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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The state received approval, effective March 1, 2024, for a comprehensive amendment to the previous renewal incorporating changes and making permanent some temporary flexibilities implemented during the Covid-19 PHE. As such, the state is seeking to incorporate internally generated updates to the waiver's appendices that align with current procedure and include the following:

General:

- Where applicable, revised language to align and create consistency with ME.0159 (MaineCare Benefits Manual, Section 21), and ME.0995 (MBM Section 20), ME.0467 (MBM Section 29), and ME.1082 (MBM Section 18).

Appendix A

- Updated Quality Improvement: Administrative Authority of the Single State Medicaid Agency, by revising the Performance Measures (a-i, PM 1 and PM 2) to align with Maine's other 1915(c) waivers and more accurately reflect the State Medicaid Agency's oversight of the performance of waiver functions.

Appendix B

- To calculate the annual individual cost of care more accurately based on the specific population receiving services under this waiver, we specified in B-2-b that the annual individual cost limit to gain access to and remain on the waiver is based upon the combined average of institutional costs for individuals receiving services in Intermediate Care Facilities and Nursing Facilities with Acquired Brain Injury classification.
- In B-6, updated and revised the level of care criteria, the process for LOC evaluation/reevaluation, and the eligibility criteria to align with current practice.

Appendix C

- In C-1/C-3 updated the service description for Home Support-Per Diem by removing the requirement that providers specify the minimum number of 1:1 direct support hours within the PCSP allowing providers greater flexibility to deliver individualized, responsive, and high-quality Home Support Per Diem services.
- Updated Assistive Technology Services by allowing qualified providers to conduct Assistive Technology Assessments via telehealth when the provider ensures that the assessment via telehealth meets the requirements of the scope of the service and updated the service description to align with Maine's other 1915(c) waivers namely, ME.0467 (Section 29).
- Revised the Service Description for Home Support-Remote Support for clarity.
- Increased the annual individual cost limit in C-4 to $286,580.30 and specified that the cost limit will increase on an annual basis proportionately to the scheduled Appendix J and I-2-a reimbursement rate increases to ensure participants do not lose access to eligible services as an unintended result of the scheduled rate increases.

Appendix E

- Removed the requirement that the participant attend skills training for continued participation in Self-Direction in E-1-m.
- Clarified the responsibilities of the Fiscal Intermediary (FI) and Supports Broker in E-2-a-ii regarding informing and making available, rather than providing, training for the Participant to fulfill their employer responsibilities so as not to imply the FMS is the employer.
- Updated E-2-a-ii by removing the requirement that the Self-Directed employee must attend Department-sponsored trainings and complete them within 6 months of hire and every 36 months thereafter. The Participant, as the employer, will train their employees according to their identified needs.
- In E-2-a-ii clarified and specified that the Supports Broker will annually provide information to the Participant, Representative and self-directed employees on and how to report abuse, neglect and exploitation and in using the self-directed incident reporting form.
- Clarified the Participant's and Representative's responsibilities in E-2-b-ii by specifying that participant and/or designated representative approve their employee's electronic timesheets for services rendered by use of the FMS web portal, or by providing signatures on paper timesheets.
- Specified in E-2-b-ii that the Participant or Representative must comply with Electronic Visit Verification (EVV) requirements unless an exception is available.

Appendix G

- Updated the date of completion of full migration to the Office of Aging and Disability Services new Management Information System, Evergreen, from Fall 2023 to Spring 2024 to ensure a smooth transition for providers and stakeholders.

Appendix J Cost Neutrality Demonstration

- Updated Cost Neutrality and Derivation of Estimates for the five-years of the waiver renewal cycle (through July 1, 2029).

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

1. Request Information (1 of 3)

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

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

Home and Community Based Services for Members with Brain Injury

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Draft ID: **ME.022.02.00**

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

Regular Waiver

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

07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

-Skilled Nursing Facility for individuals with a brain injury (NF-ABI)

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

This Home and Community Based Waiver's target population is adult participants aged 18 and over who have sustained an acquired brain injury with moderate to severe cognitive, behavioral, or functional disabilities who qualify for services through a medical and financial eligibility determination. This waiver will allow the participant to utilize existing natural and non-paid community resources supplemented by waiver services delivered in a community-based setting rather than residing in an institution.

The goal of this waiver is to provide the opportunity for full community integration and engagement by promoting the participant's autonomy, promoting the dignity of risk and minimizing the individual's dependency on paid support staff. This is achieved through a comprehensive array of services, chosen by the participant, that do not supplant existing natural and non-paid community supports and includes access and opportunities for self-direction. All waiver services are provided in the least restrictive community setting with goals to reduce dependency on paid caregivers while utilizing the supports from technology, employment, education and most importantly family and social networks. The objective of this waiver is for each participant to be able to choose from available services that best meet their needs, increase and enhance quality of life and ensure active participation in achieving person-centered goals while assuring health and welfare in the community.

Provision of waiver services is approved by the Department of Health and Human Services through the participant's care plan. Services provide support and skills restoration and enhancement in areas such as employment, community integration, home reintegration, technology as a support, and behavioral management. Services should enable the participant to live as independently as possible, to attain and maintain meaningful employment, improve overall health and quality of life and participate to the maximum extent of their abilities and capabilities.

The participant will work with a care coordinator in the development, implementation, and evaluation of the participant's care plan. The care plan is a document that contains information about the participant's goals, personal and medical history, lifestyle choices, informal and natural supports, strengths and preferences, challenges, safety risks and service needs. The care plan reflects the individual's assessed needs and includes assurances that the person will get services in integrated community settings. The care plan is revised annually and as needed to reflect the participant's changing needs, and to focus on maintaining full community integration and engagement while maintaining the participant's health and welfare in the community.

To assure services are provided in the most integrated and efficient manner, the care coordinator will support the participant in developing a care planning team. The care planning team will document progress towards the participant's goals and identify any barriers to achieving goals and objectives as outlined in the participants care plan. The team is responsible for ensuring the care plan is actualized in a meaningful manner that meets the goals and objectives of this waiver. To accomplish this, the provider will complete a service implementation plan which is reviewed and approved by the participant. The team updates the care plan as needed on an ongoing basis considering reportable events, how services are delivered, and the quality of services. The care planning process is an essential part of assuring the participant's health and welfare.

Services are delivered by qualified enrolled MaineCare service providers. Service delivery ranges from small providers to large comprehensive for profit and nonprofit agencies. Waiver services are provided in provider managed settings or the participant's home, and in other community settings, including employment settings.

The Department of Health and Human Services is responsible for assurance of health and safety of the participant, quality of the person-centered planning process, and approval of the participant's care plan. The Department is also responsible for assuring services are provided and delivered in the least restrictive setting. The Office of MaineCare Services is the administrator of the waiver, managing the waiver portal, promulgating the rules for implementation and manages the MMIS payment system. The Office of Aging and Disability Services (OADS) monitors care plan development; prior-authorizes services; approves the delivery of services; approves service settings; and manages the quality measures accordance with its policies and procedures. This is accomplished through review of reportable events, care planning documents, and provider documentation; through customer surveys and site visits; and by direct contact with the participant and provider.

The quality management process assures that services are delivered in accordance with the care plan, including type, scope, amount and frequency specified in the plan. Providers maintain documentation of participant outcomes consistent with the approved service implementation plan as applicable. Providers document progress toward goal attainment during the care planning year. Providers record within the Department's electronic database as well as within each provider own electronic database. OADS reviews notes and care planning to determine whether the services are meeting the participant's health and welfare needs, and progress is being made towards meeting the participant's goals. OADS also reviews to determine whether services are delivered in the least restrictive manner. Each waiver service provider is responsible for the delivery of services in accordance with the approved care plan.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

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

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

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

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

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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

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

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

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

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver

and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

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

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

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

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

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

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

The State followed HCBS regulations in 42 CFR § 441.301 and requested public input on this waiver renewal from _____. Tribal Consultation was done at a meeting on March 7, 2024, and in writing on _____. On _____, the waiver renewal was posted online. A provider listserv was done on that date to all MaineCare providers and interested parties. Comments were accepted from _____. In addition, a notice appeared in five (5) newspapers with the highest circulation in the State on _____. Public comments on the proposed changes were accepted until 11:59PM, _____.

The State received timely comments from _____ Commenters. The comments ranged from _____, to comments about _____. A comprehensive summary and response to comment document will be sent to CMS as part of the waiver amendment.

The active link used to post the waiver amendment application is: _____

Any interested party could go into any regional DHHS office or contact OMS or OADS for a printed copy. A printed copy could be obtained by calling Heather Bingelis at 207------ or via email at Heather.bingelis@maine.gov.

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

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

7. Contact Person(s)

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

Last Name: Leet

First Name: Thomas

Title: Long-Term Services

Agency: Department of Health and Human Services-Office of MaineCare Services (OMS)

Address: 11 State House Station

Address 2: 109 Capitol Street

City: Augusta

State: **Maine**

Zip: 04333

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

Fax: (207) 287-2675

E-mail: thomas.leet@maine.gov

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

Last Name: Fales

First Name: Derek

Title: Waiver Services Director

Agency: Department of Health and Human Services-Office of Aging and Disability Services (OADS)

Address: 11 State House Station

Address 2:

City: Augusta

State: **Maine**

Zip: 04333

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

Fax:

(207) 287-9229

E-mail:

derek.fales@maine.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Maine**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

(continued from I-2 d.)
The State of Maine DHHS Service Center and the State of Maine Claim Processing System are programmed to ensure FFP recoupments. Annual audit reviews are part of the State of Maine Single Audit and cash management.

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

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Office of Aging and Disability Services

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

The Director of MaineCare (Medicaid) reports directly to the Commissioner of the Department of Health and Human Services as does the Director of The Office of Aging and Disability Services (OADS).

a. The Office of Aging and Disability Services (OADS):
-establishes waiver eligibility and enrolls participants, including management of approved limits
-provides oversight of level of care evaluation
-establishes relationship between Department and waiver providers for waiver services
-authorizes service utilization based on participant's individual service plans
-reviews participant service plans
-oversees quality assurance and quality improvement activities

Services cannot be provided without the prior authorization of OADS, through the approval of the care plan. OADS provides a critical oversight function of waiver providers, participants and stakeholders in the State. Any discrepancies are discussed with the participant and provider and may result in corrective action requirements. As providers move to compliance with creating corrective action plans, first and foremost, waiver participants must be ensured continuity of services and continued access to care. OADS will issue written guidance and corrective action to providers, requiring providers to submit a corrective action plan that outlines a timeline for compliance. Providers will be afforded the opportunity to present how to effectively implement compliance with the corrective action requirements.

b. the document used to outline roles and responsibilities related to the operation of the waiver is Chapter 101, MaineCare Benefits Manual, Section 18, Chapters II and III.
c. The Office of MaineCare Services
-has primary responsibility for development of state policy that governs the program and reimbursement for the waiver.
-coordinates, reviews and approves communication with CMS.
-submits required and requested submissions and reports to CMS; waiver applications, amendments, 372 reports and RAI's.
-manages provider enrollments in the MaineCare program.
-executes the Medicaid provider agreement.

The state maintains a signed MOU with the Office of Aging and Disability Services (OADS). The document is in effect until amended or terminated. OMS and OADS review the document at least annually. In addition, OMS and OADS staff meet biweekly to discuss the waiver, rule, and policies in an effort to improve services and supports. The OMS and OADS directors meet monthly to discuss program improvement strategy and resolve any issues that have been escalated by staff or stakeholders.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Assessing Services Agency is a healthcare management organization. It offers multiple services, but the Department contracts with it specifically to perform the medical eligibility determinations of members for most MaineCare and state funded services that require medical eligibility determinations for service needs.

Specifically, it conducts the functional assessment that determines medical eligibility and the level of care based on needs identified in the assessment and the presence of support services including informal supports, Medicare services and other community services.

The State uses an Assessing Services Agency (ASA) to complete the assessments needed to determine medical eligibility. Upon completion of the determination of medical eligibility, the State sends out a letter to any individual who has applied for the waiver indicating whether the individual has a funded opening and may begin selecting services, or whether the individual will be placed on a waitlist in accordance with the State's Medicaid rule. OADS staff review the findings of the ASA's medical eligibility determinations and are responsible for the final determination of eligibility.

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

The Department of Health and Human Services contracts with a fiscal agent for MMIS Services. The state's contracted Fiscal Agent for the MMIS payment system manages the Qualified Provider enrollment process. OMS' rate setting unit contracts with competitively selected rate determination vendor(s) to determine waiver reimbursement.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The Office of Aging and Disability Services (OADS) and MaineCare Services; all within the Department of Health and Human Services are responsible for the single assessing agency contract performance monitoring.

The Office of MaineCare Services has a dedicated position to manage the contract with the Transportation Brokers for the Me.19 NEMT Transportation waiver.

The Office of MaineCare Services has a contract manager for the MMIS contract.

Appendix A: Waiver Administration and Operation

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

The billing report of the Assessing Services Agency details the number of initial medical eligibility determinations initially and annually, the number of level of care determinations completed, and the number of revisions created. The billing report is then used to monitor the contracted entity administrative functions in accordance with waiver requirements.

Participant waiver enrollment is monitored by monthly reports generated within OADS through tracking the start and end dates of waiver members.

Service utilization by waiver-enrolled participants is managed and monitored against approved limits in the MIHMS system so that the total maximum hours a participant may receive does not exceed the individual cost limit, unless an approved exception has been granted due to health and safety. OADS reviews and approves all participant service plans at initial enrollment and on an annual basis. Any change to the participant's service plan requires prior approval from OADS. This is to ensure waiver limits are monitored and not exceeded.

Quality assurance and quality improvement activities are conducted by DHHS. The OADS Policy and Compliance team and the waiver management team conducts a retrospective review of waiver participant files. This annual audit of records is a statistically reliable sample size of active waiver participants enrolled in the State with a ninety-five percent (95%) confidence interval and five percent (5%) margin of error. A standardized form for the audit is distributed and utilized on a statewide basis. Missing historical information or insufficient information is noted as an identified problem in the record.

OADS waiver staff:
--maintain daily phone and email contacts with care coordinators and providers
--review monthly and quarterly reports
--provide annual site visits as needed
--monitor the statewide database
--oversee provider settings
--monitor reportable events
--provide guidance and directives related to fair hearings
--review responses to an annual participant satisfaction survey
--develop and issue corrective action requirements and notification of the accepted plan of correction.

For Transportation Services Performance Measures included in the 1915b waiver (ME.19): Broker contracts with the State of Maine contain performance measures that must be reported monthly. These are reviewed by the Office of MaineCare Services for compliance with the performance metrics.

Additionally, the MMIS contract includes a service-level agreement that is reviewed and monitored by the State monthly.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☒
Waiver expenditures managed against approved levels	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of annual Quality Reports submitted by the Operating Agency, to the Medicaid Agency, in the correct format and timely. Numerator: Number of Quality Reports submitted by the Operating Agency, to the Medicaid Agency, in the correct format and timely. Denominator: Number of Quality Reports required by the Medicaid Agency.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of SMA/OA waiver quarterly monitoring meetings during which the waiver quality assurance and quality improvement activities are discussed. Numerator: Quarterly SMS/OA meetings during which waiver quality assurance and quality improvement activities are discussed; Denominator: Number of quarterly SMA/OA meetings held.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OADS works closely with the provider agencies in administration of the waiver. General methods for problem correction include researching available documentation in person's most recent assessment, case notes, and classification system, depending on the nature of the issue. Follow-up phone calls are made to parties involved to gather necessary information for problem resolution. SMA investigates any issues that revolve around claims and follows up with the provider after investigation and solution has been found.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☒	**Brain Injury**	18		☒
	☐	**HIV/AIDS**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

◉ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

The estimated annual cost of the Member's services under the waiver is equal to or less than one hundred percent (100%) of a blended rate of the statewide average annual cost of care for individuals in ICFs and ABI NF units, as determined by DHHS (the blended rate being the sum of 20% of the statewide average annual cost of care in an ICF and 80% of the statewide average annual cost of care in a ABI NF unit), unless the Member is authorized to exceed this limit pursuant to MBM Ch II Section 18, Home and Community-Based Services for Adults with Brain Injury (See §18.16) and/or other ADA modifications.

The link to Section 18, Ch II of the MBM can be found here:
https://www1.maine.gov/sos/cec/rules/10/144/ch101/c2s018.docx

The individual cost limit (as outlined in Appendix C-4) will increase on an annual basis proportionately to the scheduled Appendix J and I-2-a reimbursement rate increases to ensure participants do not lose access to eligible services as an unintended result of the scheduled rate increases.

At the time of the level of care determination, the participant's needs are identified and a proposed plan of care is developed taking into consideration all sources of support. An independent LPN/RN/ conducts the LOC determination using the Department's Medical Eligibility Determination (MED) form. If it is determined that the participant's needs cannot be met through the waiver, the plan is not authorized and alternative community and institutional options are discussed with the participant. Participants that are found ineligible for the waiver due to cost limits are issued a letter of denial and hearing rights at the time of the assessment that outline their right to appeal the decision and request a fair hearing.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

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

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

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

☒ **Other safeguard(s)**

Specify:

If there is a change in a Participant's condition or circumstances and the provision of services would exceed the cost limit, the community Care Coordinator works with the waiver Participant to consider alternative resources and options both within the community and in a facility. Institutional respite care may be used for a short period of time if the Participant is at risk and care is not available in the home. The Participant may be referred to another Home and Community Based waiver as well if that is appropriate.

If health and welfare are in jeopardy, the State can approve services above the limits for an authorized period of time.

The Department complies with the ADA as a Title II-covered entity and, as such, has policy and procedures in place to receive and process Title II modification requests, including requests to modify financial limitations pursuant to the ADA. The Department is also implementing via rulemaking an “exceptions process” through which Participants may request exceptions to exceed monetary or unit limitations on services. The process described below will appear in MBM, Ch. II, Section 18.

Participants who receive services through this Benefit and Participants applying to receive services through this Benefit may submit a Request for Exceptions. The purpose of submitting a Request for Exceptions is to ensure that Participants receive adequate and appropriate services and supports in the most integrated setting appropriate to their needs, consistent with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134, and consistent with MBM, Ch. II, Section 20 health and safety requirements. To achieve that outcome, Participants may submit a Request for Exceptions to seek services in excess of otherwise-applicable ME.1082 (MBM, Section 18) waiver monetary and/or unit caps. Participants or their Representatives may seek Exceptions by submitting a written request. Filing a Request for Exceptions is neither a waiver of nor a substitute for the Participant’s right to an administrative hearing on an appeal under Chapter I, Section 1; to file a grievance under 14-197 C.M.R. ch. 8; or to file a complaint pursuant to 34-B M.R.S. § 5611.

Requests for Exceptions must be submitted in writing on a form provided by the Department by the Participant, the Participant’s Representative, or the Participant’s Care Coordinator. Procedures and requirements for applications for Requests for Exceptions will be detailed in MBM, Ch. II, Section 18.

Procedures and requirements for the Department’s review and decision regarding a Participant’s Request for Exceptions will appear in MBM, Ch. II, Section 18. The Department shall apply some or all of the Criteria that will be set forth in MBM, Ch. II, Section 18 and issue a written decision (“Decision”) on the Request for Exceptions within sixty (60) days of receipt of all materials submitted by the Participant or requested by the Department.

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

All exceptions are subject to Utilization Review.
All exceptions must be written into the Participant’s Person-Centered Service Plan.

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

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

*the Participant's proposed community placement is not appropriate;
*the Participant's health and safety cannot be assured in the community even if the Exception is granted; or
*the Exception, if granted, would fundamentally alter these HCBS waiver services.

The Participant's Care Coordinator, the Participant, or the Participant's Representative shall note approved Exception(s) and their duration in the Participant's Person-Centered Service Plan. Exceptions granted to a Participant under this provision shall expire as set forth in the Decision. Procedures for requests for renewal of the Exception will appear in MBM, Ch. II, Section 20.

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

The Department will provide information to Participants and their Care Coordinator on the changes to the ME.1082 (Section 18) waiver program regarding the ways the Exceptions process can assist recipients of the ME.1082 (Section 18) waiver program to receive services in the most integrated setting appropriate to their needs, when such services do not fundamentally alter the ME.1082 (Section 18) waiver program.

(Per CMS IRAI 9.13.23)

The Department will provide information to Participants and their Care Coordinator on the changes to the ME.1082 (Section 18) waiver program regarding the ways the Exceptions process can assist recipients of the ME.1082 (Section 18) waiver program to receive services in the most integrated setting appropriate to their needs, when such services do not fundamentally alter the ME.1082 (Section 18) waiver program.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	250
Year 2	250
Year 3	250
Year 4	250
Year 5	250

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

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

The individual interested in this waiver service will request an eligibility determination through Maine's "no wrong door" system. Contact with Aging and Disability Resource Centers, 211, neuro-resource facilitation, advocacy organizations, or the DHHS website will direct the person to the Office of Aging & Disability Services' (OADS) Brain Injury Program staff who will assist the individual through the eligibility determination process.

General Criteria: In order to be eligible for services under this waiver, the MaineCare Member must meet the following minimum eligibility criteria.

A. Is age eighteen (18) or older.
B. Has a diagnosis of Acquired Brain Injury (see Appendix B-6-d)
C. Has received an assessment by a qualified neuropsychologist or a licensed physician who is Board certified or Board eligible in Physical Medicine and Rehabilitation as defined in MaineCare Benefits Manual (MBM), Ch II, Section 102, Rehabilitative Services. (See § 102.08-5 (B)). [Section 102 can be found: https://www1.maine.gov/sos/cec/rules/10/144/ch101/c2s102.docx]

The assessment must document all of the following:
   a. evidence of moderate to severe behavioral, cognitive, and/or functional disabilities,
   b. verification the individual is not in a persistent vegetative state, and
   c. is able to demonstrate potential for physical, behavioral, and/or cognitive rehabilitation;

D. Has a received a department-approved Health and Safety Assessment administered by the Department or its Authorized Entity with an overall score of 0.1 or higher;
E. Has received a Mayo-Portland Adaptability Inventory – 4 (or current Department-approved version of the MPAI) administered by the Department or its Authorized Entity with an item score of 3 or higher for two of the following items:
   a. Novel Problem Solving
   b. Impaired Self-Awareness
   c. Irritability, Anger, Aggression
   d. Inappropriate Social Interaction
   e. Fund of Information or Attention/Concentration or Memory

F. Has a received MED assessment for ABI NF care administered by the Department or its Authorized Entity;
G. Does not receive services under any other federally approved MaineCare home and community-based waiver program;
H. Meets all MaineCare eligibility requirements as set forth in the MaineCare Eligibility Manual;
I. The estimated annual cost of the Member's services under the waiver is equal to or less than one hundred percent (100%) of a blended rate of the statewide average annual cost of care for individuals in ICFs and ABI NF units, as determined by DHHS (the blended rate being the sum of 20% of the statewide average annual cost of care in an ICF and 80% of the statewide average annual cost of care in a ABI NF unit), unless the Member is authorized to exceed this limit pursuant to §18.16 of this rule and/or other ADA modifications;
J. Can have his or her assessed needs (including health and safety factors) and personal goals assured in the community setting as stated in § 18.04-2(D) either through waiver services or through other means; and
K. Has received a funded offer for these services.

Application Procedures: OADS must determine that the Member is medically eligible for services using the following process:

A. Application Packet Requirements: An individual seeking these waiver services must submit a completed application packet to OADS that includes each of the following:
   1. OADS-approved Application form;
   2. Choice Letter;
   3. An assessment by a qualified neuropsychologist (as defined in MBM, Ch II, Section 102, Rehabilitative Services, § 102.08-5 (B)) and/or a licensed physician who is Board certified or Board eligible in Physical Medicine and Rehabilitation; and
   4. Release of Information allowing OADS to refer the applicant for medical eligibility assessments to the ASA.

If the application packet is incomplete, OADS will notify the individual via telephone or in writing. In any case, OADS will not continue with the eligibility determination process until such time as the application packet is complete.

B. Assessments: Following receipt of a completed application packet, OADS will refer the Member to the ASA for completion of the following:

1. MED assessment indicating the Member meets NF level of care needs; and
2. Mayo Portland Adaptability Inventory- 4 (or current Department approved functional assessment) with an item score of 3 or higher for two of the following items:
    a. Novel Problem Solving
    b. Impaired Self-Awareness
    c. Irritability, Anger, Aggression
    d. Inappropriate Social Interaction
    e. Fund of Information or Attention/Concentration or Memory; and
3. The Health and Safety Assessment with an overall score of 0.1 or higher.

OADS will verify that the individual meets medical eligibility criteria based on the completed application and the MED, MAPI and Health and Safety assessments results outlined above.

C. Notice: The Department will notify the Member or the Member's guardian in writing of any decision regarding the Member's eligibility, and the availability of a funded opening under this section for the Member.

The notice will include information about the Member’s right to appeal any of these decisions, as outlined in MBM Ch I, Section 1, General Administrative Policies and Procedures (See § 1.24).

Priority: When a member is found to meet MaineCare financial eligibility and medical eligibility, the priority for an approved opening shall be established as follows:

A. Priority 1: A Member shall be identified as Priority 1 if the Member is currently residing in a facility of more than 16 beds that is engaged in providing diagnosis, treatment or care, which typically includes:

medical attention; nursing care and related services; 24-hour supervision; and coordination and integration of health or rehabilitative services; and the Member continues to meet the financial and medical

eligibility criteria at the time that an approved opening becomes available. Order of enrollment will be based on date of application; an application will be considered complete on the date upon which

items (A) and (B) from § 18.03-3, Procedures for Applying for Services and Establishing Medical Eligibility, have been completed to DHHS satisfaction and DHHS has received all documents. If there are two

applications received on the same day, the applicant with the longest continuous stay in institutional care will be prioritized first.

