Adult Services

Office of Aging and Disability Services (OADS):

The Office of Aging and Disability Services (OADS) supports Maine’s older and disabled adults by providing Adult Protective, Brain Injury, Other Related Conditions, Intellectual and Developmental Disability, Long Term Care, and Aging and Community services to the people of Maine.

OADS coordinates the programs and benefits to assure they operate consistent with the state and federal policies and the Maine Department of Health and Human Services’ goals.

In order to obtain any adult services you must have an adult case manager Section 13: Targeted Case Management. Case management services is entitlement only if the person is a MaineCare participant.

OADS covers two waivers: Section 21 and Section 29

Section 21:

Home and Community Benefits (HCB) for Members with Intellectual Disabilities or Autistic Disorder also known as Comprehensive Waiver gives members eligible for this Benefit the option to live in their own home or in another home in the community thus avoiding or delaying institutional services.

Eligibility for 21 includes: 18 years or older; has Intellectual Disability (ID) or Autism Spectrum Disorder (ASD) defined by the Diagnostic Statistical Manual (DSM); meets the medical eligibility criteria for admission to Intermediate Care Facility for Person with ID as set forth under MaineCare Benefits Manual; does not receive services under any other federally approved MaineCare home and community based waiver program; and meets all MaineCare eligibility requirements set forth in the MaineCare Eligibility Manual

Section 29:

Support Services for Adults with Intellectual Disabilities (ID) or Autistic Disorder also known as The Community Support Waiver which provides day programming and employment. Section 29 are for adults who either live with their families or live on their own. Support Services are also designed to support member in the work place. (also known as day habs)

Eligibility for Section 29 includes: 18 years or older; has Intellectual Disability (ID) or Autism Spectrum Disorder (ASD) defined by the Diagnostic Statistical Manual (DSM); meets the medical eligibility criteria for admission to Intermediate Care Facility for Person with ID as set forth under MaineCare Benefits Manual; does not receive services under any other federally approved MaineCare home and community based waiver program; meets all MaineCare eligibility requirements set forth in the MaineCare Eligibility Manual; must have an adult case manager or have begun the transition to an adult services case manager; lives with family or on their own.

Eligibility Process: There is a waiting list for services. Removal from the list is chronologically based on the date the waiver manager determines eligibility. A person will have 30 days to respond to DHHS determination that there is a funded opening. If there is no response, the member will return to the end of the waiting list.
Section 21 & 29 Assessments:

- Psychological Evaluation
- A completed copy of assessment referral form.
- A copy of the Person Centered Plan (PCP) approved and signed by the member or guardian and the case manager.
- Any other material indicating persons service needs.

Section 21 & 29 Timeframe:

- Families should gather information regarding adult services 2 years prior to the 18th birthday.
- Start the process of applying for MaineCare, and DHHS services by 17 ½ years old.
- DHHS Community Case Manager should be invited to attend the IEP meeting at age 16-18 depending on date of exit form school.

Waitlists:

Both Section 21 and 29 have a waitlist for funded service/slot.

- **Section 29** by date filed
- **Section 21** is by priorities:
  
  Priority 1: Any member on the waiting list shall be identified as Priority 1 if the member has been determined by DHHS to be in need of adult protective services and if the member continues to meet the financial and medical eligibility criteria at the time that need for adult protective services is determined.

  Priority 2: If the member has been determined to be a risk of abuse in the absence of the provision of benefit services identified in his or her service plan. Examples to be considered: 1) members whose parents have reached age 60 and are having difficulty providing the necessary supports to the member within the home and 2) a member living in an unsafe or unhealthy circumstances but who is not yet in need of adult protective services, as determined by DHHS Adult Protective Services.

  Priority 3: If the member has been determined to be a risk of abuse in the absence of the provision of benefit services identified in his or her service plan. Examples of members who shall be considered Priority 3 include: 1) member living with family, who has expressed a desire to move out of the family home; 2) member whose medical or behavioral needs are changing and who may not be able to receive appropriate services in the current living situation; 3) member who resides with family, if the family must be employed to maintain household but cannot work in the absence of the benefit being provided to the member or 4) a member who has graduated from high school in the State of Maine, has no continuing support services outside of the school system, but is in need of such services.
All human beings have value, natural abilities, dignity, and potential. By dignity, we mean: Self-respect, nobility, worthiness, and honoring choice. Through this, we set the tone for all achievement and personal growth. Transition is the movement that incorporates these inherent characteristics, creating opportunities for a meaningful and fulfilling life.

Transition is a process, not a destination or event, and leads to quality outcomes for each individual. Transition is lifelong, with milestones along the way. It is both a foundation and a springboard to a fulfilling and meaningful life that must be facilitated by the individual, family, supports, and services across all environments. Transition involves collaboration, creativity, and community, and envisions a path through which an individual figures out what he or she wants to do and how to live his or her life.

Successful transition is a journey. This journey takes the individual through many transition planning areas and promotes development of the essential elements of a fulfilling life.

**Transition Planning Areas**

The transition planning areas (see diagram) describe various transitions for the individual throughout his or her lifetime. The blueprint presumes that the person begins as a child under parental care, transitions to adulthood, and thrives in a world with continued transitions. Family and community supports are present as part of a responsive natural support network. Successful transition planning involves an individual, family, community, and government partnership. Supports for any individual should be closest to “typical” for anyone.

**Community inclusion** is based on the assumption that an individual with disabilities should not be isolated but instead should be a part of and connected within the community. It means a person is engaged socially, recreationally, and culturally. It also means that the person becomes a productive community member, pursuing talents and giving back to others. As the person differentiates from his or her parents he or she begins to exercise greater self-determination, makes more choices, and with the necessary support takes a more active role in setting and pursuing his or her own goals. As a member of the community a person is treated with dignity and respect. A person belongs.

Quality flexible wraparound supports are based on need, not on what is available. These involve varying supports as needed (from minimal to maximum, and adapting to life’s circumstances) to promote appropriate development, safety, stability, and inclusion.

The rest of the transition planning areas are self-explanatory: Planning for aging, financial management and planning, stable housing and home, employment and vocation, healthcare and wellness, transportation, and special and continuing education/lifelong learning; all enhancing community inclusion and self-determination – central to the person’s life.

**Essential Elements of a Fulfilling Life**

The interwoven essential elements of a fulfilling life (see diagram, blue font) include:

- Family and Friends
- Relationships, Intimacy, & Love
- Community & Belonging
- Quality of Life
- Natural Supports
- Dignity of Choice
- Culture, Values, & Beliefs
- Lifelong Personal Growth & Skill Building
- Dignity of Risk

These elements are achievable by way of a successful journey through the transition planning areas.

Transition is about excellence and equity. It is about investing in human potential and individual dignity.

Central to the diagram, transition involves communication, collaboration, and integration. Integration requires transcending boundaries and braiding resources to create a comprehensive whole.
Maine Coalition for Housing and Quality Services
Blueprint for Effective Transition

Goals and Objectives

1. Collaboration, integration, and communication
   a. Comprehensive whole, not silos
      i. Have everyone at the table
         1. Have first High School IEP meeting include all players: Every service sector, and every system partner involved with the person as a child and as a future adult.
         2. Ensure High School IEP meetings have an evolving membership reflecting changes in the person’s life.
         3. Have all children’s case managers working with transition-age youth become familiar with and fluent in their understanding of the adult service system and local service providers.
         4. Ensure transition-age youth have overlapping children’s case management and adult case management for a period of at least nine months to facilitate a warm handoff.
         5. Encourage all individuals to fully transition to an adult case manager at least nine months before exiting High School.
      ii. Have all parties fully participate
         1. Establish annual global participation permission by parents, or individual where appropriate, so all can easily be present at IEP meetings.
         2. Establish required participation by every service provider and every system partner involved with the individual.
         3. Ensure schools and departments will hold meetings at times that work for parents/families.
         4. Document all unmet needs and collaborate to meet each need.
         5. Ensure, that for individuals eligible for PCP’s, IEP meetings inform and overlap PCP meetings after the age of 18.
   b. Relationship building and information sharing
      i. Establish an annual statewide joint adult and children’s case managers meeting, which includes representation from school-based case managers.
      ii. Re-establish a Children’s Cabinet to improve or increase collaboration between State departments.
      iii. Convene, at least quarterly, client-specific transition meetings to include school personnel, VR counselors, children’s case managers, adult case managers, parents/guardians, any other important players, and the individual.
   c. Training
      i. Focus on quality, not compliance.
      ii. Have the State develop a statewide training for school-based and children’s case managers to learn about the adult system.
         1. Have an online training be developed and maintained, for easy access.
      iii. Have the State develop a general transition guide, which will include a checklist of things to consider when facing any transition as well as associated timelines.
      iv. Ensure adequate training for parents/guardians so they receive all available information.
      v. Educate parents regarding what is ahead (as soon as possible, ideally upon diagnosis) so they can plan for the entire public schooling career.
   d. Allow room for creativity
      i. Build on strengths
         1. Prioritize people’s strengths so they are not lost.
            a. Don’t just focus on needs.
         2. Ensure strengths are documented as part of the plan and shared with the team.
Maine Coalition for Housing and Quality Services
Blueprint for Effective Transition

