. Include on-going, year-round, regular activities to measure goal achievement.; and
- d. 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.

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.

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SECTION 29	SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER	ESTABLISHED 1/1/08 Legal Effective Date: 1/24/24
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*The Department shall submit to CMS and anticipates approval for a Waiver Amendment related to these provisions.*

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

**6. Environment**

- a. **Fire and Safety Inspections.** Upon receipt of the completed application, fire and safety inspections may be conducted by an authorized 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 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).
  - iii. Rooms and areas are clean, appropriately lit, and adequately heated and ventilated based on the needs of the Members.
  - iv. 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 are maintained in good repair and in a manner consistent with applicable codes.
  - vi. 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 services are delivered shall be integrated in and support full access to the greater community to the fullest extent including:
  - i. Be one of choice and based on the needs of the individual as indicated in the member's Personal Plan.