B. Priority 2: All other Members will be identified as Priority 2. A higher priority will be given to those Members who are at imminent risk of abuse, neglect or exploitation followed by those at anticipated risk

of abuse, neglect or exploitation or homelessness and institutionalization within the next year.

Waitlists and Funded Offers: The state does not deny access to the waiver of an otherwise eligible Member until the state-defined maximum number of unduplicated Participants served is reached in each year that the waiver is in effect.

A. Waitlists: If the number of Members who have been determined to be eligible for Section 18 waiver services exceeds the number of funded offers in any given year, OADS will establish a waiting list. Members who

have not been offered a funded offer shall be placed on the waiting list and will be prioritized such that when there is a funded opening an individual will be selected from Priority 1 first and then immediately

from Priority 2 if there are not any completed and approved applicants from Priority 1.

B. Funded Offers: An eligible waiver applicant who receives a funded offer has sixty (60) days to accept the funded offer. If the offer is not accepted via telephone, electronic communication or written

communication, the Department will issue a notice to withdraw the funded offer and provide the eligible waiver applicant with notice of their appeal rights.

In the event an eligible waiver applicant does not begin at least one service within six (6) months, or the eligible waiver applicant has ceased contact or engagement with the waiver program, the Department will

issue a written notice to withdraw the funded offer including notice of the right to appeal the action. This provision will not apply to the waiver applicant engaged in PCSP planning and development even if

services have not started.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

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

- (●) **No**
- ( ) **Yes**

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

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

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

  Select one:

  - (●) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

•Infants and Children under Age 19 (42 CFR 435.118)
•Parents and Other Caretaker Relatives (42 CFR 435.110)
•Pregnant Women (42 CFR 435.116)
•Children with Non IV-E Adoption Assistance (42 CFR 435.227)
•Former Foster Care Children (42 CFR 435.150)
•Children Age 19 & 20 (42 CFR 435.222)
•Adult Group (42 CFR 435.119)

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the state plan**

Select one:

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

(*select one*):

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

Specify the percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state Plan**

Specify:

- ○ **The following dollar amount**

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

- ○ **The following formula is used to determine the needs allowance:**

Specify:

- ○ **Other**

Specify:

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

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

Specify:

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

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

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

- ◉ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

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

  Specify:

- ○ **Other**

  Specify:

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- (●) **Other**

Specify:

The Assessing Services Agency assesses the level of care and performs the evaluations and re-evaluations under a contract with the Department/Medicaid Agency. OADS manages the contract with the Assessing Services Agency.

The Assessing Services Agency conducts and completes the Level of care determinations and redeterminations. The ASA is not a government agency, but a vendor selected through the state's procurement process.

The state's role in the evaluation/re-evaluation process includes general oversight of the Operating Agency's administration and operation of the contract with the ASA.

Additionally, the Medicaid Agency's Program Integrity Unit performs post payment reviews and audits of Participant records – including ensuring the evaluations/re-evaluations comply with Agency rules.

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

Registered Nurse, Licensed Practical Nurse, or Licensed Clinical Social Worker

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

In order to be eligible for services under this waiver, the Participant must meet the following minimum eligibility criteria.

The level of care evaluation and eligibility determination process consists of completing the following:

1. Has a diagnosis of acquired brain injury. Acquired Brain Injury means an insult to the brain resulting directly or indirectly from trauma, anoxia, or vascular lesions, or infection, which is not of a degenerative or congenital nature, can produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical functioning, can result in the disturbance of behavioral or emotional functioning, can be either temporary or permanent, and can cause partial or total functional disability or psychosocial maladjustment. (Title 22 §3086); and
2. Has a completed MED (Medical Eligibility Determination) tool for Acquired Brain Injury Nursing Facility level of care or the BMS99 for ICF/IID level of care; and
3. The individual has received an assessment by a qualified neuropsychologist (as defined in the MaineCare Benefits Manual, Rehabilitative Services, Section 102.08-5) and/or a licensed physician who is Board certified, or otherwise Board eligible in Physical Medicine and Rehabilitation; and
4. The assessment must document all of the following:
   a. evidence of moderate to severe behavioral, cognitive, and/or functional disabilities,
   b. verification the individual is not in a persistent vegetative state, and
   c. is able to demonstrate potential for physical, behavioral, and/or cognitive rehabilitation; and
5. Has a completed Department approved Health and Safety Assessment administered by the Department with an overall score of 0.1 or higher. The Department approved Health and Safety Assessment evaluates cognitive, physical, and behavioral needs related to a person's brain injury. It assesses whether a person needs support for the three areas. Additionally, it assesses if the person needs cueing, direct support, or a behavioral support. Scores range from 0-1; and
6. Has completed Mayo-Portland Adaptability Inventory – 4 (or current Department approved version of the MPAI) with an item score of 3 or higher for two of the following items:
   a. Novel Problem Solving
   b. Impaired Self-Awareness
   c. Irritability, Anger, Aggression
   d. Inappropriate Social Interactions
   e. Fund of Information or Attention/Concentration or Memory

The assessment tools are the MED, the Mayo-Portland Adaptability Inventory – 4, the Department approved Health and Safety Assessment, and a qualified clinical assessment diagnosing the acquired brain injury. The information is entered into a data system called MECARE.

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

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The level of care evaluation and re-evaluation are both conducted by the Assessing Services Agency using the Medical Eligibility Determination (MED) assessment tool for Acquired Brain Injury Nursing Facility level of care or the BMS 99 for ICD/IID level of care. This automated tool allows the qualified assessor to collect required clinical and functional information in order to determine waiver eligibility. The assessment indicates other services and supports the participant may be eligible for in addition to eligibility assessment for the waiver. The re-evaluation process does not require the participant to complete a new clinical assessment.

Level-of-care determinations are made by the Assessing Services Agency and are reviewed by staff from the Office of Aging and Disability Services. OADS staff review the findings of the ASA's assessment and are responsible for the final determination of eligibility and level-of-care.

OADS must receive a completed application for the Brain Injury Waiver in order to proceed towards medical eligibility determination. OADS reviews the application material against the publicly available application checklist. In the event the application is not complete based upon the checklist, a request for additional information is mailed to the respondent named in the application.

For initial level of care evaluations, OADS staff receives a clinical assessment, completes the MED referral form, and submits both the referral form and clinical assessment to the ASA. The ASA is responsible for scheduling and conducting the MED assessment.

For re-evaluation, Care Coordinators complete the ASA referral form and submit it and the Participant's current PCSP to the ASA. The ASA is responsible for scheduling and performing the MED assessment."

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

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

  Specify the other schedule:

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

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

  Specify the qualifications:

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

Payment to waiver providers coincides with the participant's eligibility period. The waiver service of Care Coordination ensures that assigned Care Coordinators maintain a record of start and end dates of eligibility and the need for reevaluations of participants. A referral is made to the Assessing Services Agency thirty (30) days prior to the expiration of the eligibility period.

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

The Department maintains level of care data from the MED assessment for NF level of care that is entered into the MeCare system or the BMS99 for ICF/IID level of care. The data is protected by regular State back-up procedures.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of referred applicants who received an LOC. Numerator: Number of referred applicants who received an LOC. Denominator: Number of referred applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
sub-state entity

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Number and Percent of waiver LOC assessments completed within thirty (30) days of referral to the Assessing Services Agency (ASA). Numerator: Total number of waiver LOC assessments completed within thirty (30) days of referral to the Assessing Services Agency (ASA). Denominator: Total number of waiver referrals reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Sub-state entity

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

		95% confidence level with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of initial functional assessments completed using approved functional assessment tools. Numerator: Total number of initial functional assessments completed using approved functional assessment tools. Denominator: Total number of initial functional assessments reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Sub-State entity

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of LOC determinations made using the processes and instruments described in the waiver and applied appropriately. Numerator: Total Number of LOC determinations made using the processes & instruments described in the waiver and applied appropriately. Denominator: Number of LOC determinations reviewed.

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

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

		95% confidence level with +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

The MECARE Assessment database allows the state to verify all level of care assessment information. If reassessments are not performed in a timely fashion, the new MMIS system will not reimburse for claims submitted during that time frame. All claims will rely on the proper reassessment and classification information to be entered into the system in order to pay.

b. Methods for Remediation/Fixing Individual Problems

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

For assessments, participants are informed of their appeal rights in writing. These appeal rights may be exercised upon a disagreement with a LOC determination. The Department will follow up with the assessing services agency or providers to discuss problems concerns and any necessary action needed. The Brain Injury Waiver Manager will review all appeals and monitor compliance with timelines.

The State's level of care and Health and Safety Assessments ensure the eligibility instrument tools provide a quality review and assessment of the participant's functioning to appropriately plan to support and address the participant's strengths, needs, and personal goals.

Ongoing and continuous oversight and training has been identified as the most appropriate step towards ensuring the process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care. The Department holds regular meetings with the Assessing Services Agency to ensure consistency with best practices.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Maine's state law title 22 MRSA §3174-1 mandates that every person wanting to access institutional care must have an assessment to determine the level of care he or she needs. The law also requires that each person must hear about community options and receive a recommended community plan of care enabling him or her to make an informed choice about where he or she chooses to receive care, regardless of funding source.

Following completion of the medical eligibility determination assessment, the ASA is responsible for providing information about feasible alternatives and informing the individual about their freedom of choices. Each person found eligible for ICF/IID level of care is asked to make a choice between home and community-based services and institutional care and each person found eligible for Acquired Brain Injury Nursing Facility (ABI NF) level of care is asked to make a choice between home and community-based services and institutional care.

At the time of medical eligibility determination, the participant is informed of alternatives available under waiver programs other than institutional settings and signs a choice letter that states they are choosing either a community or institutional setting.

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

The choice letter is maintained as part of the participant's record in the care coordination agency file.

Appendix B: Participant Access and Eligibility

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

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

The Department of Health and Human Services' interpreter guidelines under Chapter I of the MaineCare Benefits Manual and the DHHS language access policy are followed to provide access to waiver services for limited English proficient persons. At the time of referral for a level of care determination, the participant's primary language is documented in her or her record. If there is a need for interpreter services, this also is documented in the participant's record. The assessor is able to access the interpreter phone service or arrange for on-site interpreter at the time of assessment. Eligibility and due process letters are translated as necessary. Care Coordinators are able to access interpreter services to accommodate participants who need translation services.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Care Coordination		
Statutory Service	Career Planning		
Statutory Service	Home Support- 1/4 hour-Level I		
Statutory Service	Home Support-Per Diem Level II		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Individual Goods and Services		
Supports for Participant Direction	Supports Brokerage		
Other Service	Assistive Technology		
Other Service	Employment Specialist Services		
Other Service	Home Support- Remote Support		
Other Service	Home Support-Per Diem Level III Increased Neurobehavioral		
Other Service	Non-Medical Transportation		
Other Service	Work Ordered Day Club House		
Other Service	Work Support-Individual		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Care Coordination provides primary assistance to the waiver participant in gaining access to needed waiver and State Plan services, as well as other local, state, and federal educational, vocational, social, and medical services, regardless of the funding source for the services to which access is gained. The care coordinator coordinates and monitors the provision of all services in the care plan and is responsible for the monitoring and assurance of the implementation of the care plan. This includes monitoring of the health, welfare and safety of the participant. If Health and Welfare are in jeopardy, the Department can approve services above the limits for an authorized period. This service requires a face-to-face contact at a minimum every thirty days with documentation within the State's designated electronic database for this waiver. A participant who has this service may not have targeted case management under the State Plan.

If a participant enters a hospital or nursing facility, the care coordinator may provide Care Coordination Services to the participant provided it is within sixty (60) days of discharge from the institution. However, these services may not be billed and cannot be reimbursed until the participant is discharged back into the community and resumes waiver services.

If the Participant chooses Self-Direction, the Care Coordinator provides access to Supports Brokerage and Financial Management Services for the Participant and the Representative (as applicable). For the Participant interested in Self-Direction, the Care Coordinator provides information and assistance to ensure the Participant is able to make an informed decision regarding the available self-directed service options.

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

400 units per year.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Service Coordination Agency (SCA)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:

Agency

Provider Type:

Service Coordination Agency (SCA)

Provider Qualifications

License *(specify):*

Registered Nurse (RN) or Registered Occupational therapist (OTR) or a licensed social service or health professional.
In order to be qualified as a Registered Nurse, an individual must have:
• Completed a course of study of not less than two (2) years in an approved program in professional nursing and holds a degree, diploma or certificate.
• Documented successful passage of the required examination.
In order to be a qualified Occupational Therapist an individual must have
- completed an approved academic and field work requirements as accredited by ACOTE.
- passed the certification examination of the National Board for Certification in Occupational Therapy for an Occupational Therapist.
State Statute
• Nurse 32 MRSA §§2101-2265
• Occupational therapist – 32 MRSA §§2271-2306

Certificate *(specify):*

A certified Occupational Therapy Assistant may provide care coordination when under the direct supervision of an OT or Nationally Certified Recreation Therapist (CTRS).

Other Standard *(specify):*

All staff must also possess Certificate of Fundamentals of Brain Injury (CFBI) or department approved training. 4 years of education in health or social services field and 1 year of community experience.
All staff must have
* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

For agency, OADS verifies at time of enrollment with State Medicaid Agency and every three years thereafter.

Frequency of Verification:

Provider enrollment verifies provider qualifications at time of enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Career Planning

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Career planning is a person-centered, comprehensive employment planning and direct support service that provides assistance for waiver program participant to obtain, maintain or advance in competitive employment or self-employment at or above the State's minimum wage. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the State's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support. This service assists in identifying skills, priorities, and capabilities determined through an individualized discovery process. This may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, development of experiential learning opportunities and career options consistent with the participant's skills and interests. Career Planning may be used in preparation to gather information to be used as part of a referral to Vocational Rehabilitation. When career exploration identifies an interest in self-employment, the participant will have the opportunity to explore similar businesses and determine potential steps necessary to develop a business. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support.
Career Planning services must have the long-term goal of individual, competitive, integrated employment for which the participant is compensated at or above the minimum wage. In order to receive Career Planning services, the participant's PCSP must identify specific career goals and describe how the Career Planning services will be used to achieve those goals. Career Planning services can be provided within a variety of community settings such as a Career Center or a local business and must be documented in the Person-Centered Service Plan with related goals.

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

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

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

The maximum annual allowance is 60 hours to be delivered within a six month period. No two six month periods may be provided consecutively. Career Planning may not be provided at the same time as Home Support, Employment Specialist Services or Work Support.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Career Planning

Provider Category:
Agency
Provider Type:

OADS Approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

DSPs must have current CPR and First Aid Certification.

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

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

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.
Provider Agency must assure the following for individual DSP's:
* DSPs must be at least eighteen (18) years of age
* DSPs must have graduated from high school or acquired a GED
* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, Finance/Rate-setting, Licensing & Certification, OADS.

Frequency of Verification:

Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Home Support- 1/4 hour-Level I

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Support means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. Home Support (1/4 hour) is for individuals living independently or with others who need less than 24-hour (1:1 in person) staff support per day. These supports include adaptive skill development, assistance with activities of daily living, control of personal resources, transportation, and being prepared for opportunities to seek employment and to work in competitive, integrated settings. The participant's health and safety needs and the support needed to meet them are documented in the participant's Person-Centered Service Plan. A participant's essential personal rights of privacy, dignity, and respect, and freedom from coercion and restraint are protected. Providers must develop methods, procedures and activities to facilitate meaningful days and independent living choices about activities/services/staff for the participant. Procedures must be in place for individual(s) to access needed medical and other services to facilitate health and well-being. In-home supports services include a combination of hands-on care, habilitative supports, skill development and assistance with activities of daily living. Supports provided shall be aimed at teaching the person to increase his or her skills and self-reliance.

The cost of transportation related to the provision of Home Support is a component of the rate paid for the service. Transportation to and from Home Support is provided under the transportation brokerage and only the transportation incidental to the provision of the service is a component of the service rate for Home Support.

Payment is not to be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5. Payment is not to be made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

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

64 units per day.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Home Support (1/4 hour) may be provided by an individual who meets the requirements for Employees for self-directed services. The standards for training are set by the individual directing services. The self-directing participant or representative, as applicable, is responsible for the hiring and training of the Employee. As part of this process, the self-directing participant or representative must maintain documentation that the Employee received adequate orientation to assure that the Employee can meet the needs of the participant and demonstrate competency in all required tasks. The participant or representative is required to undergo skills training which prepares and assists the participant or representative in fulfilling these responsibilities. Employees may be members of the participant's family. If a representative is directing services on behalf of the participant, the representative may not be paid to provide care. The guardian may not be paid to provide care to the participant.
Employees must be 17 years of age or older.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant or his or her representative choosing to self-direct services with background checks facilitated by the FMS

Frequency of Verification:

At time of hiring by participant of his or her representative

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

OADS Approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DSPs must successfully complete the Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS's approved Assessment of Prior Learning, or has successfully completed the Maine College of Direct Support within six (6) months of date of hire.
DSPs must have current CPR and First Aid Certification.
A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN), or otherwise has been trained to administer medications through a training program specifically for Family-Centered or Shared Living model homes and authorized, certified, or approved by DHHS.
*All staff must also possess Certificate of Fundamentals of Brain Injury or Department approved training.

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.
Effective January 1, 2020, Provider Agency must comply with Maine DHHS Electronic Visit Verification system standards and requirements.
Provider agency must assure the following for individual DSP's:
* Be at least seventeen (17) years of age. A DSP or PSS who is between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP or PSS both of whom must be over 18 years of age. 17 year-olds will remain eligible for employment following their 18th year in the absence of an high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other DSP requirements.
*A DSP or PSS who is eighteen (18) years of age or older must have graduated from high school or acquired a GED.
* All staff must also possess Certificate of Fundamentals of Brain Injury or Department approved training.
* Reportable Events Training
* Criminal Background Check
* If an individual staff person provides transportation; a valid Maine Driver's license is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, Licensing & Certification, OADS.

Frequency of Verification:

Provider enrollment verifies provider qualifications at time of enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Home Support-Per Diem Level II

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Support means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. The agency owned or controlled setting is integrated in and facilitates the participant's full access to the greater community including: opportunities to seek employment and work in competitive, integrated settings; engage in community life; control personal resources; and receive services in the community like individuals without disabilities. These supports include adaptive skill development, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home Support also includes personal care and protective oversight and supervision.

Services are developed in accordance with the needs of the participant and include supports to foster independence and encourage development of a full life in the community, based upon what is important to and for the participant, as documented in their Person-Centered Plan (PCP). A participant's essential personal rights of privacy, dignity, and respect, and freedom from coercion and restraint are protected. Individual initiative, autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact are optimized and not regimented.
Individual choice regarding services and support, and who provides them, is facilitated.

All behavioral interventions designed to prevent or modify challenging behaviors shall be in conformance with applicable laws and regulations and agency-specific policies/procedures. Interventions and intervention plans must be individualized and designed for the purpose of enhancing the individual's quality of life, relationships with others, and ability to function as independently as possible. Such interventions shall actively include positive approaches, strategies and/or supports designed to establish or increase the person's adaptive (replacement) behaviors.

These home and community-based settings must comply with the requirements of the Global HCBS Waiver Person-Centered Planning and Settings Rule ("Global HCBS Rule"), MaineCare Benefits Manual, Chapter 1, Section 6.
Home Support (Per Diem) is reimbursed at multiple levels, i.e., 2-4 beds and 5-8 beds. There must be at least one staff person in the same setting as participants receiving services at all times (24/7) that is able to respond immediately to the requests/needs for assistance from the participants in the setting.
Participants cannot be made to attend a day program (any other service or support other than Home Support) if they choose to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if they are ill, or otherwise choose to remain at home.

Home Support-Level II is a per diem service provided in a residential home with two or more participants receiving 24/7 protective oversight and supervision.
Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Support-Per Diem Level II

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DSPs must successfully complete the Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS's approved Assessment of Prior Learning, or has successfully completed the Maine College of Direct Support within six (6) months of date of hire.
DSPs must have current CPR and First Aid Certification.
A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN), or otherwise has been trained to administer medications through a training program specifically for Family-Centered or Shared Living model homes and authorized, certified, or approved by DHHS.

*All staff must also possess a Certificate of Fundamentals of Brain Injury or Department approved training.

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS)
* Received addition approval from OADS for provision of waiver services as required in MIHMS

The Provider Agency must have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)-Home and Community Services, Residential Services and Brain Injury modules.

Provider Agency must assure the following for individual DSP's:
* Be at least seventeen (17) years of age. A DSP or PSS who is between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP or PSS both of whom must be over 18 years of age. 17 year-olds will remain eligible for employment following their 18th year in the absence of an high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other DSP requirements.
* A DSP who is eighteen (18) years of age or older must have graduated from high school or acquired a GED.
* All staff must also possess a Certificate of Fundamentals of Brain Injury or Department approved training
* Reportable Events Training
* Criminal background check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, Licensing & Certification, OADS.

Frequency of Verification:

Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Financial Management Services are a critical support for self-direction, making payments through a Fiscal Intermediary that performs financial transactions (paying for Individual Goods and Services or processing payroll for member employed services and tracking expenditures against the self-directed budget) 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) Enrollments for Employer/Employer of Record and Employees;
c) Payroll processing for employees to address federal, state and local employment tax, labor and workers' compensation insurance rules, required background checks, and other requirements that apply when the Member functions as the employer of workers;
d) Tracking spending and approving expenditures that align with the Department- approved Spending Plan Tool, including changes/additions to the list of Goods and Services;
e) Making financial transactions on behalf of the Member within the scope of select services for self-direction;
e) 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;
f) Assisting Member with resolving employee questions and complaints and remediating as appropriate; and
g) 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.

Enrollment as an FMS provider is open to all willing and qualified providers.
This service is limited to participants who direct some or all of their waiver services.
The FMS must enroll as a Medicaid provider and have a written agreement with the State Medicaid Agency.

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

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Management Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must demonstrate the ability to process timesheets and payroll, disburse the PCA payments and other needed management functions to support consumer direction.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Office of Aging and Disability Services

Frequency of Verification:

Upon enrollment with MaineCare and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual Goods and Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

The participant must use personal funds or access another funding source (through this benefit or the state plan) to purchase services, equipment, or supplies when available. When the participant does not have personal funds or funding through another source, the participant may access funds available in the participant-directed budget. The participant and/or representative and Fiscal Intermediary (FI) must attest, using the Department-approved form, that the selected Goods and Services fall within the federal requirements for the same.

Availability of funds for Individual Goods and Services is contingent upon the combined cost of mandatory self-directed services, optional self-directed services, and traditional waiver services identified in the PCSP. The participant must develop a spending plan that details all service-related costs according to the participant's authorized budget limits and calculates any remaining funds available for identified Goods and Services documented within the PCSP.

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

The coverage of this service is limited to waivers that incorporate the Budget Authority participant direction opportunity.
Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition against claiming for the costs of room and board.
Experimental or prohibited treatments are excluded.
This service is limited to participants who direct some or all of their waiver services.

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

Individual Goods and Services are subject to an annual cap of no more than $10,000.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Management Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Office of Aging and Disability Services

Frequency of Verification:

Upon enrollment with MaineCare and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Supports Brokerage

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supports Brokerage is the delivery of support and information to ensure that participants understand the responsibilities involved with Self-Direction. Duties of the Supports Broker detailed below include, but are not limited to, coaching, and advising the participant about the responsibilities of being an employer, managing their personal budget, or implementation of their PCSP. The extent of the assistance furnished to the participant or Representative is specified in the PCSP. This service does not duplicate other services, including care coordination or financial management services.

This service includes:
a) Offering support, including effective communication, and problem solving strategies, to enable participants or representatives to independently recruit, hire, train, and manage employees.
b) Supporting participants in person-centered service planning for Self-Directed Services.
c) Supporting participants to project and track costs associated with services, staffing wages, and allowable Individual Goods and Services, using the Department-approved Spending Plan Tool.
d) Working closely with Care Coordinators and Fiscal Intermediaries to ensure participants' Person-Centered Service Plans identify the mix of services (employment, State Plan, Provider-Managed Services and Self-Directed Services) and natural supports to maximize participants' flexible individual budget of Self-Directed Services.
e) Assisting in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services.
f) Supporting and monitoring participants to carry out their employer responsibilities such as recruitment activities, education of employees and scheduling.
g) Completing community mapping of all services and supports available to participants.
h) Supporting the participant to monitor spending, in conjunction with and approval by the FI, using the Department-approved Spending Plan Tool.
i) Supporting the participant to request adjustments to the PCSP as needed and ensuring those authorized adjustments are reflected in the updated Spending Plan Tool.
i) Supporting participants in meeting Electronic Visit Verification requirements and daily documentation requirements.
j) Reporting overutilization/scheduling of more staff than the budget can cover, to the OADS Resource Coordinator.

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

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

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

OADS approved provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Office of Aging and Disability Services

Frequency of Verification:

Upon enrollment with MaineCare and every 3 years thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

OADS approved provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Office of Aging and Disability Services

Frequency of Verification:

Upon enrollment with MaineCare and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

AT Services include:
A. AT-Assessment:
1. Evaluation of the AT needs of a Participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Participant in the customary environment of the Participant. Evaluation of the assistive technology needs of a Participant 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 Participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the Participant; and
4. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of Participants.