3. Have the system fund strengths, as well as needs.
4. Consider strengths related to familiarity with environment, as well as strengths portable to any environment. (You have to have the skill and consideration of the environment in which one thrives).
   a. Ensure goodness of fit between environment and skill; everything has to be a good fit.
   b. Have ongoing assessment of continued good fit.
ii. Gear plans so people experience a sense of purpose in their lives.
iii. Do what works for each individual
   1. Remember that every person is different and their needs are different – transition is not one-size-fits-all.
   2. Discern what will make a person happy and fulfilled, and build on that with all plans.
   3. Allow for appropriate risk-taking
      a. Push the envelope; provide opportunities for further growth.
      b. Build on success and failures.
   4. Don’t limit plans to what is currently available; special orders must be ok.
   5. Don’t let a person’s current capacity limit plans for future opportunities and possibilities.
iv. Build communities that allow and support people with disabilities to do anything and everything.
   1. Support teams should encourage each person to be an active participant in the community.
   2. Tap into existing community resources and create new ones as needed.

2. Individual Support, Family System Support, Natural Support
   Individual Support
   a. Ensure the individual is an active participant in all aspects of planning for his or her life.
   b. Provide adequate equipment, technology, and resources to individuals.
   c. Ensure individuals have access to appropriate mental health counseling.
   Family System Support
   a. Establish reasonable schedules for informal meetings with all players on transition. (Informal can mean phone check-in or other means of communication).
      i. Have all schools in Maine recognize that planning for transition should start no later than the first year of high school.
      ii. Allow parents to determine frequency of meetings.
      iii. Aim for quarterly meetings in second to last year of high school.
      iv. Aim for monthly meetings in last year of high school.
      v. Have all schools in Maine allow extended participation until an age out year of 22.
   b. Awareness of all options
      i. Maintain consideration of all options throughout the planning process. Explain these to every family.
      ii. Ensure that parents’ knowledge and access to resources is on par with transition participants.
   c. Address caregiver strain
      i. Provide adequate information and support to the caregiver.
      ii. Provide adequate training to caregivers when needed/requested.
         1. Help families learn how to let go and encourage increasing independence.
      iii. Recognize and respect that families know the individual best.
      iv. Provide adequate equipment, technology, and resources to caregivers.
Maine Coalition for Housing and Quality Services
Blueprint for Effective Transition

Natural Support
a. Individual natural supports
   i. Create and maintain an individualized natural support network for each person that is adequate for success.

b. Family natural supports
   i. Create and maintain a natural support network for each family that is adequate for success.

c. Community natural supports
   i. Promote awareness and understanding in the community about individual differences and needs so community members know what they can do to be natural supports.

d. Societal natural supports
   i. Promote awareness and understanding in the greater community about individual differences and needs so that each of us knows what we can do to be a natural support.

3. Self-Determination
   a. Self-advocacy skills
      i. Teach meeting skills, such as following agendas, rehearsing, and planning so one can be an active participant in his or her own meetings.
      ii. Establish concrete opportunities for self-advocacy at home, school, community, etc., throughout each day.
      iii. Learn how to actively access the community in a way that incorporates one’s own preferences and goals.
      iv. Ensure individuals have information about guardianship alternatives.
      v. Ensure individuals are aware of all options and opportunities for self-advocacy throughout transition planning.
   b. Dignity of risk, dignity of choice
      i. Teach understanding of what constitutes dignity and risk.
      ii. Establish and practice safe behaviors at home and in the community.
      iii. Teach practical and functional skills to ensure one’s safety at home and in the community.
      iv. Understand fixed rules vs. flexible guidelines for success in negotiating the world.
      v. Facilitate parents and caregivers letting go and allowing for appropriate risk taking and decision making by the individual.
      vi. Establish proactive neighborhood planning so people surrounding the individual are empowered to take an active supporting role as needed.
      vii. Help the individual and support network plan for emergencies, including recognizing what constitutes an emergency, and when it is appropriate to ask for/access help.
      viii. Teach strategies for decision making and the understanding of consequences.
      ix. Learn how to be a good customer, including how to assert one’s self to meet one’s own needs and how to achieve one’s own preferences in the context of others.
      x. Ensure individuals have information about all housing/residential options.
   c. Opportunity to learn from mistakes
      i. Ensure opportunities for the individual to debrief experiences, positive and negative, and understand them as aides to personal growth.

4. Employment and Career
   a. Focus on employment first, and other community supports second.
      i. Start early and often developing employment skills and good employee practices.
      ii. Provide school-based exposure, jobs at home, pre- and post-secondary training, job experiences, internships, career preparation, pursuit of career, and volunteer opportunities.
      iii. Ensure individuals have communication support, and have developed social skills/pragmatics adequate for success in employment and career endeavors.
      iv. Build employment experiences around individual’s interests.
      v. Have each individual leave high school with resume.
b. Be a good employee
   i. Learn how to be a good employee, including how to follow rules and norms of employment setting.
   ii. Ensure both employer and employee learn how to build skills, knowledge base, and aspirations, to allow for further growth and career opportunities.
   iii. Learn how to adapt to changes in job descriptions.

5. Quality of life
   a. Ensure each person is happy, healthy, and satisfied with his or her life
      i. Achieve or make continued progress towards the essential elements of a fulfilling life as defined by each individual in terms of:
         1. Family and Friends
         2. Relationships, Intimacy, and Love
         3. Community and Belonging
         4. Quality of Life
         5. Natural Supports
         6. Dignity of Risk
         7. Dignity of Choice
         8. Culture, Values, and Beliefs
         9. Lifelong Personal Growth & Skill Building
   b. Ensure stable housing and sense of home.
      i. Ensure affordability.
      ii. Ensure there is an adequate plan for maintenance and upkeep.
   c. Ensure access to resources adequate for housing, employment, transportation, health, community participation, and fun.
      i. Have resources include financial, personal support, and help with system navigation.
      ii. Have ongoing skilled case management services.
   d. Ensure mechanism for monitoring quality of life and changing priorities and choices.
   e. Ensure community inclusion.
      i. Ensure individuals have communication support and have developed social skills/pragmatics for successful community inclusion.
   f. Ensure community participation.
   g. Ensure each person’s identity, culture, values, and beliefs are respected and allowed to grow, evolve, and flourish.
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**Ch. II - Section 2: Adult Family Care Services**

*Definition*
Adult Family Care (AFC) Services include personal care services such as: assistance with activities of daily living and instrumental activities of daily living, personal supervision, protection from environmental hazards, diversional and motivational activities, dietary services and care management, as further defined in the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level III Residential Care Facilities or Assisted Housing Programs: Level IV Residential Care Facilities.

*Eligibility*
- Must meet financial eligibility criteria;
- Medical necessity of AFC services;
- 18 and older;
- The MDS-ALS assessment must show the member’s need for assistance or cuing with a minimum of two ADLs.

*Covered Services*
- Personal Care Services;
- Professional RN Services;
- Professional Private Duty Nursing Services, (as set forth in Section 96, may be provided to a member directly by an AFC services provider who is an RN and who is enrolled as a MaineCare provider).

*Limitations*
- Duplication of services is not allowed. It is the responsibility of the AFC services provider to coordinate services with other in-home services to address the full range of a member’s needs. Other MaineCare-covered services must not duplicate AFC covered services. For example, if a member receives Section 96, Private Duty Nursing and Personal Care Services; or Section 40, Home Health Services; or Section 19, Home and Community-Based Benefits for the Elderly and Adults with Disabilities, or Section 43, Hospice Services, all personal care services shall be delivered by the AFC services provider and not by a Certified Nursing Assistant (CNA), Home Health Aide (HHA), Personal Care Attendant (PCA) or Personal Support Specialist (PSS) as otherwise allowed in these Sections;
- Private Duty Nursing Services and Personal Care Services are subject to financial “caps” as described in Section 96, “Private Duty Nursing and Personal Care Services”. For members who receive Private Duty Nursing services, the cost of AFC services and
Private Duty Nursing services combined must not exceed the member’s approved Private Duty Nursing and Personal Care Services “cap”;
• Cannot be on Section 21 or Section 29.

Non-Covered Services
• Room and board, including the cost of meals and transportation for services that are not otherwise covered by MaineCare;
• Household or chore services unless furnished as an integral but subordinate part of the personal services, as described in Section 2.04-1A (2) that is furnished directly to the member;
• Other non-covered services as described in Chapter I of the MaineCare Benefits Manual (MBM), including services that are primarily academic, social, vocational or custodial in nature.
**Ch. II - Section 12: Consumer Directed Attendant Services**

**Definition**
Consumer Directed Attendant Services, also known as personal care attendant (PCA) services, or attendant services, enable eligible members with disabilities to re-enter or remain in the community and to maximize their independent living opportunity at home. Consumer Directed Attendant Services include assistance with activities of daily living, instrumental activities of daily living, and health maintenance activities. The eligible member hires his/her own attendant, trains the attendant, supervises the provision of covered services, completes the necessary written documentation, and if necessary, terminates services of the attendant. Personal Care Services cannot be provided by a member of the recipient’s family. The Department of Health and Human Services or the Assessing Services Agency consistent with these rules, shall determine medical eligibility for services under this Section, determine all covered services, and provide a plan of care for each new member prior to the start of services as well as all established members.

**Eligibility**
- Members eighteen years or older and physically disabled (permanent or chronic in nature);
- Financial eligibility criteria;
- Meets the medical eligibility requirements if he or she requires a combination of assistance with the required activities of daily living (Medical Eligibility Determination form);
- A registered nurse trained in conducting assessments with the Department’s approved MED form must conduct the medical eligibility assessment;
  - Must have the cognitive capacity, as measured on the MED form to be able to “self-direct” the attendant;
  - Must have a disability with functional impairments which interfere with his/her own capacity to provide self-care and daily living skills without assistance;
  - Must agree to complete initial member instruction and testing within thirty (30) days of completion of the MED form to determine medical eligibility in order to develop and verify that he or she has attained the skills needed to hire, train, schedule, discharge, and supervise attendants and document the provision of personal care services identified in the authorized plan of care.

**Covered Services**
- Care Coordination Services;
- Skills Training Services;
• Personal Care Services (PCS);
  ➢ Activities of Daily Living (ADL);
  ➢ Instrumental Activities of Daily Living (IADL).

**Limitations**
• Personal Care Services are limited to the following number of hours per week:
  ➢ Level I – 10 hours for ADLs, 2 hours for IADLs = Totaling 12 hours;
  ➢ Level II – 15 hours for ADLs, 3 hours for IADLs = Totaling 18 hours;
  ➢ Level III – 24 hours for ADLs, 4 hours for IADLs = Totaling 28 hours;
• Skills training shall not exceed 14.25 hours annually including the time required for initial instruction;
• Care Coordination Services shall not exceed 18 hours annually.

**Non-Covered Services**
• Room and board;
• Travel time and mileage by the Service Coordination Agency staff, and/or the attendant to and from the location of the member’s residence and mileage for travel by the attendant in the course of delivering a covered service;
• Case management services;
• Transportation to and from appointments;
• Household tasks except when delivered as an integral part of the authorized plan of care;
• Services provided by the member’s family member;
• Custodial care or respite care;
• Services received when a member enters a hospital, nursing facility, ICF as an inpatient, or any other Assisted Housing Program that is licensed to provide personal care services;
• Other services described as non-covered such as vocational, recreational, custodial, and educational activities;
• Services provided by a Personal Attendant who has any criminal convictions, except for Class D and Class E convictions over ten (10) years old that did not involve as a victim of the act, a patient, client, or resident of a health care entity; or any specific documented findings by the State Survey Agency of abuse, neglect or misappropriation of property of a resident, client, or patient;
• Services provided not in the presence of the member unless in the provision of covered IADL’s;
• On-call services.
Ch. II - Section 13: Targeted Case Management Services

Definitions

Child is a person between the ages of birth to eighteen (18) years of age.
Adult is any person who is eighteen (18) years of age or older or who is a legally emancipated minor.
NOTE: Adults aged eighteen (18) through twenty (20) years of age and children who are emancipated minors may choose to receive children’s behavioral health or developmental disabilities services or adult’s behavioral health or Intellectual disabilities services, whichever best meets their individual needs.

Case Management Services are those covered services provided by a social service or health professional, or other qualified staff, to identify the medical, social, educational and other needs (including housing and transportation) of the eligible member, identifies the services necessary to meet those needs, and facilitate access to those services. Case management consists of intake/assessment, plan of care development, coordination/advocacy, monitoring, and evaluation.

Comprehensive Case Manager is the one reimbursable case manager per member beginning 11/1/09. Comprehensive Case Managers must focus on coordinating and overseeing the effectiveness of all providers and benefits in responding to the member’s assessed needs.

Eligibility

- Eligible for MaineCare per MaineCare Manual, Chapter I, Section I;
- Must meet criteria for one of the following target groups:
  - Children with one of the following:
    - Behavioral Health Disorders;
    - Developmental Disabilities; and/or
    - Chronic Medical Conditions.
  - Adults with one of the following:
    - Developmental Disabilities;
    - Substance Abuse Disorders; and/or
    - HIV.
  - Members Experiencing Homelessness; and
  - Render a diagnosis, if a diagnosis is a requirement of a Targeted Case Management Eligibility Group.
Covered Services
- Comprehensive Assessment and Periodic Re-assessment;
- Development and Periodic Revision of the Individual Plan of Care;
- Referral and Related Activities;
- Monitoring and Follow-Up Activities.

Limitations
- One Comprehensive Case Management;
- Prior Authorization and Utilization Review;
- Section 13 (TCM) services provided to children with behavioral health needs, chronic health conditions, and/or developmental disabilities require prior authorization.

Non-Covered Services
- Payment for Targeted Case Management Services must not duplicate payments made to public agencies or private entities under other program authorities for case management or service coordination services;
- Case Management does not include the direct delivery of an underlying medical, educational, social or other service to which an eligible member has been referred;
- Payments for case management services under this Section must not duplicate payments for similar services made under other sections of MaineCare policy or other funding sources;
- Only one Comprehensive Targeted Case Manager is allowed;
- Payments for the documentation of progress notes are not allowable under this Section.
Definition
Community Support Services is a rehabilitative service that is provided in the context of a supportive relationship, pursuant to an individual support plan that promotes a person’s recovery and integration into the community, and sustains the person in his or her current living situation or another living situation of his or her choice.

Eligibility
- Eligible for MaineCare;
- The person is age eighteen (18) or older or is an emancipated minor; and
- Has a primary diagnosis on Axis I or Axis II of the multi-axial assessment system of the current version of the Diagnostic and Statistical Manual of Mental Disorders, except that the following diagnoses may not be primary diagnoses for purposes of this eligibility requirement:
  - Delirium, dementia, amnestic, and other cognitive disorders;
  - Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
  - Substance abuse or dependence;
  - Intellectual disability;
  - Adjustment disorders;
  - V-codes; or
  - Antisocial personality disorders; and
- Has a LOCUS score of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services and ACT, the member must have a LOCUS score of twenty (20) (Level IV) or greater;
- An AMHI Consent Decree Class Member is eligible to receive Community Integration Services by virtue of class member status without meeting other eligibility requirements;
- Eligible members who are eighteen (18) to twenty-one (21) years of age shall elect to receive services as an adult or as a child. Those members electing services as an adult are eligible for services under this Section. Those electing services as a child may be eligible for services under Chapter II, Section 65, Behavioral Health Services or Section 13 or both;
- The LOCUS must be administered, at least annually, or more frequently, if DHHS or its Authorized Agent requires it. Members receiving services as of July 1, 2009 will have a LOCUS administered at the time of their next annual review.
Covered Services

- Community Integration Services;
- Community Rehabilitation Services;
- Intensive Case Management;
- Assertive Community Treatment (ACT);
- Daily Living Support Services;
- Skills Development Services;
- Day Supports Services;
- Specialized Group Services;
- Interpreter Services.