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

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.

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

The components of Assistive Technology are subject to the following limits:
The Assistive Technology Device and related services (See B. above) are subject to a combined limit of $7056.48 annually. The services described for AT Assessment and AT Devices See A. and B. above) are subject to a combined limit of 32 units (8 hours) annually. The data Transmission Services (See C. above) are limited to $55.49 per month.

Assistive Technology Transmission may not include reimbursement for an ongoing monthly charge of participant internet services.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

OADS Approved Provider Agency

Provider Qualifications

License *(specify):*

Licensed Occupational Therapist as licensed under MRSA title 32, ch 32.
Licensed Speech Pathologist as licensed under MRSA title 32, ch 137.

Certificate *(specify):*

Direct Support Staff must be a certified Direct Support Professional (DSP) and
Certification as Rehabilitation Engineering Technologist (RET) or an Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) is required to provide Assistive Technology.

Other Standard *(specify):*

Minimum requirements may include compliance with:
Equipment must adhere to
* Local and state codes
* Underwriters Laboratories
* FCC
* NFPA Life Safety Code
* ADA
Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.
Provider Agency must assure the following for individual DSP's:
*Minimum age of 18
* Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, Finance/Rate-setting, Licensing & Regulatory services, OADS.

Frequency of Verification:

Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Employment Specialist Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Employment Specialist Services include services necessary to support a Participant in maintaining Employment. Employment Specialist Services include:

(1) periodic interventions on the job site to identify a Participant's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion;
(2) assistance in transitioning between employers when a Participant's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the Participant in acclimating to a new job; and
(3) Employment Specialist Services for job development, if Vocational Rehabilitation denies services under the Rehabilitation Act, or the services are not available to the Participant. In such cases the Employment Specialist provider must submit and retain in the Member's record, current documentation of the lack of service availability or ineligibility from Vocational Rehabilitation.

The Employment Specialist must complete the Department-approved training and may work independently or when employed by a Supported Employment provider.

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 34 C.F.R. §361.5 (c) (9). Employment Specialist Services assist a Participant to establish and or sustain a business venture that is income producing. MaineCare funds may not be used to defray the expenses associated with the start up or operating a business.

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

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

Employment Specialist Services are limited to 72 units per service year. Work Support Services cannot be provided at the same time as Employment Specialist Services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Employment Specialist
Agency	OADS Approved Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Specialist Services

Provider Category:

Individual

Provider Type:

Employment Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

DSPs must have current CPR and First Aid Certification.

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

Additionally, a DSP who provides Employment Specialist Services must have successfully completed an Employment Specialist Certification program as approved by DHHS within six months of date of hire; approved courses are listed at: http://www.employmentforme.org/providers/crp-training.html, as well as the additional employment modules within the DSP curriculum. Employment Specialist National (ACRE approved) Certification may be substituted for College of Direct Support and employment modules as it is a higher level of staff certification.

An Employment Specialist who also provides Career Planning must have completed the additional twelve (12) hours of Career Planning and Discovery provided through Maine's Workforce Development System and six (6) hours of Department approved continued education every twelve (12) months.

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.
* In addition to the requirements outlined for above, the following requirements apply to Employment Specialists:
a. Received supervision during the first six months of hire from a Certified Employment Specialist;
b. Graduated from high school or acquired a GED and is at least eighteen (18) years of age.
c. Worked for a minimum of one (1) year with a person or persons with a disability in a work setting.

* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, Finance/Rate-setting, Licensing & Certification, OADS.

Frequency of Verification:

Provider enrollment is responsible for verification of provider qualifications upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Specialist Services

Provider Category:

Agency

Provider Type:

OADS Approved Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

DSPs must have current CPR and First Aid Certification.

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

Additionally, a DSP who provides Employment Specialist Services must have successfully completed an Employment Specialist Certification program as approved by DHHS within six months of date of hire; approved courses are listed at: http://www.employmentforme.org/providers/crp-training.html, as well as the additional employment modules within the DSP curriculum. Employment Specialist National (ACRE approved) Certification may be substituted for College of Direct Support and employment modules as it is a higher level of staff certification.

An Employment Specialist who also provides Career Planning must have completed the additional twelve (12) hours of Career Planning and Discovery provided through Maine's Workforce Development System and six (6) hours of Department approved continued education every twelve (12) months.

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.
* In addition to the requirements outlined for above, the following requirements apply to Employment Specialists:
a. Received supervision during the first six months of hire from a Certified Employment Specialist.
b. Graduated from high school or acquired a GED and is at least eighteen (18) years of age.
c. Worked for a minimum of one (1) year with a person or persons with a disability.

* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, Finance/Rate-setting, Licensing & Certification, OADS.

Frequency of Verification:

Provider enrollment is responsible for verification of provider qualifications upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Support- Remote Support

HCBS Taxonomy:

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Support-Remote Support provides real-time remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, door, temperature, smoke, carbon monoxide, 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.

The service promotes independence in maintaining safety and increasing functional skills within the home environment that prepares the Participant to engage with their community in accordance with their identified needs and outcomes within the PCSP.

The remote support provider is responsible for the delivery of services (either Interactive or Monitor only) from an OADS approved provider location. This service links each participant's residence to the Remote Support provider. Staff are offsite and available via remote connection.

The Home Support-Remote Support staff members deliver one of two types of Remote Support: Interactive Support or Monitor Only Support. Interactive Support is virtual Direct Support and virtual active engagement with the Participant using an Assistive Technology Device. Monitor Only Support is virtual monitoring of the Participant without interacting using an Assistive Technology Device.

The PCSP Planning Team, in coordination with Assistive Technology consultants if needed, will determine the appropriateness of this service based on an assessment of the Participant's functional needs. The Care Coordinator is responsible for documenting appropriateness and need for the service within the PCSP. The PCSP must also document a safety/risk plan that identifies emergency back-up arrangements. Back-up plans will be specific to the Participant and based upon their individual needs.

OADS authorizes all services included in the PCSP prior to provision or delivery of any service. The PCSP reflects the participant's consent and commitment to the plan elements including all assistive communication, environmental control and safety components as evidenced by the Participant and guardian (when involved) signature(s) on the finalized PCSP.

The Participant will select and meet with the Home Support-Remote Support provider agency to assess the technology needs specific to their functional assessment and determine where necessary devices and monitors would be placed within the home environment. Though the state does not set regulations nor have oversight of Participants' private residences, the state does not allow remote monitoring cameras in bathrooms.

Prior to the provision of services to a Participant, the Home Support-Remote Support provider must attest that the systems of support, including the technology required for remote monitoring complies with all federal, state and local regulations applicable to its business including but not limited to the "Electronic Communications Privacy Act of 1986." Any services that use networked services will comply with HIPAA requirements. Additionally, all electronic systems will have back-up power connections to insure functionality in case of loss of electric power.

The provider must inform the Participant about use of and access to any devices, including the activation or deactivation of the equipment, or services delivered within their private residence. Further, the Participant must consent to the conditions of access outlined by the provider. The provider reviews and informs the Participant about all aspects of service delivery including individual privacy and the privacy of others within the Participant's private residence. Additionally, if the Participant experiences a change in support needs or status, the provider must immediately adjust the direct support services to meet those needs.

The Case Manager/Care Coordinator supports the Participant as needed ensuring informed consent through the process and documenting the Participant's consent within the PCSP.
Additionally, the Care Coordinator is responsible for monitoring and ensuring health and safety for the Participant receiving waiver services in the home in accordance with applicable sections of the MaineCare Benefits Manual including protecting individual rights and privacy.

In accordance with Appendix G of the waiver application, any violation of a Participant's rights of privacy as articulated within the Rights of Maine Citizens with Intellectual Disabilities or Autism or Acquired Brain Injury is a reportable event subject to review and intervention by both the operating agency and the States protection and advocacy entity (34-B M.R.S. § 5605; 14-197 C.M.R. ch. 1 – Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder, or Acquired Brain Injury). Additionally, all providers of HCBS

waiver services must receive training on what constitutes a reportable event (including rights violations) and how to complete the reportable event as well as any necessary follow up actions.

The State's Global HCBS Waiver Person-Centered Planning and Settings Rule (the Global Rule), implements the federal requirements for Maine's Section 1915(c) home and community-based waiver programs set forth in 42 C.F.R §441.301(c), and includes requirements for person-centered service planning and for settings in which home and community-based waiver services ("HCBS") are delivered, including requirements for provider-owned or controlled residential Services.

Specifically, §6.04(A)(3) of the Global rule ensures a Participant's rights of privacy, dignity and respect, and freedom from coercion and restraint, except restraints deployed in accordance with 34-B M.R.S. §5605(14-A) to protect the Member or others from imminent injury or in conformance with an approved behavior management program under 34-B M.R.S. §5605(13).

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

There is no overlap between Assistive Technology and Home Support-Remote Support. Assistive Technology provides for the assessment, the equipment and the cost of the monthly transmission. Home Support-Remote Support provides the staff who are monitoring the participant.

Home Support-Remote Support is a Provider-Managed Service. A provider may provide Home Support-Remote Support to more than one Member at a time.

This service must be delivered in the state of Maine. And unless there is an emergency, services out of state are not covered.

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

Remote Support is not available at the same time as any other type of Home Support or Personal Care. Home Support-Remote Support is limited to 64 units per day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

OADS Approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DSPs must successfully complete the Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS's approved Assessment of Prior Learning, or has successfully completed the Maine College of Direct Support within six (6) months of date of hire.
DSPs must have current CPR and First Aid Certification.

*All staff must also possess Certificate of Fundamentals of Brain Injury or Department approved training.

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.
Provider Agency must assure the following for individual DSP's:
* A DSP must be at least seventeen (17) years of age. A DSP who is 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. 17 year-olds will remain eligible for employment following their 18th year in the absence of an high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other DSP requirements.
* A DSP who is eighteen (18) years of age or older must have graduated from high school or acquired a GED.
* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, Finance/Rate-setting, Licensing & Certification, OADS.

Frequency of Verification:

Provider enrollment verifies provider qualifications at time of enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Support-Per Diem Level III Increased Neurobehavioral

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Support means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. The agency owned or controlled setting is integrated in and facilitates the participant's full access to the greater community including: opportunities to seek employment and work in competitive, integrated settings; engage in community life; control personal resources; and receive services in the community like individuals without disabilities. These supports include adaptive skill development, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home Support also includes personal care and protective oversight and supervision.

Services are developed in accordance with the needs of the participant and include supports to foster independence and encourage development of a full life in the community, based upon what is important to and for the participant, as documented in their Person-Centered Service Plan (PCSP). A participant's essential personal rights of privacy, dignity, and respect, and freedom from coercion and restraint are protected. Individual initiative, autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact are optimized and not regimented.

Individual choice regarding services and support, and who provides them, is facilitated.
All behavioral interventions designed to prevent or modify challenging behaviors shall be in conformance with applicable laws and regulations and agency-specific policies/procedures. Interventions and intervention plans must be individualized and designed for the purpose of enhancing the individual's quality of life, relationships with others, and ability to function as independently as possible. Such interventions shall actively include positive approaches, strategies and/or supports designed to establish or increase the person's adaptive (replacement) behaviors.

These home and community-based settings 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. Home Support (Per Diem) is reimbursed at multiple levels, i.e., 2-4 beds and 5-8 beds. There must be at least one staff person in the same setting as participants receiving services at all times (24/7) that is able to respond immediately to the requests/needs for assistance from the participants in the setting.

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

Additional qualities that comprise the service delivery of Level III Increased neurobehavioral Home Support (Residential Habilitation) Level III include an intensive neurobehavioral level of treatment. This service is for participants that have increased clinical and/or support needs relating to their behaviors associated with their brain injury. These are participants that are not typically successful without structured services in an individually tailored setting. These participants typically are not successful in group settings and therefore this service includes neurobehavioral treatment specific to the participant's needs. The rate for this service is all inclusive and therefore, includes the treatment of cognitive and behavioral needs for the participants as part of the rate.

This service is designed to reduce behaviors that limit the opportunities to maximize independence in a community-based setting. Services focus on engagement, awareness, and goal setting to promote stability and generalization of social competencies. Home Support (Per Diem) is reimbursed at multiple levels, i.e., 2-4 beds and 5-8 beds.

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

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

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

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Support-Per Diem Level III Increased Neurobehavioral

Provider Category:

Agency

Provider Type:

OADS Approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DSPs must successfully complete the Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS's approved Assessment of Prior Learning, or has successfully completed the Maine College of Direct Support within six (6) months of date of hire.
DSPs must have current CPR and First Aid Certification.
A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN), or otherwise has been trained to administer medications through a training program specifically for Family-Centered or Shared Living model homes and authorized, certified, or approved by DHHS.

*All staff must also possess a Certificate of Fundamentals of Brain Injury or Department approved training and Commission on Accreditation of Rehabilitation Facilities (CARF)-Home and Community Services, Residential Services and Brain Injury modules.

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.

The Provider Agency must have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)-Home and Community Services, Residential Services and Brain Injury modules.

Provider Agency must assure the following for individual DSP's:
* Be at least seventeen (17) years of age. A DSP who is 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. 17 year-olds will remain eligible for employment following their 18th year in the absence of an high school diploma, adult high school diploma, or high school equivalency credential (GED or HiSET), so long as they meet all other DSP requirements.
*A DSP who is eighteen (18) years of age or older must have graduated from high school or acquired a GED.

* All staff must also possess a Certificate of Fundamentals of Brain Injury or Department approved training
* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, Finance/Rate-setting, Licensing & Certification, OADS.

Frequency of Verification:

Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Non-Medical Transportation Services are offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan.
This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Non-Medical Transportation Services are authorized by the broker under a 1915(b) Me.19 Transportation waiver. Non-Medical Transportation services under the waiver are offered in accordance with the participant's service plan.
Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. Relatives and legal guardians may only be reimbursed by the broker if they indicate that they are unable to transport at no charge or there is no other viable option and there is a recommendation by the planning team.
A provider may only be reimbursed for providing transportation service when the cost of transportation is not a component of a rate paid for another service.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Broker

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Broker

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

The state's transportation services are managed through a 1915 b waiver run concurrently with this waiver. The transportation is managed through a broker. The broker's qualifications are those providers who were selected in the request for proposal process and who show documentation of their liability insurance, ability to obtain payment and performance bonds and meet other specifications as detailed in the request for proposal. The State verifies the Broker's qualifications through the RFP process and then through ongoing contract monitoring. The broker is enrolled with MaineCare.
The broker verifies the driver's qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Provider enrollment unit verifies that the broker is qualified. The broker verifies that the individual driver is qualified.

Frequency of Verification:

Provider enrollment verifies these qualifications upon enrollment and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Work Ordered Day Club House

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

These services specialize in treatment techniques for participants with acquired brain injuries. Providers of services develop and provide staff training, which focuses on the needs of individuals with an acquired brain injury identified in the Plan of care, and the specific manner in which this service will meet the participant's individual needs. The program focuses on adaptive skills and is distinct from work production objectives. These services are provided during the day through programs that are offered at facilities within the community. At the end of each day, the participant returns to his/her home.

The Work Ordered Day is designed to help individuals build skills specific to a work environment. In addition, they have the added benefit of the social engagement with others and relearning the interpersonal skills required to succeed in a work setting. This is often a barrier for individuals with brain injury in their process of returning successfully to a work environment. Having a Club House model allows for the individuals to relearn these skills in a safe and respectful environment. This is an evidence-based practice. The provider of the service focuses staff training specific to the needs of the participant as it relates to their acquired brain injury. This helps staff understand each participant and deliver the appropriate supports to the participant.

Work Ordered Day Club House is more closely approximate to day habilitation with an emphasis on building upon skills gained through the Club House model.

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

Participants may attend Work Ordered Day Club House 3 days a week, per diem (3-5 hours a day).

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Work Ordered Day Club House

Provider Category:

Agency

Provider Type:

OADS Approved Provider Agency

Provider Qualifications

License *(specify):*

Licensed Social Worker as licensed under MRSA title 32, ch 83.
Licensed Clinical Social Worker as licensed under MRSA title 32, ch 83.
Licensed Clinical Professional Counselor as licensed under MRSA title 32, ch 119.
Licensed Occupational Therapist as licensed under MRSA title 32, ch 32.
Licensed Neuropsychologist as licensed under MRSA title 32, ch 56.

Certificate *(specify):*

Certified Occupational Therapy Assistant as supervised by a Licensed Occupational Therapist (COTA).
Certified Therapeutic Recreation Specialist (CTRS).
Mental Health Rehabilitation Technician-Certified (MHRT-C).

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.

The Provider Agency must have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)-Home and Community Services, Residential Services and Brain Injury modules.

Provider Agency must assure the following for all staff:
*Minimum age of 18
* All staff must also possess a Certificate of Fundamentals of Brain Injury or Department approved training
* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, Finance/Rate-setting, Licensing & Regulatory services, OADS.

Frequency of Verification:

Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Work Support-Individual

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Work Support is direct support provided to improve a participant's ability to independently maintain employment. Participants are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid (by the employer) for the same or similar work performed by individuals without disabilities. Work Support must promote the participant's interaction with coworkers without disabilities and with integration into the workplace. The primary focus of this service is job-related and encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care. Work Support is provided at the participant's place of employment; it may be provided in a participant's home in preparation for work if it does not duplicate services already reimbursed as Home Support. The Work Support service is documented in the Person-Centered Service Plan and addresses the participant's health and safety needs in the workplace. A participant's essential personal rights of privacy, dignity, and respect, and freedom from coercion and restraint are protected.

This service is provided after a participant has received an assessment and services under the American with Disabilities Act, Section 504 of the Rehabilitation Act and need for ongoing support has been determined and documented in the Personal Plan. Documentation must be maintained in the file of each participant 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.).

Federal financial participation is not claimed for 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 aa supported employment program;
2. Payments that are passed through to users of a supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program.
This service is not available in Groups.

Work Support may be provided to self-employed participants where the participant requires support operating his or her own business. Support may be used for customized employment for participants with severe disabilities to include long term support to successfully maintain a job due to the ongoing nature of the participant's support needs, changes in life situation, or evolving and changing job responsibilities. Work Support does not include volunteer work.
The cost of transportation related to the provision of Work Support is a component of the rate paid for the service. Transportation to and from Work Support is provided under the transportation brokerage and only the transportation incidental to the provision of the service is a component of the service rate for Work Support.

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

64 units per week. Employment Specialist Services cannot be provided at the same time as Work Support Services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

OADS Approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DSPs must successfully complete the Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS's approved Assessment of Prior Learning, or has successfully completed the Maine College of Direct Support within six (6) months of date of hire.
DSPs must have current CPR and First Aid Certification.
A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN), or otherwise has been trained to administer medications through a training program specifically for Family-Centered or Shared Living model homes and authorized, certified, or approved by DHHS.
Supervisors shall be required to meet all of the requirements of the DSP position.

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

* All staff must also possess a Certificate of Fundamentals of Brain Injury or Department approved training.

Other Standard *(specify):*

Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

* Received additional approval from OADS for provision of waiver services as required in MIHMS.
Provider Agency must assure the following for individual DSP's:
* DSPs must be at least eighteen (18) years of age
* DSPs must have graduated from high school or acquired a GED

*All staff must also possess a Certificate of Fundamentals of Brain Injury or Department approved training
* Reportable Events Training
* Criminal Background Check

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, Finance/Rate-setting, Licensing & Certification, OADS.

Frequency of Verification:

Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

Appendix C: Participant Services

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

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

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

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

Provider agencies must conduct criminal background checks for prospective employees including DSPs, Personal Care Assistants/Personal Support Specialists, and Certified Nursing Assistants
State Police Background checks will be conducted by the provider prior to employment of the direct care worker. The Provider agency will verify that all staff have a criminal history check as required prior to enrollment and every two (2) years thereafter. For participants who self-direct, the FMS facilitates a criminal background check on behalf of the participant or representative for all prospective employees. The FMS also conducts background checks when the self-directing participant requires or chooses a representative. Division of Licensing and Certification (DLC), Office of Program Integrity (PIU), and OADS provide oversight through ad hoc audit and by complaint. For those providers who are licensed, DLC routinely looks at personnel records to ensure that the background checks are conducted on all direct care workers. Program Integrity reviews credentials and background checks when conducting investigations or reviews.

(Per CMS IRAI 9.13.23)

In accordance with Maine Statute, the Maine Background Check Center maintains a list of disqualifying offenses that adversely affect an individual's eligibility for employment as a direct access worker including the following:

A. Convictions or notations involving crimes or abuse related to a federally funded health care program or a state-funded health care program that mandate a disqualification from participation or employment with the program;
B. Substantiated findings that the individual has committed an act of patient or resident abuse or neglect, exploitation or a misappropriation of patient or resident property or other types of acts that the department may specify for purposes of protecting vulnerable individuals receiving care or services;
C. Convictions under federal or state law of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service;
D. Convictions under federal or state law of a criminal offense relating to the health and safety of vulnerable individuals receiving care or services;
E. Convictions relating to health care fraud in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program operated by or financed in whole or in part by any federal, state or local government agency or convictions of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct;
F. Convictions for a Class A, B or C crime in this State or similar crime in another jurisdiction for an offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance; and
G. Convictions relating to other federal or state laws, provisions of this chapter or rules adopted under this chapter that otherwise mandate an employment prohibition."

Additionally, 1.03-3 (B) Section 1, Ch I, General Administrative Policies and Procedures of the MBM establishes the conditions by which the state shall deny enrollment or subsequent enrollment of any individual or entity seeking to deliver MaineCare covered services.

MBM Section 18, Ch. II further specifies that:
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 with any victim;
D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any criminal conviction based upon 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.

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

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

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

Additionally, the provider will contact the Child and Adult Protective Services units within DHHS to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a substantiated incident of abuse, neglect or exploitation by a prospective employee, it is the provider's responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with regulation.

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

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

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

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

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

☐ **Self-directed**

☐ **Agency-operated**

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

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

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

For Transportation Services: Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge are utilized. Relatives and Legal guardians may only be reimbursed by the broker if they indicate that they are unable to transport at no charge or there is no other viable option and there is a recommendation by the personal planning team.
The Care Coordinator is responsible for ensuring the participant's health and safety needs are identified and for monitoring authorized services.

○ **Other policy.**

Specify:

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

Any person or entity showing interest in various MaineCare programs may enroll as a provider so long as all necessary qualifications are met, except for transportation 1915(b) brokers. The State has on-going open enrollment and State staff available to assist with the qualifications and enrollment process. OADS reviews and approves all provider applications. Provider recruitment is conducted by state DHHS staff. All provider requirements and procedures to qualify are on the Department's website. Verification that providers meet these requirements must be provided prior to enrollment. Additionally, Ch. I, Section 6 of the MaineCare Benefits Manual states, “To provide home and community-based waiver services, a provider must be enrolled in MaineCare as a provider by the Office of MaineCare Services, be in compliance with the Provider’s MaineCare Provider Agreement, and satisfy all provider qualification requirements set forth in the applicable HCBS waiver regulations.”

Additionally, Ch. I, Section 6 of the MaineCare Benefits Manual states, “To provide home and community-based waiver services, a provider must be enrolled in MaineCare as a provider by the Office of MaineCare Services, be in compliance with the Provider’s MaineCare Provider Agreement, and satisfy all provider qualification requirements set forth in the applicable HCBS waiver regulations.”
In addition, the provider agency must have:
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS)
2. Received addition approval from OADS for provision of waiver services as required in MIHMS Provider.
3. Copies of contracts or service agreements when the provider manages services delivered by another provider, thereby documenting the cooperative, affiliated service, or the subcontracting agreement. This agreement shall be updated and renewed at least annually.
4. Outlined the business structure in an organizational chart, identifying management, staff and other individuals compensated by the provider for assisting in the care of participant(s) and illustrating the supervisory responsibilities; include credentials as required for the service delivery.
5. Developed a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns, and volunteers.
6. Developed personnel policies that include a description of the education, experience, and training required for Direct Support Professionals, Supervisors, and Program Directors.
7. Maintained policies governing essential elements of service provision including but not limited to; Behavioral Regulations, Rights and Protection, Reports of Abuse, Neglect and Exploitation, Duration of Care, and Medication Management.
8. Developed written policies governing the development and maintenance of an effective quality management program to ensure quality service delivery consistent with federal and state laws and regulations.

(Per CMS IRAI 9.13.23)
In accordance with Maine Statute, the Maine Background Check Center maintains a list of disqualifying offenses that adversely affect an individual's eligibility for employment as a direct access worker including the following:

A. Convictions or notations involving crimes or abuse related to a federally funded health care program or a state-funded health care program that mandate a disqualification from participation or employment with the program;
B. Substantiated findings that the individual has committed an act of patient or resident abuse or neglect, exploitation or a misappropriation of patient or resident property or other types of acts that the department may specify for purposes of protecting vulnerable individuals receiving care or services;
C. Convictions under federal or state law of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service;
D. Convictions under federal or state law of a criminal offense relating to the health and safety of vulnerable individuals receiving care or services;
E. Convictions relating to health care fraud in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program operated by or financed in whole or in part by any federal, state or local government agency or convictions of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct;
F. Convictions for a Class A, B or C crime in this State or similar crime in another jurisdiction for an offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance; and
G. Convictions relating to other federal or state laws, provisions of this chapter or rules adopted under this chapter that otherwise mandate an employment prohibition.”

Additionally, 1.03-3 (B) Section 1, Ch I, General Administrative Policies and Procedures of the MBM establishes the conditions by which the state shall deny enrollment or subsequent enrollment of any individual or entity seeking to

deliver MaineCare covered services.