Limitations

- Multiple Providers: Only a single Community Support Provider may be reimbursed at the same time for services to any one member under this Section for Community Integration Services, Community Rehabilitation Services, Intensive Case Management, or Assertive Community Treatment;
- Private Non-Medical Institutions: Community Support Services cannot be provided in a Private Non-Medical Institution, as defined in the MaineCare Benefits Manual Chapters II & III Section 97, without written authorization from DHHS or its Authorized Agent in accordance with Section 17-08-2(C). In order to avoid duplication of services, providers furnishing services under Sections 17.04-3, or 17.04-4 as part of treatment in a Private Non-Medical Institution must coordinate and not duplicate services with providers of services outside the residential setting, including but not limited to services provided in MaineCare Benefits Manual, Chapter II, Section 13 and 97;
- Private Non-Medical Institutions: Community Support Services specified in Sections 17.04-2, 17.04-3, and 17.04-4 cannot be provided in a Private Non-Medical Institution, as defined in the MaineCare Benefits Manual Chapters II & III Section 97, without written authorization from DHHS or its Authorized Agent in accordance with Section 17-08-2(C);
- ACT services: If a member receives services for sixteen (16) or more days in a month, a full month of reimbursement is allowed. If a member receives services for fifteen (15) or fewer days in a month, a provider may only submit a claim for fifty percent (50%) of the monthly charge. This pertains only to the month of admission to or discharge from the ACT service;
Concurrent Provision of Services. Requests to provide concurrent services, such as any two services listed in Column B, Number 1 within each subcategory of the chart, to assist in a member’s transition from one service to another, may be requested from DHHS or its Authorized Agent in accordance with 17.08-2(C).

The following chart reflects covered services that may, and may not, be concurrently provided to a member:

<table>
<thead>
<tr>
<th>A. Type of Service</th>
<th>B. Additional Services that May be Provided Concurrently with the Service Listed in Column A</th>
<th>C. Services that may not be Provided Concurrently with the Service Listed in Column A</th>
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<tbody>
<tr>
<td>Community Integration Services</td>
<td>1. Daily Living Support Services or Skills Development Services or Day Supports Services; and 2. Specialized Group Services, unless otherwise specified; and 3. Interpreter Services</td>
<td>1. Intensive Case Management Services 2. Assertive Community Treatment 3. Community Rehabilitation Services</td>
</tr>
<tr>
<td>Intensive Case Management Services</td>
<td>1. Daily Living Support Services or Skills Development Services or Day Supports Services; and 2. Specialized Group Services, unless otherwise specified; and 3. Interpreter Services</td>
<td>1. Community Integration Services 2. Assertive Community Treatment 3. Community Rehabilitation Services</td>
</tr>
<tr>
<td>Assertive Community Treatment</td>
<td>1. Daily Living Support Services or Skills Development Services or Day Supports Services; and 2. Specialized Group Services, unless otherwise specified; and 3. Interpreter Services</td>
<td>1. Community Integration Services 2. Intensive Case Management Services 3. Community Rehabilitation Services</td>
</tr>
</tbody>
</table>
Non-covered Services:

- Programs, services, or components of services that are primarily opportunities for socialization and activities that are solely recreational in nature (such as picnics, dances, ball games, parties, field trips, religious activities and social clubs);
- Programs, services, or components of services the basic nature of which is to maintain or supplement housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry service);
- Substance Abuse treatment services which do not meet the criteria cited in Subsection 17.02-3 (A);
- Psychotherapy, as defined in Chapter II, Section 65, except for Assertive Community Treatment;
- Costs for paperwork, internal meetings, or appointment reminders associated with the delivery of covered services are built into the rates and are not reimbursable as separate services;
- Transportation Services. Costs related to transportation are built into the rates for services provided under this Section. Therefore, separate billings for travel time are not reimbursable.
Ch. II - Section 19: Home and Community Benefits for the Elderly and for Adults with Disabilities (HCB)

Definition
In-home care and other services, designed as a package, to assist eligible members to remain in their homes, or other residential community settings, and thereby avoid or delay institutional nursing facility care.

Eligibility
- 18 and older;
- Meets the medical eligibility requirements specified in Chapter II, Section 67.02, Nursing Facility Services;
- The Department or its authorized agent shall conduct a face-to-face medical eligibility assessment at the member’s residence using the MED assessment form;
- A member meets the requirements of this Section when all of the additional following conditions are met:
  - The projected cost of services under this Section needed by the member on a monthly basis is estimated to be less than one hundred percent (100%) of the average monthly MaineCare cost of care in a nursing facility; and
  - A member or applicant who meets the eligibility criteria for nursing facility level of care has been informed of, and offered the choice of available, appropriate and cost effective, home and community benefits; and
  - The member selected home and community benefits as documented by a signed choice letter; and
  - The health and welfare of the applicant/member would not be endangered if the member remained at home or in the community; and
  - The particular services needed by the member are available in the geographic area and a willing provider is available;
- Member must make themselves available for any eligibility assessment and participate to the extent needed for the assessment to be completed.
- Members will be accepted into the program on a first-come, first-served basis, based upon the availability of funding. The wait list will be maintained by the Office of Aging and Disability Services. A portion of the Member capacity of this Section is reserved for Members eligible and participating in Maine’s Money Follows the Person (Homeward Bound) program as approved by Centers for Medicare and Medicaid Services.

Covered Services
- Adult Day Health;
- Assistive Technology Device and Services;
- Assistive Technology-Remote Monitoring;
• Assistive Technology-Transmission;
• Care Coordination Services;
• Environmental Modifications;
• Financial Management Services
• Home Health Services:
  ➢ Registered Nurse;
  ➢ Licensed Practical Nurse;
  ➢ Physical Therapy;
  ➢ Occupational Therapy;
  ➢ Speech-Language Therapy;
  ➢ Home Health Aide/Certified Nursing Assistant Services (delegated and overseen by a RN);
  ➢ Medical Social Services;
• Personal Support Services (Personal Care Services);
• Attendant Services;
• Personal Emergency Response Systems (PERS);
• Respite Services;
• Transportation Services;
• Skills Training Services;

Limitations
• Except as otherwise provided in this Section, the program cap established by the Department is $4200 per Member per month;
• Skills Training Services shall not exceed 14.25 hours per annual eligibility period including the hours needed for initial instruction. These costs will not be included as part of the Member’s monthly program cap;
• FMS services are not included as part of the monthly program cap;
• Care Coordination Services received by a Member shall not exceed twenty-four (24) hours (96 units) per annual eligibility period with the following exceptions: if the Department determines that exceptional circumstances exist such that the health or welfare of a Member cannot be met under this limit, the Department may authorize additional units of care coordination service. These costs will not be included as part of the Member’s monthly program cap;
• Environmental Modifications may not exceed $3000 per annual eligibility period per Member. These costs will not be included as part of the Member’s monthly program cap;
• Assistive Technology Devices and Services may not exceed $1000 per Member per annual eligibility period. These costs are included as part of the Member’s monthly program cap;
• Assistive Technology-Transmission: These services may not exceed $600 per Member per annual eligibility period. These costs are included as part of the Member’s monthly program cap;
• Assistive Technology- Remote Monitoring: These services may not exceed $6000 per Member per annual eligibility period. These costs are included as part of the Member’s monthly program cap;
• Respite- Expenditures for Respite Care shall not exceed the allowed maximum, which is based on the cost of thirty (30) days of Nursing Facility Services at the rate as established in Chapter III, per Member per annual eligibility period. These costs are included as part of the Member’s monthly program cap;
• Personal Care or Attendant Services: The monthly program cap may be exceeded by no more than 20% for personal care or Attendant Services for Members who meet either of the following qualifications, provided that in no case shall a Member receive more than eighty-six and a quarter (86.25) hours per week of personal care and/or Attendant Services.

Non-Covered Services:
• Services that are not in the Authorized Plan of Care except as allowed under an acute/emergency episode;
• Services that are described as non-covered services in Chapter I of the MaineCare Benefits Manual including but not limited to recreational, custodial and leisure activities;
• Household tasks, except included as IADL services in the Authorized Plan of Care, according to Section 19.04;
• Personal Care Services or Attendant Services provided by a spouse of the Member, or by the parents or stepparents of a minor child who is a Member;
• Services provided by anyone prohibited from employment due to criminal background checks or annotations on the Maine Registry of Certified Nursing Assistants and Direct Care Workers;
• Custodial care or supervision;
• Personal care services delivered in a licensed or unlicensed assisted housing setting, including a residential care facility;
• Room and board and food (except when allowed as part of Adult Day Services or as part of respite services delivered in the NF setting);
• Services provided not in the presence of the Member unless in the provision of covered IADLs, such as grocery shopping or laundry while the Member remains at home;
• Services provided when the Member is in the hospital, nursing facility, PNMI, or ICF- IID;
• Supervisory visits for HHAs, CNAs, and PSSs;
• Effective as of January 1, 2015, services in excess of forty (40) hours per week provided by an individual worker to any individual Member or household;
• Services provided out of state except as otherwise specifically allowed under this Section or as authorized under Chapter I of the MaineCare Benefits Manual; and
• Personal Care or Attendant Services provided to a Member receiving respite in an institutional setting because personal care is the responsibility of that provider.
Ch. II - Section 20: Home and Community Based Benefit for Adults with Other Related Conditions

**Definition**
This benefit is a Home and Community Based Waiver for Adults with Other Related Conditions (ORC) who are 21 or older, meet institutional level of care and choose to live in the community with the support of this waiver. This Home and Community Based Waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the member. Member choice in all services and components of services is a primary goal of this waiver. Additionally, the principles of conflict-free care coordination, services provided in the least restrictive modality and effective use of assistive technology for communication, environmental control and safety are inherent to this waiver.

**Eligibility**
- Limited to the number of openings approved by the Centers for Medicare and Medicaid Services (CMS);
- 21 or older;
- Has a ‘Related Condition’ (ORC) that meets all of the following conditions that is attributable to:
  - Cerebral Palsy or Epilepsy;
  - Any other condition, other than mental illness, found to be closely related to Intellectual Disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with Intellectual Disabilities and requires treatment or services similar to these required for these persons;
- It is manifested before the person reaches age twenty two (22);
- It is likely to continue indefinitely;
- It results in substantial functional limitation in three (3) or more areas of major life activity;
- Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
- Does not receive services under any other federally approved MaineCare home and community based waiver program; and
- Meets all MaineCare eligibility requirements; and
- The estimated annual cost of the member’s services under the waiver are equal to or less than one hundred percent (100%) of the state-wide average annual cost of care for a member in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); and
- Can have his or her health and welfare needs assured in the community setting;
- Assigned to wait list in order of priority.
**Covered Services**
- Assistive Technology Device and Services
- Care Coordination Services
- Communication Aids
- Community Support Services
- Consultation Services and Assessment
- Employment Specialist Services
- Home Accessibility Adaptations
- Home Support Services
- Non-emergency Transportation Services
- Non-Traditional Communication Assessments
- Non-Traditional Communication Consultation
- Occupational Therapy (Maintenance) Services
- Personal Care Services
- Physical Therapy (Maintenance) Services
- Specialized Medical Equipment
- Speech Therapy (Maintenance) Services
- Work Support Services

**Limitations**
- Assistive Technology Services: Assistive Technology Services are limited to $6000.00 per service year.
- Care Coordination Services: Care Coordination Services are limited to 400 units per year. The Care Coordination provider may not offer any other services to the member under this Section.
- Communication Aids: Communication Aids are limited to $6000.00 per service year. Each system or device will be reviewed based on medical necessity, efficiency, and meets compatibility with safety needs.
- Community Support Services: Community Support Services are limited to 128 units per week, for an annual total of 6656 units per service year. The maximum weekly allowance for Work Support Services is 128 units, for an annual total of 6656 units. When members use a combination of both services, there is a weekly limit of 128 units per week and an annual limit of 6656 units on the total combined expenditures for the services.
- Consultation Services: Consultation Services are limited to 64 units per service year, each type of Consultation Service.
- Employment Specialist Services: Employment Specialist Services are limited to 72 units per service year.
- Home Accessibility Adaptations: Home Accessibility Adaptations are limited to $3,000.00 per service year.
- Home Support (1/4 hour): Home Support (1/4 hour) is limited to 64 units per day. Home Support (Remote Support) is limited to 64 units per day.
- Non-Traditional Communication Assessment: Non-Traditional Communication Assessment is limited to 64 units per service year.
- Non-Traditional Communication Consultation: Non-Traditional Communication Consultation is limited to 64 units per service year.
- Occupational Therapy Maintenance: Occupational Therapy Maintenance is limited to 8 units per week up to 416 units per service year.
- Personal Care Services: Personal Care Services are limited to 52 units per day.
- Physical Therapy Maintenance: Physical Therapy Maintenance is limited to 8 units per week up to 416 units per service year.
Specialized Medical Equipment and Supplies- Any item over $500.00 requires documentation from a physician, an Occupational Therapist, Physical Therapist or Speech Therapist;

Speech Therapy Maintenance is limited to 8 units per week up to 416 units per service year;

Work Support Services are limited to 128 units per week up to 6656 units per service year. The maximum weekly allowance for Community Support is 128 units, for an annual total of 6656 units. When members use a combination of both services there is an annual limit of 6656 units on the total combined expenditures for the services;

Section 20 Home and Community Based Services for Adults with Other Related Conditions may not be provided in a residence where other Home and Community Based Waiver services are provided. Exceptions to this limit will be considered on a case-by-case basis by the Department. Consideration of this exception will be contingent on the member’s Care Plan ensuring that all identified services will be delivered without compromising the quality of care, and on all aspects of the costs of services being clearly delineated in order to demonstrate that there is not blending of financial benefits between the members served.

Non-Covered Services
- Services not authorized by the Care Plan;
- Services to any member who is hospitalized, a nursing facility resident, or ICF/IID resident;
- Any service otherwise reimbursable under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, including but not limited to job development and vocational assessment or evaluations;
- Room and board; The term “room” means shelter-type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day or any other full nutritional regimen;
- Services provided directly or indirectly by the legal guardian;
- Work Support or Employment Specialist Services when the member is not engaged in employment;
- Specialized Medical Equipment and Supplies, Communication Aids, or Home Accessibility Adaptations unless the service has been determined non-reimbursable under Section 60, Medical Supplies and Durable Equipment, or other sections of the MaineCare Benefits Manual;
- Non-Duplication of Services
Ch. II - Section 21: Home and Community Based Benefit for Members with Intellectual Disabilities or Autistic Disorder

Definition
The Home and Community Based Benefit (HCB or Benefit) for Members with Intellectual Disabilities or Autistic Disorders gives members eligible for this Benefit the option to live in their own home or in another home in the community thus avoiding or delaying institutional services. The Benefit is offered in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID). The Benefit supplements, rather than replaces supportive, natural, personal, family, work, and community relationships and complements. It does not duplicate other MaineCare services. This Home and Community Benefit for members with Intellectual Disabilities or Autistic Disorder is not intended to replace Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder.