MBM Section 18, Ch. II further specifies that:
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 with any victim;
D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any criminal conviction based upon 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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and Percent of approved provider agency staff who meet license/certification requirements prior to the provision of waiver services. Numerator: Total number of approved provider agency staff who meet license/certification requirements prior to the provision of waiver services. Denominator: Total number of staff who are required to be licensed/certified.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
 # and % of clinicians providing occupational, physical, & speech maintenance therapy waiver services who are licensed/certified prior to the provision of waiver services. Num: Total number of licensed/certified occupational, physical, & speech therapists providing maintenance therapy services. Denominator: Total number of occupational, physical & speech therapists providing maintenance services.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
Number and Percent of qualified employed Direct Support Professionals (DSPs) or Personal Support Specialists (PSSs) serving waiver participants who have a background check prior to the provision of waiver services. Numerator: Total number of DSPs/PSSs who had a background check prior to provision of waiver services. Denominator: Total number of employed DSPs/PSSs.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of Personal Care Assistants/Personal Support Specialists who hold a valid certificate of completion of the PCA/PSS curriculum prior to the provision of services. Numerator: Total number of PCAs/PSSs with valid certificate prior to the provision of services. Denominator: Total number of PCAs/PSSs employed by providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of qualified employed Direct Support Professionals (DSPs) or Personal Support Specialists (PSSs) serving waiver participants who have an Adult Protective Services (APS) check prior to the provision of waiver services. Numerator: Total number of DSPs/PSSs who had an APS check prior to provision of waiver services. Denominator: Total number of employed DSPs/PSSs.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

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

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

Performance Measure:
Number and Percent of Direct Support (DSP's) who continue to meet ongoing training requirements. Numerator: Total number of DSPs completing ongoing training requirements. Denominator: Total number of DSPs required to complete ongoing training.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of Direct Support Professionals (DSPs) who have completed the DHHS-approved curriculum within 90 days from the date of hire. Numerator: Total number of DSPs completing curriculum requirement. Denominator: Total number of DSPs required to complete curriculum.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Participants will communicate concerns to their Community Care Coordinator, who will advise the participant of their options and assist with problem resolution as needed. The Community Care Coordination agency would contact the State operating agency if further assistance was needed. A participant can at any time change providers, complain or grieve an action of the provider agency, complain to Licensing (agency or individual), select a different service, involve advocates or file a formal complaint with the Department. The state ensures timely completed actions by timelines built into contract requirements and monitoring that the actions were completed. The care coordinator will document resolution in the participant's file.

The state, through the partnership between the Office of MaineCare Services and the Office of Aging and Disability Services (and with stakeholder review by the Maine Acquired Brain Injury Advisory Council) has reviewed waiver requirements for providers and had the following goals: expand the requirements for initial certification, mandate initial reviews that agency must pass prior to furnishing waiver services, scheduled certification review for all waiver providers and penalties for providers who fail to meet compliance standards, and audits of providers who provide Brain Injury services.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☒ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

A participant who receives Home Support-Per Diem Level III Increased Neurobehavioral cannot also receive Work Ordered Day Club House.

☒ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Each waiver participant must stay below the annual limit of $286,580.30. As outlined in Appendix B-2-b, the estimated annual cost of the Participant's services under the waiver is equal to or less than one hundred percent (100%) of a blended rate of the statewide average annual cost of care for individuals in ICFs and ABI NF units, as determined by DHHS (the blended rate being the sum of 20% of the statewide average annual cost of care in an ICF and 80% of the statewide average annual cost of care in a ABI NF unit), unless the Participant is authorized to exceed this limit pursuant to the Exceptions Process as outlined in Appendix B-2 of this waiver and/or other ADA modifications.

a. Because the annual limit applies to all services offered under this waiver, the participant works with the planning team to identify services and costs in the development of the waiver service plan. The participant is fully engaged in the budgetary process.

Additionally, as noted in Appendix B-2-b, the cost limit will increase on an annual basis proportionately to the scheduled Appendix J and I-2-a reimbursement rate increases to ensure participants do not lose access to eligible services as an unintended result of the scheduled rate increases.

b. The Department of Health and Human Services looked at historical claims costs and used averages as the limit for the services.
c. If utilization and unmet needs data indicate a need for changing the combined limit over the waiver period, and the financial situation allows, DHHS will consider making changes via amendment.
d. The Community Care Coordinator and planning team will work with the participant to make adjustments as necessary if there are such considerations. Safeguards could include referral to a State Plan service(s), referral to State-funded programs, or increased use of natural/informal supports. The individual budget amount is derived from the Mayo-Portland Adaptability Inventory and the Health and Safety Assessment. The Assessing Services Agency then identifies the services for which the participant is eligible, a planning process is initiated to identify choices, personal goals and planning needs. The final budget authority lies with the Department of Health and Human Services. The individual services and their caps are in the state promulgated rule for transparency.
e. Home Support or Personal Care is the one service that is most critical in responding to inadequacies of service in other areas of participants' lives. This service can serve as a buffer if the participant has issues with other services, the provider and the participant will work together to ensure health and safety.
f. Any limit(s) on services needed by a participant is discussed at the planning meeting and the plan is written accordingly.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

In January 2022, Maine promulgated Ch. 1, Section 6, Global HCBS Waiver Person Centered Planning and Settings Rule to ensure compliance with federal HCB Settings requirements.

At the time of application, OADS reviews the applicant's policies and procedures to ensure compliance with Maine's HCBS Global Rule. When the disability-specific/provider owned or controlled settings service location is identified the provider completes an HCBS Compliance Attestation form and is subject to ongoing monitoring via on-site reviews, desk level reviews or individual experience assessments.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☒ **Registered nurse, licensed to practice in the state**
- ☒ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

- ☐ **Social Worker**
  Specify qualifications:

- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

a. Care Coordinators shall meet with the participant prior to each planning meeting to provide the information that the individual needs so that they can lead the planning process as much as possible, make informed choices and decisions, and ensure conflict-free planning. The planning process must reflect the participant's cultural preferences and provide information in plain language that is accessible to the participant and, when applicable, his or her legal representative. The Care Coordinator will also document if the individual considered other settings, including non-disability specific settings.

b. The participant will determine the composition of the Planning Team. Additionally, the participant's guardian should have a participatory role, as defined by the Participant, unless state law confers decision-making authority to the legal guardian.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid

agency or the operating agency (if applicable):

To the extent services are a covered service under MaineCare, under the financial cap and ensure the health and welfare of the participant.
(a) The Care Coordinator develops and drafts the Person-Centered Service Plan (PCSP). The initial PCSP is developed before a participant starts services and is redeveloped by the planning team at least annually.
(b) The BMS99 (or the Department's current approved assessment) is completed annually to inform and support the development of the PCSP. The BMS99 addresses the participant's strengths, needs, and expressed preferences which are incorporated in his/her PCSP. The assessment identifies and summarizes the participant's medical, mental health, daily living skills, treatments/services/needs etc. as appropriate for the team's review.
(c) Prior to waiver enrollment, the OADS Care Monitor discusses with the participant and guardian (if applicable) what the participant wants and needs regarding services and supports, as well as what to expect. The OADS Care Monitor explores potential services offered through the waiver, Medicaid State Plan, and other community resources and natural supports that might meet the participant's needs. The OADS Care Monitor describes all services available, discusses options for qualified providers of the services, and emphasizes participant choice. Once on the waiver, the participant receives a Care Coordinator. The Care Coordinator reviews this information at least annually during the annual planning process and during the service monitoring process throughout the year.
(d) In accordance with Maine's Global HCBS Rule (MBM, Chapter I, Section 6), the Person-Centered Service Plan must reflect the services and supports that are important for the participant to meet the needs identified through an assessment of functional need, as well as what is important to the participant regarding preferences for the delivery of such services and supports.

The Care Coordinator undertakes a process of exploration and discovery to complete a comprehensive assessment of the participant utilizing "Charting the LifeCourse" tools embedded within the person-centered service plan. The resulting assessment and PCSP ensures the participant's goals for community living and the services and supports to support the goals are identified.

In order for the PCSP to be authorized, finalized and agreed to with informed consent of the Participant in writing, and meets the Participant's identified needs and goals, the PCSP must document signed approval by: (1) the Participant and guardian (as applicable), (2) the Care Coordinator, and (3) the individuals and providers responsible for the plan's implementation. The Care Coordinator will distribute the finalized PCSP to the Participant and other people involved in its planning and development.

(e) The Care Coordinator is the lead in assisting the participant and guardian (if applicable) in coordinating the services through the PCSP process. The planning process identifies natural supports, waiver supports, Medicaid State Plan and other generic community supports regardless of funding source. The PCSP documents all identified services and the Care Coordinator provides continuous and ongoing coordination and monitoring of service implementation.

The PCSP also identifies the providers selected by the participant to deliver services in accordance with the PCSP. Each chosen waiver provider, with the participant and guardian (if applicable), develops a service plan specific to the service to be delivered by the provider. The service provider then acts in a clerical manner and enters (or attaches) the service plan into the PCSP through a paper-based form. The Care Coordinator independently verifies with the participant and guardian (if applicable) the service plan is consistent with the needs and desires of the participant and documents agreement.
For all other waiver services, the Care Coordinator enters the service plan into the Person Centered Service Plan (PCSP) paper-based version as it was discussed and agreed upon during the planning team meeting.

(f) The PCSP lists the waiver services that are authorized for the participant which includes the amount, type, frequency, name of service provider, service funding source, and start/end dates of the service. It also lists generic services and natural supports the member receives. During the planning team meeting, the assignment of responsibilities is discussed and documented.
The Care Coordinator, participant and guardian (if applicable) are responsible for the day-to-day oversight, monitoring, and implementation of the PCSP. Minimally, and unless otherwise specified in the PCSP, the Care Coordinator meets monthly with the participant to review the PCSP implementation.

(g) The Person-Centered Service Plan must be reviewed and revised upon reassessment of functional need as required by 42 C.F.R. § 441.365(e), at least every 12 months, when the participant's circumstances or needs change significantly, or at the request of the participant or guardian (if applicable).
Changes in circumstance or need may include, but are not limited to: changes relating to the participant's physical, social,

behavioral, medical, communication, or psychological needs; or when the participant has made significant progress toward his or her goals.
The Care Coordinator must reconvene the Planning Team to revise and update the PCSP including the location where services are received. Planning meetings must be held both prior to and thirty (30) days subsequent to the planned move of a participant to a new service location in order to coordinate and to evaluate the participant's satisfaction with the change.
The revised PCSP, reflective of all changes, must be approved by the participant, guardian (if applicable), Care Coordinator, and any providers responsible for implementing the change within the PCSP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The State uses the Mayo-Portland Adaptability Inventory and a health and safety assessment developed to identify risks. The PCSP documents the participant's risks and needs as well as interventions and supports to mitigate any risks identified through the assessment process. Additionally, the PCSP planning team reviews any Reportable Events involving the participant over the past 12 months (including remediation, action steps, and outcomes). The PCSP must address any modifications to the rights articulated in the HCBS Global Waiver Persons-Centered Service Planning and Settings Rule, MBM, Chapter I, Section 6. Positive Support plans and any behavior management plans approved by the Review Committee are attached to the PCSP.

Along with the Participant, the planning team (consisting of paid providers and natural supports chosen by the Participant) identifies the risks and/or safety concerns for the Participant. The Planning Team develops, and documents strategies and backup plans targeted to mitigate the identified risks and safety concerns are reviewed with the PCSP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Choice of providers for waiver participants is assured by two complementary processes. The Office of Aging and Disability Services (OADS) maintains a provider directory on its website. Listing is voluntary and must be initiated by the provider and the Office of Aging and Disability Services (OADS) facilitates the posting. The directory is located at:

https://www.maine.gov/dhhs/oads/home-support/brain-injury/faq.html

This allows participants, families and other to search for providers within specific geographic areas and by service.

The other approach to offering choice is known as the "vendor call" process. Once a participant's team has made a service recommendation, the need is made known to all potential providers within any specified area. A brief de-personalized description of the person's needed services and any individualized specifications are sent to all providers via e-mail. Providers that express interest and have capacity to potentially support the individual, respond affirmatively and contact information is provided to the participant, family and/or Care Coordinator for follow up.

The website is on the choice letter as well as all correspondence with the participant. The Department will upon request mail a copy to a participant. The Department also has TTY by dialing 711.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Authority to approve individual service plans are delegated to OADS, the operating agency by MaineCare, the State Medicaid Agency.

The Person-Centered Service Plan (PCSP) lists the waiver services needed for the participant which includes the amount, type, frequency, name of service provider, service funding source, and start/end dates of the service. It also lists generic services and natural supports the participant receives. This section is reviewed by Office of Aging and Disability Services (OADS), the operating agency. Waiver services that are medically necessary, up to prescribed service caps, are authorized by OADS.

Additionally, OADS staff conduct a retrospective quality review of each Care Coordinator agency's PCSPs. The quality review evaluates whether PCSPs are being conducted consistent with “the Department’s standards” (VI.E) as outlined in Maine’s Person-Centered Planning Process-Instruction Manual.

The OADS Care Monitors review services and limits within the PCSP and approve the limits both annually and when there is any change in service.

OADS staff review a representative sample of all PCSPs from each individual agency provider during the agency’s re-certification process as an OADS-approved provider every three years.

Annually, the operating agency provides Quality Reports (that include appeals outcomes to assess trends in the fair hearings process and proper service planning) to the SMA. OADS and OMS meet quarterly specifically to review Quality Reports and identify trends that may require action. Additionally, OADS and OMS meet weekly to review and discuss operational aspects of the waiver to identify and address individual problems that may arise.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**

☐ **Other**
Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

A. Care Coordinators are responsible for monitoring the delivery and implementation of services and supports identified within the PCSP including ensuring the health, welfare and safety of the participant. Additionally, State Care Monitors review plans at least annually, for level of care renewal, and whenever a change in waiver services is proposed/requested.

B. There are regular reviews of each plan that are completed by the Care Coordinator. The focus of the reviews is on the needs and goals identified in the plan. The Care Coordinator supports the participant in obtaining and maintaining all waiver services and other non-waiver services identified in the plan. The Care Coordinator makes frequent checks, at minimum during 30-day face-to-face contacts, with the participant and his/her guardian to discuss whether the back-up plan is working, and makes modifications as needed until the full need is met/provider is identified. Care Coordinators use the reportable events system to assure the health, safety, and welfare of the participant. Upon identification of a service need, the Care Coordinator assists the participant in a vendor search to solicit interested, qualified providers. Through the on-going case management process, Care Coordinators and other members of the participant's service team address and coordinate a participant's access to non-waiver services in the service plan including health services. The State maintains the assessment information, Care Coordination contacts, monthly notes, participant medical information, to be aggregated at any point in time. If a problem is identified in relation to the participant, the Care Coordinator will assess the acuity and respond accordingly.

C. Unless otherwise specified in the PCSP, Care Coordinators make at least monthly contact with participants. At that time, they review the recommendations and progress to achieving the goals included in the personal plan. Identified problems can be addressed through MaineCare appeal when services have been reduced, denied, or terminated. The operating agency’s data and compliance team collects data and review of the Person-Centered Service plan. Quarterly, the Compliance Team selects a random sample of participants to review the current PCSP. This review ensures that all assessed needs (including health and safety risks) and personal goals have been addressed through waiver services or other means and that interim plans are in place for all unmet needs. Results of the analysis are shared with the Waiver Manager and the State Medicaid Agency.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and Percent of participant service plans that address all assessed health and safety needs as determined by the person-centered planning process. Numerator: Total number of participant service plans that address all health and safety needs as described by the person-centered planning process. Denominator: Total number of participant service plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of participant service plans that address participants' goals as indicated in the initial or annual assessment. Numerator: Total number of participant service plans that address participants' goals. Total number of plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
Number and Percent of all participant service plans that were updated on or before the participants' annual review date. Numerator: Total number of all participant service plans that were updated annually. Denominator: Total number of participant service plans.

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of all participant service plans that were revised due to a change in waiver participant's needs. Numerator: Total number of all participant service plans that were revised due to a change in waiver participant's needs. Denominator: Total number of participant service plans that required a revision due to a change in participant's needs.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and Percent of participants who receive services in duration and frequency

in accordance with the authorized care plan. Numerator: Total number of participants who received the services in duration and frequency in accordance with authorized care plan. Denominator: Total number of participants with authorized care plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of participants receiving the scope and amount of services as described in their authorized care plan. Numerator: Total number of participants with a paid claim receiving the scope and amount of services described in their care plan. Denominator: Total number of participant care plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of participants receiving the type of services described in their authorized care plan. Numerator: Total number of all participants with a paid claim for the service type as described in their care plan. Denominator: Total number of participant service plans reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:

Medicaid Claims Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and Percent of participants or guardians (as applicable) who signed the Choice of Waiver Services and Providers letter. Numerator: Total number participants or guardians who signed the Choice of Waiver Services and Providers letter. Denominator: Total number of waiver participants.

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

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

		Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Transportation is provided through a brokerage system in Maine, via a 1915b waiver. The transportation broker collects extensive data on performance measures for reporting on the 1915b waiver. The data will be provided to the 1915c waiver administrators for inclusion in the quality review process on an annual basis. Office of MaineCare Services and the program offices responsible for 1915c waiver administration will work together to discover, identify and remediate any problems as they arise.

b. Methods for Remediation/Fixing Individual Problems

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

An OADS staff member completes all initial care plans with participants and ensures the initial care plan meets the needs of the participant. Community Care Coordinators are then responsible to monitor implementation of the plan and update and modify as needed based on the participant's needs. OADS Staff and Community Care Coordinator engage with the participant in the person-centered planning process. If a problem is identified by the participant/guardian, the Community Care Coordinator is contacted and assesses the acuity of the problem. The Community Care Coordinator documents are communication regarding the problem and identified solution electronically in the participants record. Resolution occurs within 30 days. Reports are reviewed by OADS where corrective action planning is implemented at the agency level.

The state continues to conduct individual remediation and monitoring of all care plans as required by quality reporting standards. The state's Brain Injury Care Monitors, responsible for resource coordination and assuring participants on the waiver have care plans that address all health and welfare needs, review 100% of care plans in the State's electronic database system EIS. The State reconsidered the use of consumer satisfaction survey and instead relies upon review and data reporting from the participant's care plan as whether participant's needs are met.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The State will use the Fiscal Employer Agency (FEA) Employer Authority Model with budget authority for the delivery of self-directed services when the participant elects self-direction and provided there is sufficient support available to the participant as determined through the Person-Centered Service (PCSP) planning process. The participant or authorized representative functions as the employing authority and may hire, train, supervise and discharge their own workers. The participant chooses a Fiscal Intermediary (FI) to provide Financial Management Services (FMS) for both budget authority and employer authority. FMS is a minimum monthly service.

Additionally, depending upon which arrangement best meets the needs of the individual as detailed within the PCSP, participants have budget authority to manage and allocate funds according to clearly defined parameters set forth in a "fixed budget" or in a "flexible budget."

A fixed budget includes state-specified, direct vendor-purchased services for which the participant has only employer authority. The chosen FI pays the vendor who procures or delivers the service up to the monetary value of the authorized service. There is no flexibility in how the fixed budget is spent outside of the prior authorized amount.

A flexible budget includes state-specified services in which the participant has both employer authority and budget authority. The flexible budget arrangement allows the participant to exercise control over how their budget is spent on the services and supports needed to live in the community. The participant can determine the wages of Employees as well as the types of allowable and necessary goods and services under this flexible budget arrangement.

The process for developing the PCSP will not be different from that of traditional waiver services and must comply with the Global Person-Centered Planning and Settings Rule, MBM, Ch. I, Section 6.

The participant's support team will meet and develop the PCSP based on identified needs, expressed desires and preferences. The Care Coordinator will discuss the option of self-directed services and provide information about which services can be self-directed. Initially and annually thereafter, the Care Coordinator will utilize standardized written or electronic media materials about self-direction to inform the participant and guardian about available self-directed opportunities.

The person-centered service planning process will also determine if the participant, not subject to full guardianship, can self-direct independently or if they require an authorized representative. Care Coordinators will use a department-approved questionnaire and assessment tool to support the determination.

The Care Coordinator will submit the PCSP and a service authorization request to the Department for approval, based on Participant's documented goals and needs, that specifies the units of service assigned to each identified waiver service. The authorization request can include both traditional and self-directed waiver services.

Support Brokers provide information and assistance in support of self-direction to participants, including development of the person-centered service plan and skills training with issues related to being an employer, including worker recruitment.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

• Participants under full guardianship must have a representative acting on their behalf.
• Supports Brokerage and FMS are the minimum services for Participants to exercise Employer and Budget Authority in Self-Direction.
• PCSP process will support the participant to clarify and weigh options for self-direction including completion of a tool that will identify the need for a representative.
• Participants who wish to participate in self-direction, but who are unable or unwilling to function as the employing authority, may delegate related responsibilities to an authorized representative. The representative assumes all responsibilities as the employer on behalf of the participant but may not be employed as a direct worker.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Care Coordinator will discuss the option of self-directed services and provide information about which services can be self-directed. Initially and annually thereafter, the Care Coordinator will utilize standardized written or electronic media materials about self-direction to inform the participant and guardian about available self-directed opportunities.

During the planning phase of PCSP development, the Care Coordinator, at a minimum, will provide information about the benefits and potential liabilities associated with self-direction along with information about the participant's responsibilities when they elect to direct their services.

To promote informed decision making, the Care Coordinator must provide information regarding opportunities for self-direction during the PCSP planning process. This will allow the Participant sufficient time to weigh the pros and cons of self-direction and seek additional information, if necessary, before electing this option.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

If a participant requires or has selected a representative to direct services on their behalf, the representative may not also be paid to provide care to the participant. When a representative is directing a participant's services, the participant's guardian may not be paid to provide care to the participant.

A participant under guardianship can act as the employer of record, in name only for tax purposes, and have a representative (the guardian or a person the guardian appoints) complete the employer duties on their behalf (including signing timesheets and managing employer responsibilities).

The service provider must report to the Department when there is an allegation, assertion, or indication that any of the following have occurred with respect to a participant: Abuse, neglect, exploitation, unexplained death or a rights violation by an employee of or contractor, consultant, or volunteer for any program.

The service provider must report allegations of abuse, neglect, exploitation, or unexplained death to Adult Protective Services and other entities such as law enforcement as applicable.
The service provider must report complaints involving rights violations via the Department's Reportable Events reporting system.

The service provider must report incidents of a serious health and safety event such as an admission or assessment at an Emergency Department or hospital via the Department's Reportable Events reporting system.

At a minimum, the Care Coordinator must discuss and provide information in writing, to the participant, guardian, and Support Broker the procedures and contact information for filing a complaint during the annual person-centered planning meeting.

The Care Coordinator, Support Broker and FI must report to the Office of MaineCare Services Program Integrity Unit any complaints involving financial abuse, waste and fraud involving the Self-Directing participant, guardian or authorized representative or any entity funded through a self-directed budget. The FI must notify the Care Coordinator, and Office of Aging and Disability Services, which will result in a review and plan (as needed) for the participant's immediate health and safety as a result of these allegations. At a minimum, the FI is required to provide information and education on financial abuse, waste and fraud to the participant and representative (as applicable) and Support Broker on an annual basis for reporting to Program Integrity.

Non-legal representatives may not be paid to provide any waiver service to the participant or be paid to act as a representative.

The Fiscal Intermediary and Support Broker, as the monitors of the participant-directed budget, provide support to prevent depletion of funds associated with overutilization and address potential service delivery problems associated with underutilization. The Care Coordinator, as the monitor of health and safety and participant rights, ensures the employer of record (when not the participant) functions in the best interest in meeting the goals and outcomes within the PCSP.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Assistive Technology	☒	☐
Home Support- 1/4 hour-Level I	☒	☒
Individual Goods and Services	☒	☒
Supports Brokerage	☒	☐

Waiver Service	Employer Authority	Budget Authority
Financial Management Services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services (FMS)

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Supports Brokerage and FMS are the minimum services for a Participants to exercise Employer and Budget Authority in Self-Direction. As part of the PCSP process, the Care Coordinator will discuss Self-Direction to include a discussion and written information (as requested) regarding the availability of providers of FMS and Supports Brokerage.

Any willing and qualified provider may enroll as an FMS agency providing FI services. DHHS or its Authorized Entity requires agencies to provide high quality services that, at a minimum, meet the expectations of the participants who utilize those services. Entities must be approved by OADS and enrolled in MaineCare in accordance with regulations outlined in Ch II, Section 18 and Ch I, Section 1 of the MaineCare Benefits Manual.

Prospective FMS agencies must meet expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, quality management, and compliance with all HCBS Settings requirements. OADS may authorize agencies to deliver FMS after an application, along with supporting documentation, has been submitted for review and approval.

As part of the provider application process, in addition to the above, prospective FMS entities must demonstrate a proven ability to provide customer service to participants and the Department. This includes, but is not limited to, the use of an electronic platform offering electronic communication ensuring effective and privacy-protected exchanges regarding health information or other program and/or participant-specific information necessary for the participant to engage in and access Self-Directed Services.

Finally, the FMS provider must comply with Federal Internal Revenue Service Codes and procedures in matters related to the employment of support workers.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment for the FMS is through MMIS. The FMS is paid a set per person/per month rate for their fiscal management services.

Financial Management Service (FMS) delivered as a waiver service by a qualified Fiscal Intermediary (FI) includes performing financial transactions on behalf of the Participant to ensure the Participant and authorized Representative effectively carry out their responsibilities under the Employer Authority with Budget Authority state-selected model for Self-Direction.