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

Consistent with Subsection 21.03-1, a person is eligible for services under this Section if the person:
• Eligibility for MaineCare as determined by the DHHS, Office of Family Independence (OFI); and
• Is age eighteen (18) or older; and
• Has an Intellectual Disability or Autistic Disorder or Pervasive Developmental Disorder (NOS); and
• Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Persons with an Intellectual Disability (ICF/IID) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50; and
• Does not receive services under any other federally approved MaineCare home and community based waiver program; and
• Meets all MaineCare eligibility requirements as set forth in the MaineCare Eligibility Manual; and
• Is receiving services under the waiver for which the estimated annual cost is equal to or less than two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.
Covered Services

- Assistive Technology-Assessment
- Assistive Technology-Devices
- Assistive Technology-Transmission (Utility Services)
- Career Planning
- Home Support-Agency Per Diem
- Home Support-Family Centered
- Home Support-Quarter Hour
- Home Support-Remote Support
- Community Support
- Employment Specialist Services
- Work Support-Group
- Work Support-Individual
- Home Accessibility Adaptations
- Specialized Medical Equipment and Supplies

Communication Aids
- Non-Traditional Communication Consultation
- Non-Traditional Communication Assessments
- Consultation Services
- Counseling
- Crisis Intervention Services
- Crisis Assessment
- Non-Medical Transportation Service
- Occupational Therapy (Maintenance)
- Physical Therapy (Maintenance)
- Speech Therapy (Maintenance)
- Shared Living (Foster Care, Adult)

Limitations

- MaineCare members can receive services under only one Home and Community Waiver Benefit at any one time;
- The maximum annual allowance for Community Support is eleven hundred twenty-five (1,125) hours per year. The maximum combined annual allowance for Work Support-Group and Work Support-Individual Services is eight hundred and fifty (850) hours per year. Where the member receives Community Support services in addition to Work Support-Group and/or Work Support-Individual services, the combined cost of Community Support, Work Support-Individual and Work Support-Group may not exceed $26,455.00 annually;
- Home Accessibility Adaptations are limited to a ten thousand dollar ($10,000.00) limit in a five (5) year period with an additional annual allowance up to three hundred dollars ($300.00) for repairs and replacement per year;
- All items in excess of five hundred dollars ($500) require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member’s need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section only if they meet all requirements of this Section. This benefit applies to personal homes only; it is not available in agency owned or operated homes;
• For Specialized Medical Equipment and Supplies costing more than five hundred dollars ($500), the member must obtain documentation from a physician or other appropriate professional such as an OT, PT or Speech therapist assuring that the purchase is appropriate to meet the member’s need and is medically necessary. Specialized Medical Equipment and Supplies are limited to only specialized medical equipment and supplies that cannot be obtained, as a covered service under other sections of the MaineCare Benefits Manual will be reimbursed under this Section. These services are to be considered the property of the member;
• For communication aids costing more than five hundred dollars ($500), the member must obtain documentation from a licensed speech-language pathologist, Licensed Audiologist or a Certified Assistive Technology Professional (ATP) assuring that the purchase is appropriate to meet the member’s need and assures the medical necessity of the devices or services. Only communication aids that cannot be obtained as a covered service under other sections of the MaineCare Benefits Manual will be reimbursed under this Section;
• Consultation services are limited to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under targeted case management may not be reimbursed for consultation services;
• Crisis Intervention Services that have not been included on the Personal Plan are limited to a period not to exceed two weeks and must be authorized by the DHHS or its Authorized Entity. Crisis Intervention Services may not extend past two (2) weeks without a recommendation from the member’s Person Centered Team and additional approval from DHHS;
• Crisis Assessment Services are limited to one (1) assessment in a three-year (3) period and includes all related follow-up activities;
• A member may not receive Community Support, Employment Specialist Services or Work Support while enrolled in high school;
• A member may not receive Community Support or Home Support at his or her place of employment;
• No Family Centered Support will be approved after 12/20/2007;
• If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to the Department to continue holding the funded opening;
• Work Support-Individual services are limited to one DSP per member at a time;
• As of December 24, 2012, Home Support- Agency Per Diem placements will only be approved at sites where at a minimum two (2) members receiving Home Support- Agency Per Diem reside;
• Home Support Quarter Hour - may not exceed three hundred and thirty six (336) quarter hour units or eighty four (84) hours a week;
• Authorizations for services to be provided out of state will not exceed sixty (60) days of service within a given fiscal year and not exceed sixty (60) days within any six (6) month period except as provided in title 42 C.F.R. §431.52 (b);
• Annual MaineCare expenditures for services under this waiver for an individual member are limited to two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department;
• Assistive Technology services are not covered under this rule if they are available under another MaineCare rule. Assistive Technology-Assessment is subject to a combined limit of 32 units (8 hours) per year. Assistive Technology-Devices, including the selecting, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices, is subject to a combined limit of $6,000 per year. Assistive Technology-Transmission (Utility Services) is subject to a combined limit of $50 per month;
• Career Planning is limited to 60 hours annually to be delivered in a six-month period. No two six month periods may be provided consecutively;
• Counseling is limited to 16.25 hours annually;
• Consultation is limited to 16.50 hours annually per discipline;
• Employment Specialist Services are provided on an intermittent basis with a maximum of ten hours each month;
• Home Support-Remote Support is limited to 48 units (12 hours) per day.

Non-Covered Services
• Services not identified by the Personal Plan;
• Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;
• Services to any member who is a nursing facility resident, or ICF/IID resident;
• Services that are reimbursable under any other sections of the MaineCare Benefits Manual;
• Any service otherwise reimbursable under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, including but not limited to job development and vocational assessment or evaluations;
• Room and board; The term “room” means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the member’s home. Board also does not include the delivery of a single meal to a participant at his/her own home through a meals-on-wheels service;
• Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the member’s parent, sibling or other biological family member;
• Work Support-Individual, Work Support-Group, or Employment Specialist Services when the member is not engaged in employment. Work Support-Group must be provided at the member’s place of employment; it may be provided in a member’s home in preparation for work if it does not duplicate services already reimbursed as Home Support, Community Support or Employment Specialist Services;

• Specialized Medical Equipment and Supplies, Communication Aids, or Home Accessibility Adaptations unless the service has been determined non-reimbursable under Medical Supplies and Durable Equipment, Section 60 or other sections of the MaineCare Benefits Manual;

• MaineCare members can receive services under only one Home and Community Waiver Benefit at any one time;

• A member may not receive Community Support while enrolled in high school. Community Support is not provided in the member’s place of employment.
**Ch. II - Section 22: Home and Community Benefits for the Physically Disabled**

**Purpose**
The purpose of this benefit is to provide medically necessary home and community benefits to MaineCare members who are physically disabled and age eighteen (18) and over.

**Eligibility**
- Financial eligibility criteria;
- Members age eighteen (18) and over;
- An applicant meets the medical eligibility requirements for benefits under this section if he/she meets the eligibility criteria specified in the MaineCare Benefits Manual, Chapter II, Section 67, Nursing Facility Services;
- The member must have the cognitive capacity, as assessed on the MED form to be able to “self-direct” their attendant(s). The Assessing Services Agency will assess cognitive capacity as part of each member’s eligibility determination using the MED findings;
- The member must not have a guardian or a conservator;
- A member who meets the eligibility criteria for nursing facility level of care has been informed of, and offered the choice of available, appropriate, and cost-effective, home and community benefits;
- The member selected benefits as documented by a signed Choice Letter;
- The health and welfare of the member would not be endangered if the member remained at home or in the community;
- Benefits needed by member are available (in the geographic area) and a willing provider is available;
- Member has a disability with functional impairments, which interfere with his/her own capacity to provide self-care and daily living skills without assistance. The member’s disability must be permanent or chronic in nature as verified by the member’s physician;
- The member must agree to complete initial member instruction and testing with thirty (30) days of completion of the MED form to determine medical eligibility in order to develop and verify that he or she has attained the skills needed to hire and train, schedule and supervise attendants, and document the provision of personal care services identified in the Assessing Services Agency’s authorized plan of care;
- The member must not be residing in a hospital, nursing facility, private non-medical institution, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) as an inpatient;
• The member must not reside in Assisted Living or in Adult Family Care Home (as defined in MaineCare Benefits Manual, Chapters II and III, Section 2), or other residential setting including a Private Non-Medical Institution (MBM, Chapters II and III, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source, (i.e. private or MaineCare);

• The member must not be receiving personal care services under the Private Duty Nursing/Personal Care Services Section or be receiving any Home and Community Benefits, In Home Community and Support Services for Elderly and Other Adults, or any other MaineCare benefit that allows personal care services as a covered service;

• Members will be accepted for benefits under this section on a first-come, first-served basis. The Office of Adults with Cognitive and Physical Disabilities will maintain member waiting lists based on date of eligibility determination; and

• The member, in addition to meeting all of the above criteria, must hire an attendant. Should the member fail to hire an attendant, his/her eligibility for such services may end.

Covered Services
• Covered services must be required in order to maintain the member’s current health status, or prevent or delay deterioration of a member’s health and/or avoid long-term institutional care;

• Skills Training - recruiting, interviewing, selecting, training, scheduling, discharging and directing a competent attendant;

• Supports Brokerage functions provided by the Service Coordination Agency;

• Financial Management Services - verifying attendant citizenship status, Collect and process timesheets, Process payroll, withholdings, filings and payment of applicable Federal, state, and local employment-related taxes and insurances;

• Personal Care Attendant Services (PCA);

• Assistance with ADL tasks and also may include IADLs and/or health maintenance activities;

• Personal Emergency Response System (PERS).