At a minimum, the FMS must deliver the following supports to the Self-Directing Participant or Representative (when involved):

Employer authority: (minimum supports)
- Assist the participants in verifying employee's citizenship status and completing the necessary background checks
- Collect and processes timesheets of the employees approved by the participant or authorized representative
- Process payroll, withholding, filing and payment of applicable federal, state and local employment- related taxes and insurance

Budget Authority: (minimum supports)
- Maintain a separate account for each participant's budget
- Track and report payments made and balances of participants self-directed funds
- Provide participant with reports of expenditures and the state of the participant’s self-directed budget

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-**

related taxes and insurance

☒ **Other**

Specify:

Assists with criminal background check of workers, including OIG check.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other services and supports**

Specify:

The FI must ensure the employer (participant or representative) is aware that they may negotiate a stipend or wage adjustment to assist the employee with costs of procuring their own benefits, such as healthcare coverage. The Department does not require employers to offer health insurance coverage.

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

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other**

Specify:

Demonstrate evidence of satisfactory customer service to participants including but not limited to options for electronic communication.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS agency is subject to the current processes for oversight, monitoring, and financial integrity assurances enumerated in Appendix I-1 of this waiver amendment, including integrity at the individual level and overall MaineCare integrity.

As noted, agency billing for delivered services requires medical eligibility, financial eligibility, the PCSP and the service authorization. Claims are rejected for any date where both medical and financial eligibility are not in place or when the PA does not match the individual classification code assigned.

The state Medicaid program is subjected to an annual Single State Audit by the Office of the State Auditor on all programs by a State auditor and the Program Integrity Unit, a separate agency from the Office of the State Auditor, also conducts continuous and ongoing audits triggered by anomalies related to claims as well as complaints/inquiries made directly to the PIU.

The Operating Agency also oversees and monitors FMS entities through review of quarterly complaint logs, reports, annual surveys, as well as ad hoc reviews and inquiries based on complaint. The annual survey to participants who choose self-direction includes questions related to experiences of the participant with the FMS.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

During the planning phase of PCSP development, the Care Coordinator, at a minimum, will provide information about the benefits and potential liabilities associated with self-direction along with information about the participant's responsibilities when they elect to direct their services.

Information on self-direction must be provided on a timely basis to permit informed decision making by the participant, allowing sufficient time for the participant to weigh the pros and cons of self-direction and obtain additional information as necessary before electing this option.

Supports Brokers deliver support and information to ensure that the Participant understands the responsibilities involved with Self-Direction. Duties of the Supports Broker include coaching and advising the Member about the responsibilities of being an employer, managing their personal budget, or implementation of their PCSP.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Career Planning	☐
Assistive Technology	☐
Work Ordered Day **Club House**	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Non-Medical Transportation	☐
Home Support- 1/4 hour-Level I	☐
Home Support- Remote Support	☐
Home Support-Per Diem Level III Increased Neurobehavioral	☐
Individual Goods and Services	☐
Home Support-Per Diem Level II	☐
Supports Brokerage	☒
Financial Management Services	☒
Care Coordination	☒
Work Support-Individual	☐
Employment Specialist Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

In accordance with Title 34-B §5466, participants are entitled to have access to an advocate. Care Coordinators must ensure participants are aware of this entitlement prior to the planning meeting to allow for inclusion of an advocate if the participants so choose.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily

terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant or a representative chooses to stop self-direction, the Care Coordinator or FI will assist the participant in accessing self-direction through the appointment of another representative or services through the traditional agency model, whichever is appropriate. All efforts will be made to transition the person without any gap in service.

If the Participant decides to move forward with terminating Self-Directed Services, the Case Manager is responsible for arranging agency-directed services and supports in the short term while a long-term plan is developed.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If a participant or representative fails to hire an employee, or if the participant or representative is unable to manage their employees with program requirements, the use of self-direction may be involuntarily terminated for that participant.

Additionally, a participant who overutilizes and schedules employees more hours than the authorized budget can cover, may receive a written warning from the Department. The written warning may include a requirement to receive increased assistance from the Support Broker to remedy the contributing factors leading to overutilization. Upon the third occurrence within a twelve-month period, the Department may issue a notice of suspension or termination of the option to self-direct.

If the State terminates the ability to self-direct for a waiver participant, the Care Coordinator will assist the participant in accessing services through the traditional agency model, or if appropriate through a representative or a change in representative. All efforts will be made to transition the person without any gap in service. The Department will issue due process, when the option is involuntary, allowing the participant to access a fair hearing regarding the decision to terminate this service delivery option.

The Case Manager is responsible for arranging agency services and supports in the short term while a long-term plan is developed.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		0
Year 2		0
Year 3		0
Year 4		27
Year 5		32

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The background check and criminal history checks are completed by the Fiscal Intermediary. This function is reimbursed as part of the established per Participant/per month reimbursement rate.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☒ **Other**

Specify:

In order to fulfill their employer responsibilities, the FI makes skills training available to the Participants and Representative. The FI will make available skills training to the participant and/or representative in advance of conducting the employer functions including recruiting, hiring, orienting and training, supervising, or discharging employees.

In collaboration with the FI, the participant or representative, as applicable, will recruit and hire prospective staff once the FI has verified that the employee is eligible for hire. The participant and/or representative must also set the standards for orienting and training newly hired employees to assure that the employee meets the individualized needs of the Member and demonstrates competency in all required tasks. The participant and/or representative must maintain employee orientation and training documentation such as: CPR and First Aid certification cards, as well as a record of disability-related training for each staff member.

Direct Support Workers may be friends or family of the participant, including their spouse or the legal guardian. If a participant requires or has selected a representative to direct services on their behalf, the representative may not also be paid to provide care to the Member. When a representative is directing a participant's services, the participant's guardian may not be paid to provide care to the participant.

The participant, with the assistance of a Support Broker, will have the ability to hire staff that meet provider qualifications as verified by the FI, establish the rate to be paid, use budgeted dollars to pay for additional hours of service if necessary, and utilize the Individual Goods and Services as outlined in the service description.

Annually, the Support Broker will provide information for the participant, representative (as necessary) and direct support workers information on and how to report abuse, neglect and exploitation to include using the self-directed incident reporting form.

The staff member’s rate of pay must be within the minimum wage and no more than two hundred (200) percent of the minimum wage set by the State of Local Authority.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in**

Appendix C-1/C-3

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☒ **Other**

Specify:

The participant and/or designated representative approve self-directed employee electronic timesheets for services rendered by use of the FMS web portal, or by providing signatures on paper timesheets. Electronic Visit Verification is required unless an exception is available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Care Coordinator will develop a service authorization with units of service assigned to each waiver service based on the goals and needs identified in the PCSP. The participant's annual budget is calculated by converting the units of service to a total dollar amount. The Care coordinator submits the participant's budget to the Department for final approval and communicates final approval to the participant, the representative (as applicable), and the Support Broker. Budgets that do not include the costs of Financial Management Services and Support Brokerage will not be approved.

The participant's Self-Directed Services, when converted to a dollar amount, must sufficiently meet the budget requirements for payment of Financial Management Services and Supports Brokerage, as noted above. The Care Coordinator deducts the monthly expenditures for mandatory FMS (per member/per month reimbursement rate) and Supports Brokerage (quarter-hour fee-for-service, monthly minimum reimbursement rate) Services. The participant and/or representative, in collaboration with the Support Broker and FI, will develop a spending plan from the remaining budget amount using the Department-approved Spending Plan Tool. Based on the service authorizations and approved individual budget, the participant may choose any combination of traditional, Provider-Managed Services and/or Self-Directed Services, determine staff wages, and plan for the use of conserved funds/Goods and Services.

Any budget dollars not subsumed by authorized units or saved through wage negotiations or tax changes can be applied to the Individual Goods and Services identified by the participant.

The Support Broker ensures the participant’s self-directed services meet the minimum health and well-being needs as identified through the PCSP planning process. A participant may not “cash out” their services for the sole purpose of using Individual Goods and Services.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Care Coordinator shall submit the participant's budget to the Department for final approval and communicate final approval to the participant/authorized representative and the Support Broker.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

With full budget authority, the participant is allowed to modify the frequency and amount of currently approved services within the established annual budget amount without prior approval or updates to the Service Implementation Plan or the PCSP. The FI will ensure the changes are allowed and fall within the Participant's authorized annual budget, and reflect the changes in the established budget on record.

Examples of allowable changes without prior approval may include adjusting hours of direct support services on any given day/week to meet individual needs, accessing a different vendor (i.e. a transportation company such as Uber or Lyft) under the Goods and Services budget limit for an approved purchase identified in the Participant's plan, or changing allowable Goods and Services when the participant's need for additional or alternate items/equipment/services dictate.

Alternately, both the SIP and PCSP must be updated and signed when the participant and/or representative wishes to modify the budget by adding new waiver services or increasing hours of service that would require a new or updated authorization for services. The Care Coordinator, in collaboration with the representative (when applicable), Support Broker, and FI, will support the participant to reflect these changes within the PCSP and secure necessary authorizations.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Supports Broker, Care Coordinator, and Fiscal Intermediary will work in conjunction to ensure the PCSP identifies the mix of services (employment, State Plan, Provider-Managed Services and Self-Directed Services) and natural supports to maximize the participant's flexible individual budget of Self-Directed Services.

A participant must use personal funds or access another funding source (through this benefit or the state plan) to purchase services, equipment, or supplies when available. When the participant does not have personal funds or funding through another source, the participant may access funds available in the participant-directed budget. The participant and/or representative, and FI must attest, using the Department-approved form, that the selected Goods and Services fall within the federal requirements for the same.

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

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

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

A participant who overutilizes and schedules employees more hours than the authorized budget can cover, may receive a written warning from the Department. The written warning may include a requirement to receive increased assistance from the Support Broker to remedy the contributing factors leading to overutilization. Upon the third occurrence within a twelve-month period, the Department may issue a notice of suspension or termination of the option to self-direct.

The FI or Supports Broker will review monthly expenditures and can provide reports and information to the Participant as needed regarding the Participant's real-time account balance of available funds, or use of funds over time, etc.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

A representative of the operating agency (OADS) who is assigned to meet with members who may be applying for the waiver, provides written information on Grievance and Appeals processes which include how to request a hearing. Care Coordinators provide the same written information to participants/guardians during annual service planning (which is then documented in the Person Centered Service Plan). All written notices that reduce, terminate, or deny services to any participant include written information on Grievances and Appeals processes.

The Department of Health and Human Services mails or delivers in person written notice when there has been a denial, termination, suspension or reduction of eligibility for MaineCare or covered services. DHHS's Office of Family Independence (OFI) sends notices regarding MaineCare eligibility; the Office of Aging and Disability Services (as well as the Assessing Services Agency) mails out level of care determinations; and OADS mails out notices of any reduction, denial, or termination for covered services.

Specific information that must be in this notice includes:
• A statement of the intended action;
• An explanation of the reasons for the action, as well as a specific citation to the underlying state or federal regulations that support the action;
• A statement that the participant has a right to a hearing;
• An explanation of exactly how to obtain a hearing;
• A statement that a participant may be represented by legal counsel, relatives, friends or a spokesperson and a list of selected legal service providers available to assist the participant in arranging for legal counsel;
• The name and telephone number of the person who should be contacted, should the participant have questions regarding the notice; and
• An explanation of the circumstances under which medical eligibility for MaineCare or covered services are continued if a hearing is requested.
Additionally, the following is copied from: Chapter 1, MaineCare Benefits Manual, General Administrative Policies and Procedures. Notices requesting fair hearings are kept in the Medicaid Agency's Health Care Management Unit.

1.22-3 Procedure to Request an Administrative Hearing

A member may request an administrative hearing if he or she is aggrieved by any Departmental action that may deny, terminate, reduce, or suspend services provided by MaineCare. The Department may respond to a series of individual requests for a hearing by conducting a single group hearing. Members must follow the procedures described in this section when requesting an administrative hearing.

A. A member or his/her authorized representative may request an administrative hearing.
B. Unless otherwise specified in this Chapter, a request for an administrative hearing must be received within sixty (60) calendar days of the date of written notification to the member of the action the member wishes to appeal.
C. Unless otherwise specified in this Manual, the request must be made by the member or his or her representative, in writing or verbally, to: MaineCare Member Services, P. O. Box 709, Augusta, ME 04332, or an address otherwise specified by the Department in a written notice, for a hearing with the Office of Administrative Hearings, Department of Health and Human Services. For the purposes of determining when a hearing was requested, the date of the hearing request shall be the date on which the request for a hearing is received by MaineCare Member Services. The date a verbal request for an administrative hearing is made is considered the date of request for the hearing. MaineCare Member Services may also request that a verbal request for an administrative hearing be followed up in writing but may not delay or deny a request on the basis that a written follow-up has not been received. MaineCare Member Services shall send a fax or copy of all hearing requests to the Director of MaineCare Services, and to the Office of Administrative Hearings, within one (1) business day of receiving the request.
D. The hearing will be held in conformity with the Maine Administrative Procedure Act, 5 M.R.S.A. §8001 et. seq. and the Department's Administrative Hearings Regulations.
E. The hearing will be conducted at a time, date and place convenient to the parties and at the discretion of the Office of Administrative Hearings, and a preliminary notice will be given at least ten (10) calendar days, from the mailing date. Shorter notice may be given in order to comply with provisions of Section 1.14-1 governing denials of mental health services. In scheduling a hearing, there may be instances where the hearing officer shall schedule the hearing at a location near the member or by telephone or interactive television system.
F. The Department and the member may be represented by others, including legal counsel and may have witnesses appear on his or her behalf.
G. An impartial official will conduct the hearing.
H. The hearing officer on his or her own motion or at the request of either Department representatives or the member may request or subpoena persons to appear where that person can be expected to present testimony or documents relating to the issues at the hearing. The cost of the subpoena shall be borne by the Department.

I. When a medical assessment as defined in 42 CFR § 431.240 (3) (b) by a medical authority other than the one involved in the decision under question is requested by the hearing officer or the participant, and considered necessary by the hearing officer, it will be obtained at the Department's expense, and forwarded to the participant or the member's representative and hearing officer allowing both parties to comment.
J. When the member, the Department, or an Authorized Agent of the Department requests a delay, the hearing officer may reschedule the hearing, after notice to both parties.
K. The decisions, rendered by the hearing authority, in the name of the Maine Department of Health and Human Services will be binding upon the Department, unless the Commissioner directs the hearing officer to make a proposed decision reserving final decision-making authorization to him or herself.
L. Any person who is dissatisfied with the hearing authority's decision has the right to judicial review under Maine Rules of Civil Procedure, Rule 80C.

FOR MORE INFORMATION WRITE OR CALL Maine Department of Health and Human Services Office of Administrative Hearings 35 Anthony Ave 11 State House Station Augusta, ME 04333-0011 TEL: (207)624-5350 FAX: (207)287-8448 TTY: 211(Hearing Impaired)

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

14-197 C.M.R. ch. 8: Rule Describing Grievance Process For Persons with Intellectual Disabilities and Autism Spectrum Disorder or Acquired Brain Injury describes the process by which persons with Intellectual Disabilities, Autism Spectrum Disorder or Acquired Brain Injury, who are receiving services or supports from the Department, can seek to enforce their rights or process their grievances. The Office of Aging and Disabilities Services, Developmental Disability and Brain Injury Services operates the grievance process that is specific to persons with Acquired Brain Injury

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that

participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) The nature of grievances/complaints addressed by the system are related to the action or inaction of (1) the Department, or (2) an individual or agency providing services or supports to a person with Acquired Brain Injury; or a complaint which alleges either (1) a violation of the person's rights or (2) the person's dissatisfaction with present services or supports. The link to 14-197 C.M.R. ch. 8 is https://www1.maine.gov/sos/cec/rules/14/197/197c008.docx
b) The Department has established three levels of grievance resolution. These are described below: Level I provides an opportunity for the person and his/her Care Coordinator to attempt to resolve the issue informally within a period of 16 calendar days. If the grievance cannot be resolved, the Care Coordinator shall refer the grievance to the OADS Program Administrator, Level II grievance. Level II provides an opportunity for the OADS Program Administrator to participate and attempt to resolve the grievance within thirty (30) calendar days. If OADS identifies resolution of the Grievance, OADS will propose such resolution in writing twelve (12) calendar days. If the Grievant responds within twelve (12) calendar days, OADS shall issue a decision stating the Department's position on the Grievance within twelve (12) calendar days from the date by which the response was due. If there is no resolution the grievance proceeds to Level III Resolution _ Formal Administrative Hearing. At Level III, the participant has twelve calendar days of receipt of the decision or OADS' failure to issue a decision as required to make the request for a Formal Administrative Hearing and the OADS Program Administrator forwards the request within five (5) days to the OADS Central Office. Within the next ten (10) calendar days it is sent on to the Hearings Unit.
c) see information at the link above
In addition to the grievance process above, when participants are denied a service or receive a reduction in services, they are notified of their rights to request a fair hearing.

The Office of Aging and Disability Services maintains information regarding the grievance and fair hearings processes, including plain language documents regarding the grievance process and hyperlinks to the Fair Hearing process, on their public-facing website at the following link:
https://www.maine.gov/dhhs/oads/home-support/disability-with-autism/grievance-process.html.

Additionally, when a provider is made aware that a Person Receiving Services has a Grievance, the Provider must document the Grievance. Providers must make reasonable efforts to resolve Grievances and disputes as they arise and shall have up to ten (10) calendar days to resolve any Grievance or dispute. The Department may require Providers to maintain written policies and procedures for Grievance Resolution. If the Grievance has not been resolved within ten (10) calendar days, the Provider shall notify the person's Care Coordinator in writing, who shall in turn document the Grievance in the person's record and commence the Department's Level I Grievance resolution process described above.

When a participant elects to file a grievance or make a complaint, the participant is informed that doing so is not a pre-requisite or substitute for a Fair Hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In accordance with 14-197 C.M.R. Ch. 12, Reportable Events System, all waiver service providers must inform OADS of certain events known as Reportable Events within 1 business day of the event.

Further, 14-197 C.M.R. Ch. 12, describes each incident type, reporting requirements, follow-up and timeliness of reporting. All reportable events are considered significant events which require reporting to OADS within 1 business day. Reportable events include: death, suicide attempt, suicide threat, emergency department visit, planned or unplanned hospitalization, medication error, medical treatment outside of a hospital setting, serious injury, lost or missing individual, physical plant disaster, law enforcement intervention, transportation accident, physical assault, emergency restraint, and rights violation. Required reporters include any individual involved in the support of an individual receiving services, including, but not limited to mandated reporters.

Waiver service providers or the OADS Incident Data Specialists (IDS) enter reportable events directly into an electronic database system. OADS expects all providers to conduct follow-up reviews on all reportable events to determine and record the cause of critical incidents and develop strategies to reduce or mitigate the risk of future occurrences.

Additionally, all waiver service providers are mandated reporters, required to report all known or suspected incidents of abuse, neglect, and exploitation of incapacitated or dependent adults, including individuals with intellectual disabilities or autism and individuals with acquired brain injury directly to Adult Protective Services (Maine Revised Statues Title 22, Ch. 958-A, Adult Protective Services Act and 10-149, C.M.R. Ch. 1, Adult Protective Services System). All reports of abuse, neglect and exploitation are currently entered into the APS data system, called Evergreen, which tracks referral, investigation, and substantiation. OADS offers training to providers on mandatory reporting and adult protective investigations.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

OADS Intake Staff provide information that is understandable and accessible to participants regarding rights and protections including the Department’s Adult Protection Services intake line and online reporting information. Care Coordinators provide the same information during initial and annual service planning or more frequently when the participant’s needs dictate.

Additionally, Care Coordinators must inform participants concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives) can notify appropriate authorities. Alternately, the Care Coordinator informs the participant and guardian (if applicable) of the availability of information through Adult Protective Services or the statewide Crisis hotline.

Training is available through Disability Rights Maine (DRM) and local Self-Advocacy Groups. DRM’s training specific to Behavior Rights and Regulations and supported decision making is reserved for members, families and guardians. However, DRM also offers training through the State Education Training Unit available to the general public.

Adult Protective Services offers in-person trainings state-wide multiple times each year on red flags of abuse, neglect, and exploitation and how to report to APS. An APS Mandated Reporter online training is also available on the State’s website, which includes a quiz and a certificate of completion based on successful completion of the quiz. See, Adult Protective Services and Guardianship - https://www.maine.gov/dhhs/oads/aps-guardianship/index.html
Additionally, the website listed above also includes training and information concerning protection from abuse, neglect and exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives

reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Office of Aging and Disability Services is launching a new electronic client database system called “Evergreen”. Evergreen will have the capacity to allow OADS to track progress on the performance measures included in this waiver. It is anticipated that the migration of data currently housed in EIS will be completed in Spring 2024. Providers are currently receiving training in the entry and use of the new case management database.

According to current practice, each District’s Operating Agency Quality Review Team reviews all reportable events, daily. The reports are initially reviewed by the QA Supervisor who triages the event using the event triage tool. Composite scores of the triage tool are used to guide further action. Events scoring a composite 9 or above are referred for progressive corrective action. Events scoring 4-8, or meeting other criteria (prior Deficiency of same type identified, etc.) may also be referred for progressive corrective action. The events are then forwarded to the QA Caseworker for review that may include either a desk or site review.

Additionally, in screening events, quality workers assure proper referrals are made in circumstances where abuse, fraud, or violation of rules governed by other bodies are detected. Rights violations are reviewed and addressed by Disability Rights Maine. All events concerning rights violations and restraint are also reviewed by the Disability Services Crisis Case Managers.

Rights violations are reviewed and addressed by Disability Rights Maine. The Brain Injury Care Monitor review may include either a desk or site review.

Policies are in place to protect individual rights concerning the use of restraint and restrictive interventions, MBM, Chapter 1, Section 6.

All reports of rights violations and the use of restraints are sent the state’s protection and advocacy agency, Disability Rights Maine (DRM). DRM has access to the reportable events system and records the action taken with respect to rights violation and the use of restraints.

Other matters that are categorized as rights violations are sent to DRM. As required by contract, DRM completes a preliminary investigation of reports tagged to advocacy to determine whether it warrants further investigation as a possible rights violation, should be closed out or referred to another entity for further review/follow up (e.g., APS referral).
All medication errors that result in serious injury are entered into the state’s database systems as a reportable event. Reportable events are monitored and reviewed by the BI Care Monitors.

Adult Protective Services (APS) is responsible for all investigations of abuse, neglect and exploitation. APS shall document all steps taken to collect facts to reach a finding, including dates of phone calls, interviews, site visits, and document reviews. Subject to the confidentiality provisions of 22 M.R.S. §3474(2)(A), when APS receives a report that a person is suspected of Abusing, Neglecting, or Exploiting an Incapacitated or Dependent Adult, APS shall immediately report the suspected Abuse, Neglect, or Exploitation to the appropriate district attorney’s office, whether or not APS investigates the report.

Adult Protective Services reviews, prioritizes, and investigates reports in accordance with 10-149 C.M.R. ch. 1. Reports of abuse, neglect, and exploitation are received by APS Central Intake via a 1-800 number, email, fax, and an online form. Mandated reporters are required to call the 1-800 number to make reports in accordance with 22 M.R.S. § 3477. APS Central Intake receives reports 24/7. Summary information on all APS reports that are screened in is forwarded to the DA’s Offices for the counties were the client(s) reside.

Based on prioritization, an APS Investigation may begin on the date the Report is received through APS Central Intake and will begin no later than five (5) business days from the date the Report is received. Final written findings shall be entered into the electronic APS system by the assigned APS Caseworker no later than thirty (30) days from the date of assignment to the APS Caseworker. In the event an APS Investigation cannot be completed within thirty (30) days of assignment, the APS Caseworker shall document the reasons and estimate the number of days needed to complete the investigation in writing. An APS Supervisor shall review and approve the APS Investigation extension and document same. Any necessary subsequent extensions shall be reviewed and documented through the same process.

When APS issues a Substantiation finding against an individual, the individual shall be notified in writing including the potential consequences of the Substantiation. A Substantiation notice shall be accompanied by a written notice to the

individual of the right to appeal the Substantiation finding to the Department's Administrative Hearings Unit. The written notice shall include a summary of the substantiation findings, information on the appeal process, and information on the right to request an expedited hearing.

When an individual who is found Substantiated by APS exercises the right of appeal, the hearing on the appeal shall be scheduled as soon as possible but no later than sixty (60) days after the appeal request is made, unless he or she requests an extension. The individual who was Abused, Neglected, or Exploited, his or her guardian if applicable, and Disability Rights Maine shall receive notice of the hearing and may request the status of an intervenor at the hearing.

In all APS Investigations, information related to the Investigation and the outcome of same may be shared with participants, family or legal representatives and other relevant parties in accordance with the confidentiality requirements outlined in 22 M.R.S. § 3474 and processes specified in 10-149 C.M.R. ch. 1.
Similarly, as noted above, within 5 business days from receiving the report of a rights violation, DRM contacts the individual who is the subject of the reportable event and works with the individual to produce a positive outcome.

Please see attached rules governing the Adult Protective System.
https://www1.maine.gov/sos/cec/rules/10/149/149c001.docx

All participant deaths are forwarded to APS Central Intake by IDS upon receipt of a death summary in the Critical Incident Management system. APS Central Intake routes each report of member death to the district office in the county where the member resided. An APS supervisor reviews the report, makes follow up calls as needed, and, if the information gathered suggests that the death may have been connected to or due to abuse, neglect, or exploitation, the supervisor contacts law enforcement (if not previously contacted) and the Office of the Chief Medical Examiner and assigns the case to a caseworker for further investigation.

The State has expectations for both providers and Care Coordinators regarding the processes and timeframes for responding to Reportable Events. Providers are required to complete a reportable event internal review and remediation for each and every reportable event. The Internal Review may involve, but is not limited to, the following: Communication with the individual receiving services, communication with any witnesses to the reportable event, survey of the area where the reportable event occurred and communicate with the individual receiving services' Care Coordinator to determine the cause to the reportable event and to identify remediation steps to prevent or reduce future recurrences.

Provider Follow-Up Reports are due within 30 calendar days of the reportable event.

In addition to APS and DRM, the Division of Licensing and Certification, the Office of Attorney General, Health Care Crimes Unit, and state and local law enforcement agencies conduct investigations when warranted depending upon the severity of the case. Finally, individual provider agencies will typically conduct and document an internal investigation process that is distinctly maintained outside of the participant's records.

The Provider Follow-up Report is submitted through the reportable events system and attached to the record of the individual receiving services. The Provider Follow-up Report includes the following information: The date and time of the reportable event and, if the reportable event is reported more than one business day from the time of the reportable event, an explanation for the delay in reporting; a summary of the circumstance that resulted in the reportable incident; an outline of any remediation steps that were taken following the event to prevent or decrease recurrence; the date of any implementation steps; the party or parties responsible for implementing remediation action steps; an explanation as to why no remediation action steps are necessary, if appropriate. The Provider Follow-Up Report is submitted within 30 calendar days of the event.

Each business day, Incident Data Specialists (IDS) review and route reportable events electronically to the appropriate entity based on type of incident. Assigned Care Coordinators are alerted when a reportable event is logged for an individual receiving services. Providers are required to conduct an administrative review within 30 days of a reportable event to discover the cause of the event and implement any actions to either reduce or prevent recurrence. These efforts are documented on the Provider Follow-up Report and attached to the record of the individual receiving services. The Care Coordinator reviews the reportable event and consults with the provider to discuss remediation action steps being considered and ensure the individual/guardian have input into the action steps to either reduce or prevent recurrence. The Care Coordinator also makes changes to the person-centered plans, if appropriate. The Care Coordinator documents this

contact in the participant's record, attached to the Reportable Event.

OADS has developed an electronic Critical Incident Dashboard that includes reportable events as reported by community-based providers, Care Coordinators, and individuals with Acquired Brain Injury. Information regarding critical incidents, 30-day follow-up reports, deaths and any identified trends is discussed with community providers quarterly. A significant detail of the Critical Incident Dashboard is the use of claims data to monitor emergency department events to ensure that community-based providers are reporting these incidents and linking all deaths with the State's Vital Records Death Registry, again ensuring that all deaths have been reported. Other components of the Critical Incident Dashboard include:

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

As mentioned above, this data is used at quarterly provider meetings and to implement plans of correction to improve outcomes, if needed.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Office of Aging and Disability Services (OADS) the State Operating Agency is responsible for overseeing and response to critical incidents. OADS has developed a critical incident dashboard that provides the State Operating Agency the ability to search and review critical incidents by provider Agency during a specified timeframe. The following information is displayed and reviewed during quarterly provider meetings: total number of critical incidents by agency total number of members served by agency; total number of critical incidents by member; highest number of critical incidents by member and event category; a narrative description of each critical incident; provider timeliness of reporting critical incidents; list of clients with late reports (greater than 1 business day); timeliness of submitting Provider Follow-Up Reports; a list of clients with no Provider Follow-up Report submitted; total number of deaths and a narrative description of the death.

This information is discussed quarterly with providers along with the implementation and effectiveness of remediation steps of critical incidents that occurred during that same timeframe.

OADS completes (issues) a Critical Incident Trend Analysis Report that highlights, in aggregate the same information listed above. The purpose is to communicate information about trends and use the data to plan, prioritize and implement proactive initiatives to reduce or prevent incidents from recurring.

APS provides a report that describes the total number of investigations where the client was determined to be an individual receiving Home and Community Based Services. The report will capture the total number of substantiated allegations of abuse, neglect (including self-neglect), and exploitation.

The critical incident data to include incidents of abuse, neglect and exploitation will be reviewed, analyzed, and result in recommendations regarding incident management. Significant findings are reviewed by the waiver management team who makes recommendations to the Executive Management Team of the Office of MaineCare Services and the Office of Aging and Disability Services for providers and/or systemic follow up.

Event screening occurs on a routine basis, within 14 days of reportable event entry. Additionally, provider agencies meet quarterly with quality caseworkers to review data compliance, quality, and agency quality improvement efforts. The APS report is generated and distributed annually.

Regarding the frequency at which reports and recommendations are issued:

a. OADS completes a Critical Incident Trend Report annually.
b. APS provides a report that describes the total number of investigations where the individual was determined to be a recipient of Home and Community Based Services annually.
c. OADS Adult Protective Services provides data on substantiated incidents of abuse, neglect and exploitation, which is reviewed and analyzed, resulting in annual recommendations through a collaboration between OADS Quality Management and OADS Data and Compliance Unit.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints or seclusion is not allowed under this waiver. Detection of their use -- through home visits, complaint process, Adult Protective Service investigations, or provider audits -- constitutes reason for termination of the worker serving the participant. The use of unauthorized restraints and seclusion are a rights violation within the critical events protocol. When there are concerns about a participant, which would include unauthorized restraint or seclusion, APS would contact the State Operating Agency to discuss any concerns or findings.

The Department has statutory Adult Protective responsibility for participants served in this waiver. The Adult Protective unit operates under the Department of Health and Human Services. Any reports of potential use of restraint or seclusion are reported to APS for investigation and follow up.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State does not permit the utilization of aversive methods to modify behavior. The State defines Aversive methods as an intervention or action intended to modify behavior that could cause harm or damage to a Person, or could arouse fear or distress in that Person, even when the intervention or action appears to be pleasant or neutral to others.

The State includes a process for the participant and/or legal guardian through informed consent to implement an HCBS modification, the HCBS modification must be based on specific and individualized assessed needs identified in a current assessment of the individual, be necessary to ensure the health, safety and wellbeing being of the person, and approved by the person and/or legal guardian. The addendum once approve must be attached to the care plan to make it a part of the care plan. All provider must follow requirements for HCBS modifications as located in §6.04(B)(2-4) of the Global Settings Rule, 10-144 C.M.R. Ch. 101, Ch. 1, Section 6.

The Care Planning team, in accordance with MaineCare Benefits Manual, Ch. II, Section 18.04 Care Plan Development, must evaluate factors that may be contributing to the occurrence of the behavior. Restrictive interventions must be developed by a Department approved licensed clinician. The written plan is reviewed on a semi-annual basis and must be reviewed by the Department Oversight Committee. Such factors may include but are not limited to

(1) Illness, Disease, Medication Interaction,
(2) Impact of Acquired Brain Injury on behavior,
(3) Psychiatric conditions, and
(4) Significant life events.

In the event that factors such as those listed above exist, the planning team may still determine that a behavioral plan is indicated, but the planning team shall include, as part of the plan, its rationale for so deciding.

The behavioral intervention procedure must include all of the following:
(1) Consent by the individual or the guardian if one has been appointed;
(2) A concise and accurate identification and description of the specific behavior(s) to be addressed and the behavioral goal;
(3) A Functional Analysis of Behavior including the history of the behavior and what positive methods have been utilized in the past;
(4) A description of the baseline measurements of the frequency, duration, intensity and/or severity of the behavior(s);
(5) A concise and precise description of the methodology for consistently implementing the plan;
(6) A description of the means of recording and measuring of the frequency, duration, intensity and/or severity of episodes of the specific behavior(s) and the use of interventions;
(7) A schedule for periodic review of the plan, which shall be at least semi-annually;
(8) Criteria for the discontinuation of the plan, whether because it has been successful, its continued implementation is unlikely to be successful, or it is causing the individual more harm than benefit. There may be behavioral plans which show slow progress. These plans may require implementation and monitoring over an extended period of time.

Positive Behavioral Supports
A. Positive behavioral supports are those which are directed toward reducing an individual’s maladaptive behavior, but which do not entail any limitations upon the individual’s rights. The planning team shall approve all behavioral interventions.

B. Examples of such interventions include but are not limited to:
(1) Rewarding positive behavior,
(2) Rewarding the absence of dangerous behavior,
(3) Modeling of appropriate behavior,
(4) Environmental alteration,
(5) Teaching of skills,
(6) Teaching of Coping Skills, self-management, self-calming skills, and

(7) Refocusing.

Positive or neutral interventions may be used on an informal basis for individual safety or to promote a harmonious, supportive environment. The planning team must approve systematic use of an intervention.

Mildly Intrusive Interventions
A. Mildly intrusive interventions are characterized as those in which some form of limitation is imposed upon the individual, but the individual voluntarily complies with this imposition. Examples of mildly intrusive interventions include but are not limited to:
(1) Nonexclusionary timeout,
(2) Verbal reprimand, and
(3) Extinction (withdrawal of attention or planned ignoring of the target behavior that is in response to the behavior that is disruptive but not harmful or destructive. This is a mildly intrusive intervention.)
B. An individual's voluntary compliance in a mildly intrusive plan is essential. Coercion is not permitted. Even in cases where a guardian has approved a plan, implementation is predicated upon the individual's voluntary compliance.

Moderately Intrusive Interventions
A. Moderately intrusive interventions are characterized by a greater degree of limitation being imposed upon the individual, but the individual voluntarily complies with this imposition. Examples of moderately intrusive interventions include, but are not limited to:
(1) Overcorrection,
(2) Token Economy,
(3) Contingent Reinforcement using rewards based upon normal rights of access.
An individual's voluntary compliance in a moderately intrusive plan is essential. Coercion is not permitted, but planning teams must be mindful of the possibility of more extreme behavior if compliance is not achieved. Even in cases where a guardian has suggested a procedure, implementation is predicated upon the individual's voluntary compliance.
Blocking, depending upon how and when it is used, may be an emergency or a programmatic intrusive intervention.
(1) Blocking used by a staff person to deflect a potentially dangerous movement (e.g., a blow) and this response is not part of a behavioral plan, then blocking must be reported as an emergency restraint.
(2) Blocking may be used as part of a plan to replace stereotypical, potentially harmful behaviors with preferable substitutes. A planning team may determine that the plan is either moderately or severely intrusive, subject to the necessary levels of planning team approval and review.

BEHAVIORAL INTERVENTIONS
Principles
Individuals served by the Department are entitled to the same rights as every other Maine citizen, except as limited by reason of guardianship. Any behavioral intervention that limits the exercise of any of an individual's rights must adhere to the following principles:

A. The limiting intervention must be reviewed at least semiannually and approved by the Care Planning committee as defined in MaineCare Benefits Manual, Ch. II, Section 18 Behavioral Interventions.
B. The intervention must be approved, in writing, by the individual or by the guardian when one has been appointed. Withdrawal of approval requires immediate termination of the intervention.
C. The use of an intervention must always be preceded by a Functional Analysis of Behavior and documented efforts to address the dangerous or maladaptive behavior by the use of positive techniques or less intrusive approaches, which have been tried systematically and determined to be ineffective.
D. Moderately intrusive interventions must be part of the written plan and approved by the planning team. The Department Oversight Committee, following review and approval by the planning team, must approve severely intrusive interventions.
E. Individuals with Acquired Brain Injury have a right to receive effective intervention. While there are risks inherent in employing some behavioral interventions, it should also be noted that in some cases there are risks in not employing behavioral interventions.
F. Interventions must be limited to the individual in question. The imposition of group interventions is prohibited.

Positive Environment
In accordance with assurance made throughout this waiver, the Department is obligated to ensure that all individuals have the opportunity to live in a safe, supportive environment. As stated above, every individual is entitled to the same rights afforded every citizen of Maine, except as limited by guardianship. Any interventions that restrict an individual's rights, even if a guardian approves, will not be approved, unless the individual has been provided with necessary positive supports and appropriate services.

Prohibited Interventions
The following procedures and interventions are expressly forbidden in all circumstances:

(1) Intentional infliction of pain or injury,
(2) The intentional instilling of fear of pain or injury,
(3) Actions or language intended to humiliate, dehumanize or degrade an individual,
(4) Denial of basic rights including, but not limited to meals, sleep, adequate clothing, medications, medical treatment, and therapy, and
(5) The use of experimental interventions or those without scientific basis or merit.
A service provider's use of any such procedures will be a cause of investigation and action by the Department, including, when appropriate, referral to law enforcement agency, Disability Right Maine, the Department's Licensing Authority, Medicaid Program Integrity, the Attorney General's Health Crimes Unit, and Adult Protective Services.

Any limitation, whether actual or implied, upon an individual's freedom of movement or exercise of a right is expressly forbidden unless it is either in response to an emergency, or a formal and approved portion of an individual's treatment plan.

Meetings of the planning team to develop or review behavioral interventions:
When it is proposed that a particular intervention be systematically used to change or eliminate a specific behavior of an individual, written documentation of the proposed use of the intervention must be included in the individual's planning process. A planning team must approve this process.
The planning team must always include the individual and the guardian when one has been appointed. It must also include the Care Coordinator, who must coordinate the inclusion of any other relevant planning team members. The planning team must include representatives of every site at which the behavioral treatment procedure is to be implemented.
The Department Oversight Committee includes the Program Manager of Brain Injury Services, and at least two other Department staff with expertise in the behavioral health field.
Any evidence of a pattern of use or abuse is reviewed by the appropriate State staff and referrals to Adult Protective Services, Department's Licensing Authority, Medicaid Program Integrity, and the Attorney Generals' Health Crimes Unit are made as applicable. The Office of Aging and Disability Services within the Department of Health and Human Services looks at aggregated data regarding restraint use across the state. Any anomalies across consumers, providers or services are evaluated for explanation and justification. In addition, all direct support professional employees are mandated reporters and therefore required to report any unauthorized use of a restrictive intervention.
Any evidence of a pattern of use or abuse is reviewed by the appropriate State staff and referrals to Adult Protective Services, Department's Licensing Authority, Medicaid Program Integrity, and the Attorney Generals' Health Crimes Unit are made as applicable. The Office of Aging and Disability Services within the Department of Health and Human Services looks at aggregated data regarding restraint use across the state. Any anomalies across consumers, providers or services are evaluated for explanation and justification. In addition, all direct support professional employees are mandated reporters and therefore required to report any unauthorized use of a restrictive intervention.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Office of Aging and Disability Services and Disability Rights Maine have the responsibility of overseeing the use of restrictive interventions.
This is done as follows:

The Review Committee

A. A Review Committee is designated by the Department. Each review committee is made up of at least three representatives from the Department.

B. This committee is responsible, as outlined above, for reviewing and approving all restrictive interventions on a case-by-case basis, at least quarterly. The committee may elect to conduct reviews more frequently.

C. Any committee approval and approval with modifications must be unanimous.

D. The Review Committee has two distinct categories of review obligation, and the minutes of its deliberations on each case must reflect that it has covered both:

(1) That a proposed restrictive intervention plan takes all possible steps to protect the health, safety, and rights of the individual, and

(2) That the plan is clear and comprehensible to all its users.

All restrictive interventions are mandated reportable events in the EIS system, in accordance with the Reportable Events Rule, 14-97 C.M.R. Ch. 12. This information is reviewed for patterns of misuse or abuse. Any evidence of a pattern of use or abuse is reviewed by the appropriate State staff. DHHS looks at aggregated data regarding restraint use across the State. Any anomalies across consumers, providers or services are evaluated for explanation and justification. In addition, all direct support professional employees are mandated reporters and therefore required to report any unauthorized use of a restrictive intervention.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Office of Aging and Disability Services (the State Operating Agency) has the responsibility to detect the unauthorized use of seclusion. This is not permitted at any time, and it is reported through reportable events system and/or through reports to APS system. Seclusion is defined as the solitary involuntary confinement of a Person for any period of time in a room or a specific area from which egress is denied by a locking mechanism, barrier or other imposed physical limitation. This is a Prohibited Practice. Any use of a prohibited intervention must be reported through the reportable events system.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication monitoring focuses on events related to medication taken by an individual receiving services that leads to a health or safety concern of a serious nature based on inappropriate prescription, packaging, dispensing, administration, monitoring or an individual's refusal to take medication where serious health or safety implications can result.

Providers who hold license(s) and certification(s) have ongoing responsibility for monitoring participant medication regimens. The methods for conducting and monitoring depend on the level of license and certification. The Department requires Direct Support Professionals who administer medications hold a Certified Residential Medication Administration (CRMA) certificate.

Medications are administered only by a written order of a physician and the drug regimen must be reviewed every six months by a physician or other appropriate monitoring body. Daily notation of medication received by a participant must be documented in the participant's record.

Many provider agencies employ or contract with nurse consultants who monitor medication administration within their agencies. All providers must monitor the health and safety of their participants, including those that self-administer medications. The Department requires provider agencies to have policies requiring that participant guardians/families are notified and authorize all medication changes. Medication Error is an event relating to a medication taken by an Individual Receiving Services that leads to a health or safety concern of a serious and immediate nature based on inappropriate prescription, packaging, dispensing, administration, monitoring, or an individual's refusal to take a medication where serious health or safety implications result.

All medication errors are entered into the state EIS systems as a reportable event. Reportable events are monitored by OADS staff.

Reportable events are monitored by Brain Injury Care Monitors. Reportable Events are reported by the providers, Care Coordinators, etc. and reviewed by Brain Injury Care Monitors. The BI Care Monitor can complete a more intensive review, either a desk level or site review. This level of review involves reading case notes, calls to providers and Care Coordinators and others determine if corrective action needs to be initiated.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The State utilizes the Reportable Events System to receive information relative to inappropriate medication management. Potentially harmful practices are identified by provider or the State Operating Agency. The Office of Aging and Disability Services is responsible for oversight and ensuring appropriate follow-up. Anyone assisting in the administration of medication in a licensed residence must complete a Certified Residential Medication Assistant (CRMA) training and be re-certified every two years. This training is monitored by the Department, Division of Licensing and Certification, and includes training and certification of Registered Nurse instructors. This training includes the nurse trainer observing the trainee administering medication.

Reportable Events are reported by the providers, Care Coordinators, etc. and reviewed by BI Care Monitor. The BI Care Monitor can complete a more intensive review, either a desk level or site review. This level of review involves reading case notes, calls to providers and Care Coordinators and others determine if corrective action needs to be initiated.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Anyone assisting in the administration of medication in a licensed residence must complete a Certified Residential Medication Assistant (CRMA) training and be re-certified every two years. This training is monitored by the DHHS, Division of Licensing and Certification, and includes training and certification of Registered Nurse instructors. This training includes the nurse trainer observing the trainee administering medication.

Staff who work in DHHS licensed facilities must meet the training and certification standards for Certified Residential Medication Aide (CRMA). This requirement is included in State licensing regulations and also State MaineCare policy (Sec. 18 of MaineCare Benefits Manual) that governs this waiver.

Waiver rules require the same training for Work Support and Home Support.

Many provider agencies employ or contract for nurse consultants who monitor medication administration within their agencies.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Department of Health and Human Services, Office of Aging and Disability Services is responsible for oversight and receiving error reports.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record and report as a Reportable Event any medication error in the Reportable Events System that leads to a health or safety concern of a serious and immediate nature due to any of the following:
(a) Refusal to take a prescribed medication;
(b) Taking medication in an incorrect dosage, form, or route of administration;
(c) Taking medication on an incorrect schedule;
(d) Taking medication, which was not prescribed;
(e) An allergic reaction to a medication; or
(f) Incorrect procedure followed for assisting an Individual Receiving Services with self-medication.

(c) Specify the types of medication errors that providers must *report* to the state:

Same as above.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Office of Aging and Disability Services, designated State Operating Agency, is responsible for monitoring the performance of providers through the Reportable Events System. Monitoring is accomplished through the Reportable Events Dashboard. Medications events are aggregated by provider, individual, and type of medication event. The findings are discussed with the provider at quarterly intervals with the goal of ensuring the health, safety and welfare of the individual.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
 # & % of participants or legal guardians who annually receive information & education about how to report abuse, neglect, exploitation & other critical incidents. Num: Total # of participants or legal guardians who annually received information and education about how to report abuse, neglect, exploitation & other critical incidents annually. Den: Total # of waiver participants or legal guardians.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Management database

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of reports of abuse, neglect, and exploitation that are investigated by APS. Numerator: Total number of abuse, neglect, and exploitation reports that are investigated by APS. Denominator: Total number of reports of abuse, neglect, and exploitation that were screened in (i.e., met APS jurisdiction criteria) for investigation by APS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective Services database

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of abuse, neglect, and exploitation incidents reviewed/investigated within the required timeframes. Numerator: Total number of abuse, neglect, and exploitation incidents reviewed/investigated within the required timeframes. Denominator: Total number of abuse, neglect, and exploitation incidents received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective Services system

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of deaths reviewed by APS for abuse, neglect, or exploitation. Numerator: Total number of deaths reviewed by APS for abuse, neglect, or exploitation. Denominator: Total number of deaths reported to APS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective Services system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of alleged incidents of abuse, neglect, & exploitation that were referred by APS to the appropriate District Attorney's Office. Num.: Total # of alleged incidents of abuse, neglect, & exploitation that were referred by APS to the appropriate DA's Office. Den.: Total # of alleged abuse, neglect, & exploitation incidents that were required to be referred by APS to the appropriate DA's Office

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective Services system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incident trends that resulted in a systemic intervention being completed. Numerator: Number of critical incident trends that resulted in a systemic intervention being completed. Denominator: Number of critical incident trends identified for systemic interventions.

Data Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incident reports with a cause identified. Numerator: Number of critical incident reports with a cause identified. Denominator: Total number of critical incident reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical incident management system

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of provider critical incident follow-up reports submitted within 30 calendar days from the date of the critical incident. Numerator: Total number of provider critical incident follow-up reports submitted within 30 calendar days from the date of the critical incident. Denominator: Total number of critical incidents requiring a follow-up report.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Management System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of corrective action requirements that are issued to providers with corrective action plans that are completed. Numerator: Number of corrective action requirements that are issued to providers with corrective action plans that are completed. Denominator: Total number of corrective action requirements that are issued to providers with corrective action plans.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of systemic interventions that resulted in a change in policy/procedure. Numerator: Total number of systemic interventions resulting in a change of policy/procedure. Denominator: Total number of systemic interventions.

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and Percent of critical incident reports that do not include unauthorized restrictive interventions, as reported through the critical incident management system. Numerator: Total number of critical incident reports that do not include restrictive interventions. Denominator: Total number of critical incident reports.

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

Critical Incident Management System

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of providers with policies and procedures in place that prohibit the use of restraints and seclusion. Numerator: Total number of providers that have policies and procedures in place that prohibit the use of restraints and seclusion. Denominator: Total number of provider policies and procedures reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval w/ +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and Percent of all participants receiving a physical health exam on an annual basis. Numerator: Total number of all participants receiving a physical health exam on an annual basis. Denominator: Total number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims data

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Brain Injury Care Monitors review Brain Injury Reportable events and seek clarification when more information is needed. Brain Injury Care Monitors make reports to Licensing and APS when these reports are warranted upon review of a Reportable Event.

The OADS care monitors directly monitor the system of care provided to waiver participants through review and approval of all care plans, review of reportable events follow-up reports and review and investigation of all service settings under the waiver.

If the provider is found to be noncompliant with the Department's provider agreement and MaineCare rules and policies, the State will take appropriate action which may include terminating the Provider Agreement.

Any employee under investigation for abuse, neglect or exploitation by adult protective services or another State agency, such as the Attorney Generals Health Crimes Unit is not permitted to provide service to any Brain Injury waiver participant until the investigation is completed and the investigation is closed without findings. The community care coordinator informs OADS care monitors of issues related to reportable events and the providers' response to these incidents on an ongoing basis. OADS care monitors serve as an external monitor to ensure the quality of care provided to participants and to maintain the participants' health and welfare.

OADS monitors the reportable events database that tracks categories and responses through a follow-up report requirement of the provider. OADS waiver manager reviews provider quarterly reportable events report and identifies trends and outcomes. This information assists OADS to identify trends in reportable events within the services system, take corrective measures to minimize the probability of a recurrence of the same or similar situations, and to develop and implement appropriate staff training programs.

OADS care monitors conduct on-site surveys of waiver service providers reviewing their policies and procedures for managing Reportable Events and ensure providers are tracking reportable events and follow-up reports to identify trends and develop plans to mitigate and prevent future incidents.

The Office of Aging and Disability Services (OADS) has initiated the following practices to ensure the health, safety, and welfare of consumers: A new rule change effective May 2018 regarding Reportable Events and required follow up by providers. The updated rule aligns with statute and addressed a streamlined process for APS Central Intake, investigations, final written findings and substantiations. OADS initiated the creation of a Critical Incident Dashboard allowing for continued analysis of critical incidents for those individuals receiving services through a home and community based waiver. OADS expanded individualized, quarterly provider meetings to include all providers of home and community based services. These meetings are convened to address systems issues and challenges and build on collaborative and professional opportunities. Each quarterly meeting addresses critical incidents: e.g. timeliness, the number, type, and frequency of critical incidents per individual and any corrective action that may be warranted.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Office of MaineCare (OMS), the State Medicaid Agency and the Office of Aging and Disability Services (OADS), the designated Operating Agency work together to ensure the health, safety and welfare of the individuals receiving services and supports through this waiver. The Operating Agency and Medicaid Agency have regular meetings for system monitoring.