Limitations
• MaineCare will reimburse for no more than eighty-six and one-quarter (86.25) hours of personal attendant services per week under this Section;

• Skills training should not exceed fourteen and one quarter (14.25) hours annually, including the two (2) hours required for initial instruction;

• Supports Brokerage shall not exceed eighteen (18) hours annually.

Non-Covered Services
• Room and board;
- Travel time and mileage by the Assessing Services Agency, Service Coordination Agency, staff, and/or the attendant to and from the location of the member’s residence or mileage for travel by the attendant in the course of delivering a covered service;
- Transportation to and from medical appointments is not covered under this Section and must be referred to a local MaineCare transportation agency (see Chapters II and III, Section 113 of the MaineCare Benefits Manual);
- Household tasks except when delivered as an integral part of the authorized plan of care;
- Services provided by the member’s family member, as defined in Section 22.02-9;
- Custodial care or respite care;
- Personal attendant services received when a member enters a hospital, nursing facility, private non-medical institution, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) as an inpatient;
- The member is residing in Assisted Living or Adult Family Care Home (as defined in MaineCare Benefits Manual, Chapters II and III, Section 2,) or other residential setting including a Private Non-Medical Institution (MBM, Chapters II and III, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source, (i.e. private or MaineCare);
- The member is receiving personal care services under the Private Duty Nursing/Personal Care Services or any Home and Community Benefits or In-Home Community and Support Services for Elderly and Other Adults;
- Services provided by an attendant who has any criminal convictions, except for Class D and Class E convictions over ten (10) years old that did not involve as a victim of the act, a patient, client, or resident of a health care entity; or (b) any specific documented findings by the State survey agency of abuse, neglect or misappropriation of property of a resident, client or patient;
- Services provided outside the presence of the member; unless in the provision of covered IADLs;
- Services offered under this benefit will exclude expenses for transportation and recreational or leisure activities, as well as, the actual time involved in transporting the member to recreational or leisure activities;
- On-call services;
- Services that exceed the limits described in Section 22.06;
- Separate billings for the time spent performing separate administrative tasks are not covered.
**Ch. II - Section 26: Day Health Services**

**Definition**
Day Health Services are health services that are needed to insure the optimal functioning of the member that are provided through a day health service. These services must be provided under an individual plan of care and outside the member's residence.

**Eligibility**
- 18 years of age and older;
- Financial eligibility criteria;
- Medical eligibility assessment meets the criteria set forth:
  - **Level I:** Requires daily; seven (7) days per week “Cuing”; OR at least “limited assistance” and a “one-person physical assist” are needed with at least two (2) of the following activities of daily living:
    - Bed Mobility;
    - Transfer;
    - Locomotion;
    - Eating;
    - Toilet Use;
    - Bathing;
    - Dressing
  - **Level II:** At least “extensive assistance” and a “one-person physical assist” are needed for at least two (2) of the following five (5) activities of daily living listed in 26.02-2 (A) (2):
    - Bed mobility;
    - Transfer;
    - Locomotion;
    - Eating;
    - Toilet use; OR
    - Member meets two (2) of the following three (3) criteria:
      - Cognition Threshold;
      - Behavior threshold;
      - At least “limited assistance” and a “one-person physical assist” is needed for at least one (1) of the following five (5) activities of daily living listed in 26.02-2 (A) (2).
Level III: A member must meet the medical eligibility requirements detailed in Chapter II, Section 67.02, Nursing Facility Services.

**Covered Services**
Day health services are those services provided outside the member’s residence at a site licensed by the Bureau of Elder and Adult Services, on a regularly scheduled basis. The ongoing service may include, based on individual needs:
- Monitoring of health care;
- Supervision, assistance with activities of daily living;
- Nursing;
- Rehabilitation;
- Health promotion activities;
- Exercise groups;
- Counseling;
- Noon meals and snacks are provided as a part of day health services.

**Limitations**
- Members eligible for Level I of care may receive up to sixteen (16) hours per week of covered services;
- Members eligible for Level II of care may receive up to twenty-four (24) hours per week of covered services;
- Members eligible for Level III of care may receive up to forty (40) hours per week of covered services.

**Non-Covered Services**
- Day health services delivered to a member who is a resident in a Private Non-Medical Institution (PNMI) cannot be reimbursed under this rule.
Ch. II - Section 28: Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations

Eligibility
To be found eligible for Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations, a member must be under twenty-one years of age and meet all of the following criteria:

- Meet the financial eligibility criteria;
- All services must be medically necessary per Chapter I, Section 1.02-4.D.

Specific Eligibility Criteria
- A completed multi-axial evaluation with an Axis I or Axis II behavioral health diagnosis from most recent DSM or an Axis I diagnosis from the most recent Diagnostic Classification of Mental Health or Developmental Disorders of Infancy and Early Childhood Manual (DC-03);
- A member aged birth through five (5) years, who has a diagnosis from a physician (including psychiatrist) of a specific congenital or acquired condition, and a written assessment by a physician (including psychiatrist) that there is a significant probability that because of that condition, the member will meet the functional impairment criteria later in life if medically necessary services and supports are not provided to the member;
- Family Participation is required in treatment services to the greatest degree possible given the individual needs as well as family circumstances.

Covered Services
- Treatment Services for Children with Cognitive Impairments and Functional Limitations – Medically necessary treatment services for members under the age of twenty one (21) designed to retain or improve functional abilities which have been negatively impacted by the effects of cognitive or functional impairment and are focused on behavior modification and management, social development, and acquisition and retention of developmentally appropriate skills (see 28.04-1 for list of services covered);
- Specialized Services for Children with Cognitive Impairments and Functional Limitations – Medically necessary evidenced based treat services for members under the age of twenty one (21) that utilize behavioral interventions designed to improve socially significant behaviors and developmentally appropriate skills to a measurable degree (see 28.04-2 for list of services covered).
Limitations

- MaineCare will limit reimbursement for services under this Section to those covered services documented and approved in the treatment plan that are medically necessary and developmentally appropriate;
- Non-Duplication of Services: A member may not receive services if they are in a residential treatment facility or if they are receiving services in an institution, including, but not limited to Section 45, Hospital Services, Section 46, Psychiatric Facility Services, Section 50, ICF-IID, Section 67, Nursing Facilities and Section 97, Appendix D, Private Non-Medical Institutions;
- Group Treatment: Reimbursement for group treatment must be prior authorized. Group Treatment is limited to no more than eight (8) members in a group. When group treatment is provided to a group of more than four (4) members it must be provided by at least two (2) qualified staff at a time.

Non-Covered Services

- MaineCare does not cover services that are primarily academic, vocational, social, recreational, or custodial in nature.
Ch. II - Section 29: Support Services for Adults with Intellectual Disabilities or Autistic Disorder

Definition:
Support Services for Adults with Intellectual Disabilities or Autistic Disorder for adults who either live with their families or live on their own. Support Services are also designed to support members in the workplace.

Eligibility
• Funded opening;
• Is age eighteen (18) or older; and
• Has an Intellectual Disability or Autistic Disorder; and
• Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50; and
• Does not receive services under any other federally approved MaineCare Home and Community Based waiver program; and
• Meets all MaineCare eligibility requirements as set forth in the MaineCare Eligibility Manual; and
• Lives with family or on their own; and
• The estimated annual cost of the member’s services under the waiver is equal to or less than fifty percent (50%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.