OADS has two primary dashboards that enable it to collect and synthesize data: the Reportable Events Dashboard and the Waiver Dashboard. The Reportable Events Dashboard includes all reportable events as reported by community providers and includes date of incident, critical incidents by provider, location of incident, number of incidents by individual, incidents by type, timeliness of reporting, completeness of 30-day follow- reports and trends over time. On a quarterly basis the information housed in the Reportable Events Dashboard is reviewed with community providers to discuss the reduction or prevention of incidents and opportunities for improvement. In addition, each quarter deaths of individuals are matched against the State's Death registry to ensure that all deaths are reported by community providers and critical incidents are matched against emergency department Medicaid Claims data to ensure that all critical incidents are reported to OADS.

The Waiver Dashboard allows the user to review expenditures by waiver, procedure code, participant, provider and service location. This data can be trended on a quarterly or annual basis. The data comes from Medicaid's Data Analytics Platform (DAP).

Instances of abuse, neglect and exploitation identified by mandated reporters or through the reportable event review process, are referred to Adult Protective Services (APS) for investigation and may result in substantiation. Summary information on all APS reports that are screened are forwarded to the DA's Offices for the counties where the client(s) reside.

A performance measures workplan has been developed for this waiver that identifies lead staff, assigned staff start and end dates, data sources and status ensuring that each sub-assurance and performance measure are completed on a quarterly or annual basis. Values are compared against minimum expectations by OADS staff on a quarterly basis and measures needing improvements are addressed using a variety of strategies up to and including corrective actions.

Developmental foundations, including needed statutory changes, are complete and a Mortality Review Panel is staffed and writing procedures for operation. The Panel will review discrete mortality events as well as aggregate mortality data At present, all mortality events are reviewed by Adult Protective Services to screen for indications of abuse, neglect, or exploitation.

Beginning in late 2023, OADS plans to resume collecting experience of care data by piloting a new survey. The new survey is the Consumer Assessment of Healthcare Provider and Systems, Home and Community Based Services version. Results from future surveys will be shared with both internal and external stakeholder groups. OADS will consider survey findings as part of our overall future quality improvement efforts.

All providers in this waiver must comply with all applicable federal and state law, including applicable Maine licensing laws and regulations. Additionally, the Department is in the process of enhancing our corrective action process. The enhanced Plan of Corrective Action (POCA) process expands upon the quality assurance activities and provide increased protections for participants by ensuring providers comply with service requirements, have sufficient clinical and administrative capability to carry out the intent of the service, and have taken steps to assure the safety, quality, and accessibility of the service for participants. The process includes noticing providers of specific deficiencies as well as the timeframes for correcting, and remediating identified problems and may require the provider to submit a Plan of Corrective Action.

The Plan of Corrective Action must meet specific criteria including, but not limited to, the following:
a) The POCA must be a specific plan which describes how the deficiency (event, incident or risk) will be corrected, including the actions which will be taken to bring about correction.
b) The POCA must address correction of the specific event(s) cited.
c) The POCA must identify actions steps to prevent the deficiency/risk from recurring/occurring.
d) The POCA must clearly delineate the frequency each element of the plan is to occur.
e) The POCA must identify by title the individual(s) responsible for the implementation and monitoring of the plan.

f) The POCA must provide date(s) by which all components of the plan will be implemented, and the corrections completed.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

OADS (the Operating Agency) and OMS (the Medicaid Agency) have the primary responsibility for monitoring the effectiveness of the system design changes.
Focus Area 1 – Participant Focus
• Choice forms are completed for either institutional care or HCBS services
• Reporting critical incidents in particular abuse neglect and exploitation
• Care coordinators review and address unmet needs
• Annual preventive health care visits
• Level of Care assessments are reviewed and approved by qualified staff
• OADS staff meet quarterly with providers to review aggregate data as well as member-specific data, looking for trends and changing conditions

Focus Area 2 – Participant-Centered Service Planning
• Annual review of PCP plans to ensure that the plan addresses health and safety risks, and goals
• PCSPs are based on assessed needs
• Critical incidents and reports of abuse, neglect and exploitation are addressed in the plan, if appropriate.
• Behavioral intervention plan data is reviewed prior to the approval of a continuation request for any behavioral intervention plan to assure health, safety and welfare

Focus Area 3 – Provider Capacity and Capabilities
• All providers are enrolled as MaineCare (Medicaid) providers
• Providers are approved based on meeting all the initial provider requirements
• All providers maintain licensure and certification as applicable
• Settings where waiver services are provided are monitored for compliance for HCBS standards
• Agency providers meet quarterly with OADS staff to review data and trends.

Focus Area 4 – Participant Safeguards
• Critical Incident Dashboard is monitored to protect participants
• 30-day follow-up plans address the causes and provider actions to reduce or prevent future occurrence
• Care Coordinators review and document psychotropic medications as part of the person-centered service planning process.
• Restrictive interventions are monitored
• All reportable events are reviewed to assess for proper reporting of abuse and neglect, provider compliance with rules and regulations, and to assess for necessity of corrective actions

Focus Area 5 – Participant Rights and Responsibilities
• Notification of rights, appeals process, and grievances
• Grievance and appeals are resolved timely, according to rule

Focus Area 6 – Participant Outcomes and Satisfaction
• Participants are satisfied with the services and supports they receive
• Participants are integrated into the community
• Participants are employed

Focus Area 7 – System Performance
• Continuous quality improvement is implemented to ensure quality outcomes

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The State utilizes annual reporting on compliance with waiver requirements from various data sources: annual reports from Assessing Services Agency, MECARE Assessment data, Claims data, Referrals to Adult Protective Services and policy or system changes made as a result of review of the performance measures.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population

03/19/2024

in the last 12 months ***(Select one):***

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

Neurobehavioral Services (within the Office of Aging and Disability Services) has its own Consumer Satisfaction Survey which asks questions that explore Home- and Community-Based requirements. The survey is recorded with a participant on an annual basis and is completed by the participant's community Care Coordinator.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Integrity of payments at the individual level:
Maine has developed a subsystem to its MMIS system that provides checks and balances to assure that medical eligibility determination and prior authorization have occurred and are valid for the dates of services billed. The classification dates entered 1) match the time period of medical eligibility determined as part of the assessment for waiver services and 2) provide system authorization to assure the participant has been determined eligible for a specific MaineCare program to allow claims to be paid for specific procedure codes. Medical eligibility classification codes are not entered into the subsystem without verification that financial eligibility has been determined. Claims are rejected for any date where both medical and financial eligibility are not in place. The subsystem also tracks persons under appeal to assure continued payment of services if a timely appeal was filed. Each program requiring medical eligibility determination and/or prior authorization of the service has an individual classification code.

Overall Medicaid program integrity:
Chapter I of the MaineCare Benefits Manual (MBM), (https://www.maine.gov/sos/cec/rules/10/ch101.htm) Section 1.16 for Audits states that The Division of Audit or duly Authorized Agents appointed by the Department of Health and Human Services (DHHS) have the authority to monitor payments to any MaineCare provider by an audit or post-payment review. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements. Additionally, on an annual basis, the MaineCare (Medicaid) Program is wholly subjected to a Single State Audit conducted by the Office of the State Auditor.

The Division of Audit conducts audits and issues final cost settlements on all MaineCare cost reimbursed programs. MaineCare's Program Integrity Unit (PIU), as a duly authorized agent, is tasked with identifying fraud, waste and abuse within the MaineCare program and reviews MaineCare providers to ensure compliance with the MaineCare Benefits Manual including documentation, medical necessity, coding, and billing compliance.

For this waiver, rates are published by the Department and the services are subject to compliance reviews. The Department may recover any amounts due the State based on MBM, Chapter I. Unless the services are of an institutional nature, a yearly independent financial audit is not required. Under Chapter III (Allowances for Services) of the MBM, providers are responsible for maintaining adequate financial and statistical records and making them available when requested for inspection by authorized representatives of DHHS, Maine Attorney General's Office, or the Federal Government. Providers shall maintain accurate financial records for the services provided separate from other financial records.

The Program Integrity Unit conducts continuous and on-going audits on providers through post-payment reviews of MaineCare providers based on complaints, referrals, and/or data analytics. The methods that are used to audit include the use of statistically valid random samples, complaint-focused reviews, and full reviews. Data-driven reviews may not require a review of records or may require the provider to do a self-audit. The scope can vary from a short timeframe to a full 5-year review. An annual work plan determines the services to be reviewed, in addition to complaints and other referrals received. Program Integrity uses a confidence interval 90% and +/- 5% for SVRS.

When the Program Integrity Unit does a review based on a statistically valid random sample (SVRS), it starts with a well-defined universe of claims and uses the RAT-Stats v. 2010 program to obtain the SVRS by claim line. A statistician developed an extrapolation tool for use by the Program Integrity Unit (implemented in 2016) which determines the overpayment amount using a 5% margin of error. All reviews in which the Program Integrity Unit uses a SVRS are done following this process.

The Program Integrity Unit (PIU) does not currently have the ability to run a report that captures the number of cases done based on a SVRS, but an estimate of the frequency would be approximately 20-35% of the time. For certain services, MaineCare needs to look at all participants in a specific location in order to determine staff to client ratios, therefore a SVRS would not be appropriate.

In the event that the Department of Health and Human Services (DHHS) is aware that a new provider will be providing a service that has a high capacity for fraud and abuse (such as personal care services), Program Integrity will prioritize that agency. This may range from a desk-level review of claims data to a full review of provider records. Additionally, the Department (DHHS) conducts routine statistical analysis of provider claims data in order to identify billing outliers. The Department then further investigates these outliers. Finally, the Department has engaged in targeted reviews of certain Medicaid services, in response to concerns about potential widespread deficiencies across providers.

Outliers are determined based on a variety of factors, such as the number of services, amount paid, units per participant, or services per participant. Factors are reviewed across the same service type or provider type to compare providers against their peers, using a specified standard deviation above the mean. Some services may require a different factor to be

considered an outlier, such as an absence of care (e.g. DME prescribed with no prior relationship, or non-emergency transportation without a corresponding medical claim); where another service may require looking at factors to determine overutilization or upcoding, such as a percentage of what was billed (e.g. percentage of high-level office visits to total office visits). The frequency in which these analyses typically occur is annually, based on an annual work plan.

Provider types with high capacities for fraud and abuse are prioritized in Program Integrity's annual work plan. Program Integrity Unit (PIU) uses a data-driven approach, and the outcome helps determine the type of review. If the provider has also been the subject of complaints or other concerns, that may warrant a full review. If the provider's claims are homogenous, PIU would tend to use a SVRS. Otherwise, PIU would do a desk-level or full review. In some instances, PIU does not need to review records, such as for coding or limits issues, and that information can be used to strengthen claims edits processing. Program Integrity strives to make the most of PIU resources, including utilizing the Unified Program Integrity Contractor (for the State of Maine, this contractor is Safeguard Services, LLC) for reviews of high-risk provider types.

The State has not engaged in targeted reviews because of widespread deficiencies, but rather, has engaged in targeted reviews to look for such deficiencies. Some services that have been reviewed using this type of approach are Home and Community Based Services and Personal Care Services. Deficiencies noted (though not necessarily widespread) included lack of or untimely background checks on employees, staffing ratios not being met (HCBS services), overbilling units (PCS), and general documentation deficiencies. The actions taken to resolve these issues include recouping overpayments from providers, referrals to Licensing, and recommendations brought forth for policy and system enhancements.

On-site reviews are conducted. Typical reasons for conducting an on-site review include whether there are concerns of fraud, if the provider is not cooperating with record requests by mail, or there is a need to see where records are secured or to review a provider's electronic health record system.

Maine's Program Integrity Unit plans to use EVV during post-payment review/audits. Program Integrity staff will compare the information in the EVV to the records submitted by the provider and the claims paid by MaineCare.

Program Integrity will utilize the EVV reports to inform decision-making regarding providers that should be selected for post-payment review. Providers with a high number of exceptions per employee, per consumer, or agency-wide will be prioritized. The Program Integrity sampling approach will include using statistically valid random samples (confidence interval 90% and +/- 5%) of claims for some providers but may also include looking at specific claims based on exceptions for other providers.

Maine has specific reporting requirements outlined in our policies. Regardless of the source, all complaints received in Program Integrity are logged and triaged within 48 hours. The triage process identifies whether there are any participant safety concerns, and if so, an immediate referral is made to Adult Protective Services or Child Protective Services. The complaint then may be passed on to an auditor for further review. Outliers are identified based on payment amounts and amount paid per recipient being one standard deviation above the mean. Identifying growth over time entails looking at all claims for a specific service over a 2-5 year period to determine if the units increased by 100% or more from one year to the next. Maine's Program Integrity Unit may choose to review providers that are relatively new to the program to check for compliance, or providers that have never been reviewed, even if their claims appear appropriate.

Providers delivering Home Support (1/4 hour)-Level I Services must comply with Maine DHHS Electronic Visit Verification system standards and requirements for these services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and Percent of claims coded and paid in accordance with reimbursement methodology. Numerator: Total number of all claims coded and paid in accordance with the reimbursement methodology. Denominator: Total number of all claims coded and paid.

Data Source *(Select one):*
Financial audits
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and Percent of compliance of rate determinations made with the approved rate methodology. Numerator: Total number of service rate changes aligning with rate methodology. Denominator: Total number of service rate changes.

Data Source *(Select one):*
Other

If 'Other' is selected, specify:
claims processing system (MIHMS)

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

The current MMIS system limits all services provided under the waiver to what is permitted by the policy for each classification group. Claims are denied if improper rates are billed or units of service are billed in excess of the limits outlined in policy.

b. Methods for Remediation/Fixing Individual Problems

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

If concerns are raised by a provider regarding claims, the provider contacts the provider relations specialist through the Medicaid agency. If additional policy issues are identified, OADS requests data from OMS to verify the information. OADS and OMS work together to develop a plan for making changes in policy, provider's billing process and/or the MMIS system.

If the State Medicaid Agency were to identify a problem with claims, they would be evaluated further by having a discussion with the agency submitting the claim. The provider would then need to correct the claim. If there was any indication that the provider knowingly submitted inaccurate claims, or appeared fraudulent in any way, the State's program integrity unit would be contacted. Program Integrity would pull provider records, claims information, member records etc...to determine if there are errors between the service delivered, what's authorized, and how it is billed. Depending on the errors or discrepancies detected, program integrity could seek recoupment, terminate the provider agreement, or even refer the provider to the Health Care Crimes unit of the State's Attorney General's Office.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Office of MaineCare Services (OMS) of the Maine Department of Health and Human Services (Department), in collaboration with the Office of Aging and Disability Services (OADS), is responsible for establishing provider payment rates for waiver services. Historically, the Department has established payment rates through a variety of mechanisms, including consideration of historic cost and budget data, comparisons to rates paid for similar services in other programs, and targeted rate studies. Rates for this waiver are subject to review and amendment by the State legislature. The Maine Administrative Procedure Act (APA) applies uniform requirements to state agencies with rulemaking power and sets minimum standards for agencies to follow in adopting and implementing changes to rules. All MaineCare policies are posted on the Department's website for access at any time. The provider fee schedule is published in the MaineCare Benefits Manual, Chapter III, Section 18. https://www.maine.gov/sos/cec/rules/10/ch101.htm. Additionally, please see section Main 6-I of this approved Waiver for more information on how the state solicits public input for waiver amendments and renewals.

Waiver services are reimbursed on a prospective, fee-for-service basis, with a few exceptions.
All rates were last updated by the Department in January 2022, to accomplish two aims: (1) ensure compliance with the requirements of P.L. 2021, ch. 398, Part AAAA (as described below), and (2) provide the COLA authorized by P.L 2021, section AAAA (as described below).

Rates based on 2020 rate study:
Burns & Associates, Inc. completed a rate study in 2020 that included multiple ME.1082 services. These rates were subsequently published by the Department. The rate models used to establish the rates (below) were based on data from a number of different sources, including:
• A provider survey conducted in 2019
• Maine-specific wage data from the Bureau of Labor Statistics' May 2019 dataset, inflated to January 2021 using Maine-specific historic wage growth data from the Bureau of Economic Analysis
• Employee benefits data from the Bureau of Labor Statistics' 2019 National Compensation Survey and health insurance cost data from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey; and
• The Internal Revenue Services' 2020 standard mileage rate

The ME.1082 rates that were revised and updated by the rate study included the services listed below. Three services are reimbursed per diem (Home Support-Level II, Home Support-Level III, and Work Ordered Day Club House), and Career Planning is reimbursed on an hourly basis. All other rates are per quarter hour.
• Career Planning
• Home Support-1/4 hour-Level I
• Home Support-Per Diem-Level II (2-4 beds)
• Home Support-Per Diem-Level II (5-8 beds)
• Home Support-Per Diem-Level III Increased Neurobehavioral (2-4 beds)
• Home Support-Per Diem-Level III Increased Neurobehavioral (5-8 beds)
• Employment Specialist Services
• Work Ordered Day Club House
• Work Support
• Home Support-Remote Support (based on the direct care rate for Home Support-1/4 hour)

Rates not covered by the Burns & Associates rate study are reimbursed as follows:
• Assistive Technology-Assessment is reimbursed by quarter hour and was based on the rate for a similar service in the state plan, although the providers differ slightly in that providers serving waiver participants must have experience with Intellectual Disabilities.
• Assistive Technology-Device is reimbursed based on actual costs, subject to prior approval and up to the approved limit.
• Assistive Technology-Transmission is reimbursed on a monthly basis capped at $55.49 based on provider cost data
• Care Coordination is reimbursed by quarter hour and was based on the rate for similar a service in the state plan.
• The self-direction service rates are based on the following:
a) Supports Brokerage-1/4 hour is based on the reimbursement rates for Care Coordination Services in ME1082.
b) Financial Management Services – Per Member Per Month is based on the combined reimbursement rates within ME.0276 for Financial Management Services - Per member Per Month and Skills Training Services.
c) Individual Goods and Services does not have a specified rate but is reimbursed by invoice.
• Non-Medical Transportation is reimbursed on a per-member per-month basis, according to a full risk capitation model. The rates were calculated by Deloitte Consulting LLP and are consistent with CMS requirements that the capitation rates

be actuarially sound and appropriate. The database variables (by region) included paid amount, number of rides, rides per thousand, average cost per ride, miles, miles per ride, cost per ride, and base per member per month.

Additionally, rate changes have resulted from specific legislation. For example, retroactive rate and service cap increases that were effective January 1, 2021 resulted from the Maine Legislature's passage of P.L. 2019 ch. 616, An Act Making Supplemental Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2020 and June 30, 2021. The Act provided funding for rate adjustments for specific services, to reflect the rate models prepared for the Department by Burns & Associates, Inc.

Recent legislation will systematize rate setting on an ongoing basis. This will enhance the Department's ability to ensure that rates are regularly reviewed for economy, efficiency, and quality of care, and that rates are sufficient to enlist enough providers. PL 2021, ch. 639 was enacted in 2022 and took effect August 8, 2022. As passed, PL 2021, ch. 639 creates a new stand-alone section of Maine law (22 MRSA §3173-J) that codifies the processes and principles for the MaineCare Rate System. These processes and principles include setting a schedule for regular rate review and adjustment, to be reviewed annually in consultation with a Technical Advisory Panel (TAP); reviewing relevant state and national data to inform rate amounts and payment models, with an emphasis on models that promote high value services by connecting reimbursement to performance; and formalizing a clear and transparent process for rate determination that includes public notice and comment.

On an ongoing basis, the OMS rate-setting unit will regularly review and adjust rates in compliance with PL 2021, ch. 398, AAAA. The new law requires that, effective January 1, 2022, the labor components of MaineCare reimbursement rates for specified services delivered by essential support workers must equal at least 125% of the minimum wage established in Title 26, section 664, subsection 1. Essential support workers are individuals who by virtue of employment generally provide to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or have direct access to provide care and services to clients, patients or residents regardless of the setting. 22 M.R.S. 7401. In addition, Part AAAA states that the reimbursement rate must include an amount necessary to reimburse the provider for taxes and benefits related to the wages. 22 M.R.S. 7402(2). Section AAAA-2 of the Act specifies that the 125% of minimum wage requirement for essential support workers applies to ME.1082 services.

PL 2021, ch. 398, OOO authorizes the Department to implement cost of living increases (COLAs) for services provided under ME.1082. Each January 1, services will receive an annual COLA equal to the percentage increase in the state minimum wage as set by the Department of Labor consistent with 26 MRS Section 664. Services that received an increase to their rate within the previous 12-month period will not receive the annual COLA increase effective the following January 1. Pursuant to 22 M.R.S. § 7402(2), the legislation requires annual January ME.1082 COLA updates to ensure that reimbursement rates continue to comply with 22 M.R.S. Chapter 1627 going forward.

As a general rule, HCBS rates do not vary by geography or by provider, regardless of type of service.

Rates apply consistently to all providers.

All payment rates for ME.0276 can be viewed at https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx

Rate methodologies are the same for self-directed services as those that are provider managed.

The state will be making proportionate increases to Self-Directed Services in compliance with PL 2021, ch. 398, AAAA, requiring the labor components of MaineCare reimbursement rates for specified services delivered by essential support workers must equal at least 125% of the minimum wage.

The self-direction service rates are based on the following:
a) Supports Brokerage-1/4 hour is based on the reimbursement rates for Care Coordination Services in ME1082.
b) Financial Management Services – Per Member Per Month is based on the combined reimbursement rates within ME.0276 for Financial Management Services - Per member Per Month and Skills Training Services.
c) Individual Goods and Services does not have a specified rate by reimbursed by invoice – we do not have a specified rate – it is paid by invoice.

Reimbursement rates effective March 1, 2024 (permanently adding reimbursement rates previously approved under Appendix K authority for January 1,2023) are implemented to comply with PL 2021, ch. 398, Part AAAA, An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2021, June 30, 2022 and June 30, 2023. These service reimbursement rates received an adjustment on January 1, 2023, and January 1, 2024, equal to the percentage increase in the state minimum wage as set by the Department of Labor.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers services bill the Department directly through the MMIS system. Claims are processed and paid directly to each provider.
For Transportation Services-The Broker shall receive a monthly capitated per-member–per month (PMPM) payment for each member whose eligibility for the current month has been confirmed by the Department regardless of the members NEMT service use. This is a full risk contract outside of the MMIS system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

a. A participant is not eligible for waiver services until both financial and medical eligibility have been established. Claims would not be processed without establishing eligibility as well as classification for services.

b. Upon assessment of the participant, the medical eligibility data is entered into MeCare. Start and end dates for services are entered also. These dates correspond to the dates in which a provider can submit claims. If an end date has been reached and the participant has not been reassessed for continued medical eligibility and classified with a new set of start and end dates, claims for services provided to that member will not be paid. The Plan of care (POC) that is developed is based upon the scores, timeframes and findings recorded in the Medical Eligibility Determination (MED) level of care. The provider agency provides the covered services in accordance with authorized plan of care.

Additionally, effective January 1, 2021, Maine implemented Electronic Visit Verification (EVV) for 1915(c) Authority waiver programs delivering personal care services within the home. Maine contracted with its Fiscal Agent, Gainwell, for an EVV solution. Gainwell has subcontracted with Sandata for the following EVV solution components: mobile and telephony applications that allow providers to create EVV records, a "3rd party aggregator" that allows providers with other EVV systems to submit data into Sandata, a portal to allow provider staff to manage accounts and records, and claims editing within the MMIS to match claims for PCS services with EVV records. The system requires that all visit records include member ID, caretaker ID, date of service, start and end times of the service, location, and CPT or HCPCS code.

The Maine EVV system includes a pre-payment validation process as well as post-payment review process. Pre-payment validation includes a 30-day pend process such that claims for services subject to EVV will pend for up to 30 days while the system searches for a matching EVV record and deny when no verified EVV record is found. The post-payment process includes ongoing monitoring and surveillance of claims data as described below.

c. Ongoing monitoring is conducted by the operating agency and includes on-site visits to monitor compliance with the waiver document, regulations and contract performance. If, at any time, the services provided do not conform to the POC, OADS will notify the Medicaid agency which will then audit all claims for wrongful payment.

Payment for services provided is a multistep process. This is specifically outlined in the Maine MaineCare Benefits Manual, Chapter I- Section 1 General Administrative Policies and Procedures, Chapter II-Specific Policies by Service, and Chapter III Allowances for Services describes in detail the reimbursement, payment process, and audit oversight including utilization review. Chapter I of the MaineCare Benefits Manual, Section 1.17 Utilization Review states the following:

The Department or its Authorized Agent is responsible for carrying out a series of safeguarding measures. These measures safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assessing the quality of such services available under MaineCare. The Department may use consultants and peer reviewers with expertise appropriate to the medical care or services to be reviewed.

The Department has the authority to request medical records and other records as necessary to support utilization review, utilization management, concurrent review, or other service review activities. Providers must respond to requests in a timely manner and at no charge to the Department.

Chapter I of the MaineCare Benefits Manual, Section 1.18 Program Integrity states the following:

The Program Integrity Unit, Division of Audit and /or the Department's Authorized Agent are responsible for surveillance and referral activities that may include, but are not limited to:
A. A continuous sampling review of the utilization of care and services for which payment is claimed;
B. An on-going sample evaluation of the necessity, quality, quantity and timeliness of the services provided to members;
C. An extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare;
D. A post-payment review that may consist of member utilization profiles, provider services profiles, claims, all pertinent professional and financial records, and information received from other sources;
E. The implementation of the Restriction Plans;
F. Referral to appropriate licensing boards or registries; and
G. Referral to the Maine Attorney General's Office, Healthcare Crimes Unit, for those cases in which fraudulent activity is suspected.

The Department and its professional advisors regard the maintenance of adequate clinical and other required financial and product-related records as essential for the delivery of quality care. In addition, providers should be aware that comprehensive records, including but not limited to treatment/service plans, progress notes, product and/or service order forms, invoices, and documentation of delivery of services and /or products provided are key documents for post-payment reviews. In the absence of proper and comprehensive records, no payment will be made and/or payments previously made may be recouped.

Once an overpayment has been identified and is finally determined, a Notice of Debt is sent over to the Maine Department of Health and Human Services' Service Center for collection. The Service Center will arrange for the repayment of the debt with the provider. The Service Center recoups in a variety of ways including lump sum payment, installment payment plans, or offsetting against future Medicaid reimbursement.
** Due to the character count limit, please see Additional Needed Information.*

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a. All waiver services are paid through the MMIS, with the exception of the per member per month (PMPM) broker free for Transportation Services. Transportation is reimbursed through a 1915b Me.19 Maine Non-emergency Transportation Waiver capitated system with contracted brokers outside the MMIS system.
b. The process for making the payments is through contracted services, the entity that processes these payments is the Department of Administration and Finance.
c. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data.
d. The basis of the draw is through the Maine Medicaid chart of accounts. The appropriation and unit / Object codes for entry onto line 19A of the CMS64 report are as follows:
Appropriation: 0147-
Unit for waivered services: 3618
Object codes: 67A7;
Cash draws for the federal portion of the Payment Management System are completed regularly through the Batch Interface claims processing system; and accounted for through the accounting appropriation 0147 for Medicaid. The unit for waivered services is 3618 using object code 67A7.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For Transportation Services- The limited fiscal agent is selected through an rfp process. The waiver services that the fiscal agent will make payment for are Transportation Services. The fiscal agent pays through a capitated system. Chapter I of the MaineCare Benefits Manual authorizes audits for Services. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data. The broker for transportation is one of 3 contracted entities for the 8 regions depending upon the region in the state. Region 3 is served by Penquis Community Action Program, Region 8 is served by Logisticare Solutions, LLC, and Regions 1,2,4,5,6,and 7 are served by Coordinated Transportation Solutions, Inc.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-

c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The rate structure for services delivered in residential settings is based solely on the cost of delivering the service and does not include room and board costs. Cost of room and board is paid for separately by participant funds (e.g. SSI). Any payments made to room and board does not process through the MMIS claim system and is therefore not included with the cost.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*92255.38*	*29634.68*	*121890.06*	*277603.64*	*8976.66*	*286580.30*	*164690.24*
2	*95070.87*	*30553.36*	*125624.23*	*286209.36*	*9254.93*	*295464.29*	*169840.06*
3	*97974.63*	*31500.51*	*129475.14*	*295081.85*	*9541.83*	*304623.68*	*175148.54*
4	*100967.79*	*32477.02*	*133444.81*	*304229.38*	*9837.63*	*314067.01*	*180622.20*
5	*104053.74*	*33483.81*	*137537.55*	*313660.49*	*10142.60*	*323803.09*	*186265.54*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*	
		Level of Care:	*Level of Care:*
		Nursing Facility	*ICF/IID*
Year 1	*250*	*50*	*200*
Year 2	*250*	*50*	*200*

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	ICF/IID
Year 3	250	50	200
Year 4	250	50	200
Year 5	250	50	200

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average LOS is 315 days. This number is based on current utilization information from the most recent 372 report for July 2021 - June 2022.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

D Derivation: For Services in the Waiver, actual utilization was analyzed from SFY 2022 as well as SFY 2022 numbers of users, average usage per user, and the most recent approved rates for the Schedule D estimates by procedure code. In addition, the 372 Report from July 1, 2021 to June 30, 2022 was reviewed and used as the "base line".

An estimate of 250 members was used. In addition, the detailed query information to generate the 372 report is reviewed annually. Utilization information is periodically reviewed during budget reviews. The CMS 372 report contains important utilization information such as percentages of utilization for specific services which can be compared to the total current waiver population. The information was used to make future predictions of services. Years 1-5 utilization by members is expected to remain constant.

The Transportation estimates are based the new PMPM's and added to waiver Years 1 - 5 for the Concurrent 1915 (b) Non-Emergency Transportation Waiver.

Rates for WY1 were based on the most recent fee schedule published by MaineCare which is effective July 1, 2024. For WYs 2-5 we projected an increase in rates year over year of 3.1%. This increase is based on the inflation rate from the CPI Index for All Urban Consumers for the 12-month period ending November 2023.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Included in the D' calculation is the cost of all State Plan services furnished while the participant was on the waiver. Also included is the cost of short-term institutionalization which began after the person's first day of waiver services and ended before the end of the waiver year if the person returned to the waiver after institutionalization.

Factor D' Projections were based the July 1, 2021 to June 30, 2022 372 Report recently compiled which shows a $27,879.37 total Factor D' amount per client. This amount was trended up by 3.1% over two years to meet our starting date of this renewal of July 1, 2024, making our starting D' amount $29,634.68. This amount was used for Waiver Year 1 and trended by 3.1% for WYs 2-5. The rate of 3.1% was used as it is the most recent inflation rate from the CPI Index for All Urban Consumers (12-month period ending November 2023).

Costs for prescribed drugs were not included in the calculation.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G for WY 1 was calculated by looking at actual established yearly caps established for ICFs and specialized brain injury nursing facilities for SFY 2024 (July 2023 – June 2024). This calculation used the following formula:
80% ICF Yearly Cap + 20% specialized brain injury NF yearly CAP = Total Annual Comparison CAP
Total Annual Comparison CAP – G' = Factor G WY1 Projection
*80% of ICF Yearly Cap = $303,275.08 * .80 = $ 242,620.06*
*20% of specialized brain injury NF yearly CAP = $219,801.18 * .20 = $43,960.24*
Total Annual Comparison CAP = $286,580.30
G' factor for other services / drug costs WY1 = $8976.66

$286,580.30 - $8976.66 = $277,603.64
Total WY1 projection for G = $277,603.64.

This total was then trended up by 3.1% inflation rate for WYs 2-5. The rate of 3.1% was used as it is the most recent inflation rate from the CPI Index for All Urban Consumers (12-month period ending November 2023).

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' projection for WY1 was determined by starting with the most recent 372 report dated July 1, 2021 to June 30, 2022. This value of $8,444.95 was trended up year over year at 3.1% for two years to reach our starting point of this renewal of July 1, 2024. The total for WY1 was set at $8,976.66 as a result and then trended upwards year over year at 3.1% for WYs 2-5. The rate of 3.1% was used as it is the most recent inflation rate from the CPI Index for All Urban Consumers (12-month period ending November 2023).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Care Coordination	
Career Planning	
Home Support- 1/4 hour-Level I	
Home Support-Per Diem Level II	
Financial Management Services	
Individual Goods and Services	
Supports Brokerage	

Waiver Services	
Assistive Technology	
Employment Specialist Services	
Home Support- Remote Support	
Home Support-Per Diem Level III Increased Neurobehavioral	
Non-Medical Transportation	
Work Ordered Day Club House	
Work Support-Individual	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:							**480150.00**
Case Management: T1016 U9	☐	1/4 hour	250	97.00	19.80	**480150.00**	
Career Planning Total:							**32568.00**
Career Planning: T2015 U9	☐	per hour	15	32.00	67.85	**32568.00**	
Home Support- 1/4 hour-Level I Total:							**225040.00**
Home Support Level I: T2017 U9	☐	1/4 hour	20	970.00	11.60	**225040.00**	
Home Support-Per Diem Level II Total:							**14277751.68**
Home Support Level II (2-4 Beds): T2016 U9	☐	per diem	32	264.00	467.52	**3949608.96**	
Home Support Level II (5-8 beds) T2016 U9 TT	☐	per diem	96	287.00	374.86	**10328142.72**	
Financial Management							**49221.12**

GRAND TOTAL:	**23063844.11**
Total: Services included in capitation:	414420.00
Total: Services not included in capitation:	22649424.11
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**92255.38**
Services included in capitation:	1658.00
Services not included in capitation:	90597.70
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Financial Management: T2040 U9 U6	☐	per month	32	12.00	128.18	**49221.12**	
Individual Goods and Services Total:							**207528.96**
Individual Goods and Services: T2028 U9 U6	☐	per invoice	32	12.00	540.44	**207528.96**	
Supports Brokerage Total:							**111552.00**
Supports Brokerage: T2041 U9 U6	☐	1/4 hour	32	200.00	17.43	**111552.00**	
Assistive Technology Total:							**368559.46**
Assistive Technology Transmission: T2035 U9	☐	per month	74	9.00	55.49	**36956.34**	
Assistive Technology Device: A9279 U9	☐	per invoice	45	1.00	7056.48	**317541.60**	
Assistive Technology Assessment: 97755 U9	☐	1/4 hour	76	11.00	16.82	**14061.52**	
Employment Specialist Services Total:							**16.00**
Employment Specialist Services: T2019 U9	☐	1/4 hour	1	1.00	16.00	**16.00**	
Home Support-Remote Support Total:							**43854.65**
Monitor Only: T2017 QC	☐	1/4 hour	3	4279.00	3.25	**41720.25**	
Interactive Support: T2017 GT	☐	1/4 hour	4	46.00	11.60	**2134.40**	
Home Support-Per Diem Level III Increased Neurobehavioral Total:							**6602218.44**
Home Support Level III Increased Neurobehavioral (2-4 beds): T2016 U9 TG	☐	per diem	12	326.00	645.87	**2526643.44**	

GRAND TOTAL:	**23063844.11**
Total: Services included in capitation:	414420.00
Total: Services not included in capitation:	22649424.11
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**92255.38**
Services included in capitation:	1658.00
Services not included in capitation:	90597.70
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Support Level III Increased Neurobehavioral (5-8 beds): T2016 U9 TG TT	☐	per diem	30	250.00	543.41	4075575.00	
Non-Medical Transportation Total:							414420.00
Non-Medical Transportation	☒	PMPM	250	12.00	138.14	414420.00	
Work Ordered Day Club House Total:							180364.80
Work Ordered Day Club House: S5102 U9	☐	per diem	32	44.00	128.10	180364.80	
Work Support-Individual Total:							70599.00
Work Support-Individual: H2023 U9	☐	1/4 hour	10	505.00	13.98	70599.00	

GRAND TOTAL:	**23063844.11**
Total: Services included in capitation:	414420.00
Total: Services not included in capitation:	22649424.11
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**92255.38**
Services included in capitation:	1658.00
Services not included in capitation:	90597.70
Average Length of Stay on the Waiver:	315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:							494942.50
Case Management: T1016 U9	☐	1/4 hour	250	97.00	20.41	494942.50	

GRAND TOTAL:	**23767716.51**
Total: Services included in capitation:	427290.00
Total: Services not included in capitation:	23340426.51
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**95070.87**
Services included in capitation:	1709.00
Services not included in capitation:	93361.71
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Planning Total:							**33576.00**
Career Planning: T2015 U9	☐	per hour	15	32.00	69.95	**33576.00**	
Home Support- 1/4 hour-Level I Total:							**232024.00**
Home Support Level I: T2017 U9	☐	1/4 hour	20	970.00	11.96	**232024.00**	
Home Support-Per Diem Level II Total:							**14720317.44**
Home Support Level II (2-4 Beds): T2016 U9	☐	per diem	32	264.00	482.01	**4072020.48**	
Home Support Level II (5-8 beds) T2016 U9 TT	☐	per diem	96	287.00	386.48	**10648296.96**	
Financial Management Services Total:							**50745.60**
Financial Management: T2040 U9 U6	☐	per month	32	12.00	132.15	**50745.60**	
Individual Goods and Services Total:							**213960.96**
Individual Goods and Services: T2028 U9 U6	☐	per invoice	32	12.00	557.19	**213960.96**	
Supports Brokerage Total:							**115008.00**
Supports Brokerage: T2041 U9 U6	☐	1/4 hour	32	200.00	17.97	**115008.00**	
Assistive Technology Total:							**368994.18**
Assistive Technology Transmission: T2035 U9	☐	per month	74	9.00	55.49	**36956.34**	
Assistive Technology Device: A9279 U9	☐	per invoice	45	1.00	7056.48	**317541.60**	
Assistive Technology Assessment: 97755 U9	☐	1/4 hour	76	11.00	17.34	**14496.24**	
Employment Specialist Services Total:							**16.50**

GRAND TOTAL:	**23767716.51**
Total: Services included in capitation:	427290.00
Total: Services not included in capitation:	23340426.51
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**95070.87**
Services included in capitation:	1709.00
Services not included in capitation:	93361.71
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Specialist Services: T2019 U9	☐	1/4 hour	1	1.00	16.50	16.50	
Home Support-Remote Support Total:							45204.59
Monitor Only: T2017 QC	☐	1/4 hour	3	4279.00	3.35	43003.95	
Interactive Support: T2017 GT	☐	1/4 hour	4	46.00	11.96	2200.64	
Home Support-Per Diem Level III Increased Neurobehavioral Total:							6806911.68
Home Support Level III Increased Neurobehavioral (2-4 beds): T2016 U9 TG	☐	per diem	12	326.00	665.89	2604961.68	
Home Support Level III Increased Neurobehavioral (5-8 beds): T2016 U9 TG TT	☐	per diem	30	250.00	560.26	4201950.00	
Non-Medical Transportation Total:							427290.00
Non-Medical Transportation	☒	PMPM	250	12.00	142.43	427290.00	
Work Ordered Day Club House Total:							185954.56
Work Ordered Day Club House: S5102 U9	☐	per diem	32	44.00	132.07	185954.56	
Work Support-Individual Total:							72770.50
Work Support-Individual: H2023 U9	☐	1/4 hour	10	505.00	14.41	72770.50	

GRAND TOTAL:	**23767716.51**
Total: Services included in capitation:	427290.00
Total: Services not included in capitation:	23340426.51
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**95070.87**
Services included in capitation:	1709.00
Services not included in capitation:	93361.71
Average Length of Stay on the Waiver:	315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User,*

and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:							**510462.50**
Case Management: T1016 U9	☐	1/4 hour	250	97.00	21.05	**510462.50**	
Career Planning Total:							**34632.00**
Career Planning: T2015 U9	☐	per hour	15	32.00	72.15	**34632.00**	
Home Support- 1/4 hour-Level I Total:							**239202.00**
Home Support Level I: T2017 U9	☐	1/4 hour	20	970.00	12.33	**239202.00**	
Home Support-Per Diem Level II Total:							**15176688.00**
Home Support Level II (2-4 Beds): T2016 U9	☐	per diem	32	264.00	496.96	**4198318.08**	
Home Support Level II (5-8 beds) T2016 U9 TT	☐	per diem	96	287.00	398.46	**10978369.92**	
Financial Management Services Total:							**52320.00**
Financial Management: T2040 U9 U6	☐	per month	32	12.00	136.25	**52320.00**	
Individual Goods and Services Total:							**220596.48**
Individual Goods and Services: T2028 U9 U6	☐	per invoice	32	12.00	574.47	**220596.48**	
Supports Brokerage Total:							**118592.00**
Supports Brokerage: T2041 U9 U6	☐	1/4 hour	32	200.00	18.53	**118592.00**	
Assistive Technology Total:							**369445.62**
Assistive Technology Transmission: T2035 U9	☐	per month	74	9.00	55.49	**36956.34**	

GRAND TOTAL:	**24493657.70**
Total: Services included in capitation:	440520.00
Total: Services not included in capitation:	24053137.70
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**97974.63**
Services included in capitation:	1762.00
Services not included in capitation:	96212.55
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Device: A9279 U9	☐	per invoice	45	1.00	7056.48	317541.60	
Assistive Technology Assessment: 97755 U9	☐	1/4 hour	76	11.00	17.88	14947.68	
Employment Specialist Services Total:							17.01
Employment Specialist Services: T2019 U9	☐	1/4 hour	1	1.00	17.01	17.01	
Home Support-Remote Support Total:							46556.37
Monitor Only: T2017 QC	☐	1/4 hour	3	4279.00	3.45	44287.65	
Interactive Support: T2017 GT	☐	1/4 hour	4	46.00	12.33	2268.72	
Home Support-Per Diem Level III Increased Neurobehavioral Total:							7017855.36
Home Support Level III Increased Neurobehavioral (2-4 beds): T2016 U9 TG	☐	per diem	12	326.00	686.53	2685705.36	
Home Support Level III Increased Neurobehavioral (5-8 beds): T2016 U9 TG TT	☐	per diem	30	250.00	577.62	4332150.00	
Non-Medical Transportation Total:							440520.00
Non-Medical Transportation	☒	PMPM	250	12.00	146.84	440520.00	
Work Ordered Day Club House Total:							191727.36
Work Ordered Day Club House: S5102 U9	☐	per diem	32	44.00	136.17	191727.36	
Work Support-Individual Total:							75043.00
Work Support-Individual:	☐					75043.00	

GRAND TOTAL:	24493657.70
Total: Services included in capitation:	440520.00
Total: Services not included in capitation:	24053137.70
Total Estimated Unduplicated Participants:	250
Factor D (Divide total by number of participants):	97974.63
Services included in capitation:	1762.00
Services not included in capitation:	96212.55
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
H2023 U9		1/4 hour	10	505.00	14.86		
					GRAND TOTAL:		24493657.70
					Total: Services included in capitation:		440520.00
					Total: Services not included in capitation:		24053137.70
					Total Estimated Unduplicated Participants:		250
					Factor D (Divide total by number of participants):		97974.63
					Services included in capitation:		1762.00
					Services not included in capitation:		96212.55
					Average Length of Stay on the Waiver:		315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:							526225.00
Case Management: T1016 U9	☐	1/4 hour	250	97.00	21.70	526225.00	
Career Planning Total:							35692.80
Career Planning: T2015 U9	☐	per hour	15	32.00	74.36	35692.80	
Home Support- 1/4 hour-Level I Total:							246574.00
Home Support Level I: T2017 U9	☐	1/4 hour	20	970.00	12.71	246574.00	
Home Support-Per Diem Level II Total:							15647054.40
Home Support Level II (2-4 Beds): T2016 U9	☐	per diem	32	264.00	512.36	4328417.28	
Home Support Level II (5-8 beds) T2016 U9 TT	☐	per diem	96	287.00	410.81	11318637.12	
					GRAND TOTAL:		25241946.97
					Total: Services included in capitation:		454170.00
					Total: Services not included in capitation:		24787776.97
					Total Estimated Unduplicated Participants:		250
					Factor D (Divide total by number of participants):		100967.79
					Services included in capitation:		1817.00
					Services not included in capitation:		99151.11
					Average Length of Stay on the Waiver:		315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							**53940.48**
Financial Management: T2040 U9 U6	☐	per month	32	12.00	140.47	**53940.48**	
Individual Goods and Services Total:							**227435.52**
Individual Goods and Services: T2028 U9 U6	☐	per invoice	32	12.00	592.28	**227435.52**	
Supports Brokerage Total:							**122240.00**
Supports Brokerage: T2041 U9 U6	☐	1/4 hour	32	200.00	19.10	**122240.00**	
Assistive Technology Total:							**369905.42**
Assistive Technology Transmission: T2035 U9	☐	per month	74	9.00	55.49	**36956.34**	
Assistive Technology Device: A9279 U9	☐	per invoice	45	1.00	7056.48	**317541.60**	
Assistive Technology Assessment: 97755 U9	☐	1/4 hour	76	11.00	18.43	**15407.48**	
Employment Specialist Services Total:							**17.53**
Employment Specialist Services: T2019 U9	☐	1/4 hour	1	1.00	17.53	**17.53**	
Home Support-Remote Support Total:							**48038.36**
Monitor Only: T2017 QC	☐	1/4 hour	3	4279.00	3.56	**45699.72**	
Interactive Support: T2017 GT	☐	1/4 hour	4	46.00	12.71	**2338.64**	
Home Support-Per Diem Level III Increased Neurobehavioral Total:							**7235466.84**
Home Support Level III Increased Neurobehavioral (2-4 beds):	☐	per diem	12	326.00	707.82	**2768991.84**	

GRAND TOTAL:	**25241946.97**
Total: Services included in capitation:	454170.00
Total: Services not included in capitation:	24787776.97
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**100967.79**
Services included in capitation:	1817.00
Services not included in capitation:	99151.11
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
T2016 U9 TG							
Home Support Level III Increased Neurobehavioral (5-8 beds): T2016 U9 TG TT	☐	per diem	30	250.00	595.53	**4466475.00**	
Non-Medical Transportation Total:							**454170.00**
Non-Medical Transportation	☒	PMPM	250	12.00	151.39	**454170.00**	
Work Ordered Day Club House Total:							**197669.12**
Work Ordered Day Club House: S5102 U9	☐	per diem	32	44.00	140.39	**197669.12**	
Work Support-Individual Total:							**77517.50**
Work Support-Individual: H2023 U9	☐	1/4 hour	10	505.00	15.35	**77517.50**	

GRAND TOTAL:	**25241946.97**
Total: Services included in capitation:	454170.00
Total: Services not included in capitation:	24787776.97
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**100967.79**
Services included in capitation:	1817.00
Services not included in capitation:	99151.11
Average Length of Stay on the Waiver:	315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Coordination Total:							**542472.50**
Case	☐					**542472.50**	

GRAND TOTAL:	**26013434.99**
Total: Services included in capitation:	468240.00
Total: Services not included in capitation:	25545194.99
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**104053.74**
Services included in capitation:	1873.00
Services not included in capitation:	102180.78
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Management: T1016 U9		*1/4 hour*	*250*	*97.00*	*22.37*		
Career Planning Total:							***36796.80***
Career Planning: T2015 U9	☐	*per hour*	*15*	*32.00*	*76.66*	***36796.80***	
Home Support- 1/4 hour-Level I Total:							***254334.00***
Home Support Level I: T2017 U9	☐	*1/4 hour*	*20*	*970.00*	*13.11*	***254334.00***	
Home Support-Per Diem Level II Total:							***16132221.12***
Home Support Level II (2-4 Beds): T2016 U9	☐	*per diem*	*32*	*264.00*	*528.24*	***4462571.52***	
Home Support Level II (5-8 beds) T2016 U9 TT	☐	*per diem*	*96*	*287.00*	*423.55*	***11669649.60***	
Financial Management Services Total:							***55614.72***
Financial Management: T2040 U9 U6	☐	*per month*	*32*	*12.00*	*144.83*	***55614.72***	
Individual Goods and Services Total:							***234485.76***
Individual Goods and Services: T2028 U9 U6	☐	*per invoice*	*32*	*12.00*	*610.64*	***234485.76***	
Supports Brokerage Total:							***126016.00***
Supports Brokerage: T2041 U9 U6	☐	*1/4 hour*	*32*	*200.00*	*19.69*	***126016.00***	
Assistive Technology Total:							***370381.94***
Assistive Technology Transmission: T2035 U9	☐	*per month*	*74*	*9.00*	*55.49*	***36956.34***	
Assistive Technology Device: A9279 U9	☐	*per invoice*	*45*	*1.00*	*7056.48*	***317541.60***	
Assistive Technology Assessment: 97755 U9	☐	*1/4 hour*	*76*	*11.00*	*19.00*	***15884.00***	
Employment							***18.08***

GRAND TOTAL:		***26013434.99***
Total: Services included in capitation:		*468240.00*
Total: Services not included in capitation:		*25545194.99*
Total Estimated Unduplicated Participants:		***250***
Factor D (Divide total by number of participants):		***104053.74***
Services included in capitation:		*1873.00*
Services not included in capitation:		*102180.78*
Average Length of Stay on the Waiver:	*315*	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialist Services Total:							
Employment Specialist Services: T2019 U9	☐	1/4 hour	1	1.00	18.08	**18.08**	
Home Support-Remote Support Total:							**49524.03**
Monitor Only: T2017 QC	☐	1/4 hour	3	4279.00	3.67	**47111.79**	
Interactive Support: T2017 GT	☐	1/4 hour	4	46.00	13.11	**2412.24**	
Home Support-Per Diem Level III Increased Neurobehavioral Total:							**7459746.12**
Home Support Level III Increased Neurobehavioral (2-4 beds): T2016 U9 TG	☐	per diem	12	326.00	729.76	**2854821.12**	
Home Support Level III Increased Neurobehavioral (5-8 beds): T2016 U9 TG TT	☐	per diem	30	250.00	613.99	**4604925.00**	
Non-Medical Transportation Total:							**468240.00**
Non-Medical Transportation	☒	PMPM	250	12.00	156.08	**468240.00**	
Work Ordered Day Club House Total:							**203793.92**
Work Ordered Day Club House: S5102 U9	☐	per diem	32	44.00	144.74	**203793.92**	
Work Support-Individual Total:							**79790.00**
Work Support-Individual: H2023 U9	☐	1/4 hour	10	505.00	15.80	**79790.00**	

GRAND TOTAL:	**26013434.99**
Total: Services included in capitation:	468240.00
Total: Services not included in capitation:	25545194.99
Total Estimated Unduplicated Participants:	**250**
Factor D (Divide total by number of participants):	**104053.74**
Services included in capitation:	1873.00
Services not included in capitation:	102180.78
Average Length of Stay on the Waiver:	315