Covered Services
• Assistive Technology-Assessment, Devices, and Transmission (Utility Services);
• Career Planning;
• Community Support;
• Employment Specialist Services;
• Work Support;
• Work Support Group;
• Work Support Individual;
• Home Accessibility Adaptations;
• Home Support-Quarter Hour;
• Home Support-Remote Support;
• Transportation;
• Respite Services

Limitations
• Members can receive services under only one Home and Community Waiver Benefit at any one time;
• The combined annual limit for members who receive Home Support (Remote or ¼ hour), Community Support, Work Support-Individual or Work Support-Group, Assistive Technology and Career Planning is Twenty three thousand, seven hundred and seventy one dollars ($23,771.00);
• Home Support-Quarter Hour is limited to 18 hours (72 units ¼ hour) per week. Home Support-Remote Support is limited to 18 hours per week (72 units);
• The maximum annual allowance for Community Support is eleven hundred and twenty five (1,125) hours (forty five hundred (4500) quarter hour units) per year. For purposes of this cap, a year is defined as from July 1 to the following June 30;
• Employment Specialist Services are provided on an intermittent basis with a maximum of ten (10) hours (forty (40) quarter hour units) each month;
• The maximum annual allowance for Work Support-Individual or Work Support-Group is not to exceed six hundred (600) hours (twenty four hundred (2400) quarter hour units) per year. For purposes of this cap, a year is defined as from July 1 to the following June 30;
• Home Accessibility Adaptations are limited to five thousand dollars ($5,000) in a three (3) year (thirty six (36) months) period with an additional annual allowance up to three hundred dollars ($300) for repairs and replacement per year. General household repairs are not included in this service. All items in excess of five hundred ($500) dollars require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member’s need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit can be reimbursed under this section;
• A provider may only be reimbursed for providing transportation services when the cost of transportation is not a component of a rate paid for another service;
• Respite Services are limited to one thousand dollars ($1000.00) per year. Additionally, the quarter hour (1/4) billing for Respite shall not exceed the per diem limit of (Ninety dollars ($90.00) for each date of service. Reimbursement for Respite is a quarter (1/4) hour billing code. After thirty three (33) quarter hour units of consecutive Respite Services, the provider must bill using the per diem billing code. The quarter hour (1/4) Respite amount billed any single day cannot exceed the Respite per diem rate of Ninety ($90.00) dollars;
• Services reimbursed under this section are not available to members who reside in an ICF/IID, nursing facility or are inpatients of a hospital;
• Member may not receive services that are comparable or duplicative under another Section of the MaineCare Benefits Manual at the same time as services provided under this waiver benefit. Such comparable or duplicative services include, but are not limited to services covered under the MaineCare Benefits Manual, Section 2, Adult Family Care Services; Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities; Section 21, Home and Community Benefits for Person with Intellectual Disabilities or Autistic Disorder; Section 22, Home and Community Benefits for the Physically Disabled; Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations; Section 45, Hospital Services; Section 46, Psychiatric Facility Services; Section 50, ICF/IID Services; Section 67, Nursing Facility Services and Section 97, Private Non-Medical Institution Services;
• Member may not receive Community Support while enrolled in high school. A member may not receive Community Support at his or her place of employment;
• Member may not receive Employment Specialist Services while enrolled in high school;
• Member may not receive Work Support-Individual or Work Support-Group while enrolled in high school. A member may have services authorized while still enrolled in high school; however, the start date of the service may only begin after the date of graduation or termination of enrollment;
• Work Support Services are limited to one Direct Support Professional per member at a time;
• The total amount of Services authorized may not exceed 50% of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department;
• If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to the Department to continue holding the funded opening;
• Assistive Technology services are not covered under this rule if they are available under another MaineCare rule. Assistive Technology-Assessment is subject to a combined limit of 32 units (8 hours) per year. Assistive Technology-Devices, including the selecting, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices, is subject to a combined limit of $6,000 per year. Assistive Technology-Transmission (Utility Services) is subject to a combined limit of $50 per month;
• Career Planning is limited to 60 hours annually to be delivered in a six-month period. No two six-month periods may be provided consecutively.
Non-Covered Services

- Services not identified by the Personal Plan;
- Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;
- Services to any member who is a nursing facility resident, or ICF/IID resident;
- Services that are reimbursable under any other sections of the MaineCare Benefits Manual;
- Any service otherwise reimbursable under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, including but not limited to job development and vocational assessment or evaluations;
- Room and board; The term “room” means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day; or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the member’s home. Board also does not include the delivery of a single meal to a member at his/her own home through a meals-on-wheels service;
- With the exception of transportation, services covered under 29.05-5, services provided directly or indirectly by a person legally responsible for the member, including the member’s spouse or a member’s parents, stepparents, or guardian. A guardian who is unrelated cannot be directly or indirectly reimbursed for services;
- Work Support-Individual or Work Support-Group or Employment Specialist Services when the member is not engaged in employment;
- Home Accessibility Adaptations unless the service has been determined non reimbursable under Medical Supplies and Durable Equipment, Section 60 or other sections of the MaineCare Benefits Manual;
- A member may not have wages from employment paid for with MaineCare reimbursement; and
- Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the member’s parent, sibling or other biological family member. This rule will not be avoided by adult adoption.
Introduction
MaineCare members who are at least five (5) years of age and under seventeen (17) years and who have Intellectual Disabilities or Pervasive Developmental Disorders are eligible for this Home and Community Waiver Benefit. The intent of this service is to provide members the opportunity to remain in their own homes or in other homes in the community, avoiding or delaying institutional care.

Eligibility
- Members must meet the criteria in section 32.03-3 and must have an Intellectual Disability or a Pervasive Developmental Disorder (PDD); and
- A documented assessment of functional impairment;
- When a member is found to be eligible under Sections 32.03-1 and 32.03-2 for these services, the priority for a funded opening shall be established in accordance with a weighted assessment as documented in the member’s medical record and a wait list;
- Member must be at least five (5) years of age and under seventeen (17) years;
- Once admitted a member may remain in it until his or her 21st birthday, assuming that the member continues to meet other conditions of eligibility;
- Member must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual (MEM);
- All Home and Community Waiver benefit services provided must be reviewed and authorized at least annually by the DHHS or its Authorized Agent;
- Member must meet the medical eligibility criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Section 50 or a Psychiatric Hospital Section 46;
- The estimated cost of the member’s waiver services cannot exceed the cost limits specified in 32.06 of this rule.

Covered Services
- Home Support Services, including the following:
  - Personal assistance;
  - Self-care;
  - Self-management;
  - Activities that support personal development;
  - Activities that support personal well-being;
- Respite Services;
- Home Accessibility Adaptations;
- Consultation Services;
- Communication Aids;
- Transportation.

**Limitations**

- Members who meet the medical eligibility criteria for admission to an ICF/IID as set forth in MaineCare Benefits Manual, Chapter II, Section 50 will be limited to one hundred percent (100%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by DHHS;
- Members who meet medical eligibility criteria for admission to a Psychiatric Hospital as set forth in MaineCare Benefits Manual, Chapter II, Section 46 will be limited to one hundred percent (100%) of the state-wide average annual cost of care for an individual in an inpatient psychiatric facility for individuals age 21 and under, as determined by DHHS;
- Home Accessibility Adaptations are subject to a ten thousand dollar ($10,000.00) limit in a five (5) year period with an additional annual allowance of up to three hundred dollars ($300.00) for repairs and replacement per year;
- Communication aids costing more than five hundred dollars ($500), the member must obtain documentation from a licensed speech-language pathologist assuring that the purchase is appropriate to meet the member’s need and assuring the medical necessity of the devices or services;
- Consultation Services are limited to those providers not already reimbursed for consultation as part of another service.
- Respite Services are limited to three (3) days per month.

**Non-Covered Services**

- Services not identified by the Waiver Service Plan;
- Services to any MaineCare member who receives services under any other federally approved MaineCare waiver program;
- Services to any member who is a nursing facility resident or ICF/IID resident;
- Services reimbursable under any other section of the MaineCare Benefits Manual;
- Job development and vocational assessment or evaluation;
- Room and board;
- Communication Aids or Home Accessibility Adaptations unless the service has been determined non-reimbursable under Medical Supplies and Durable Equipment, Section 60 or other sections of the MaineCare Benefits Manual.
**Ch. II - Section 40: Home Health Services**

**Definition**
Home Health Services are those skilled nursing and home health aide services, physical and occupational therapy services, speech-language pathology services, medical social services, and the provision of certain medical supplies, needed on a “part-time” or “intermittent” basis. Services are delivered by a Medicare certified home health agency to a member in his or her home or in other particular settings with limitations as described in Section 40.06.

**Eligibility**
- Children and adults;
- Must meet the financial eligibility criteria for MaineCare;
- Home Health Services Medical Eligibility Requirements:
  - Medical condition of the member must be such that it can be safely and appropriately treated by the home health agency under a plan of care reviewed and signed by a physician every certification period; and
  - The member must be in a place of residence and NOT in an institution; and
  - Services shall not be provided if services are available and safely accessible to the member on an outpatient basis; and
  - Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness/injury where these indications are part of a longstanding pattern of the member’s condition and there is no significant change in health status; and
  - The condition of the member must require skilled nursing care on a “part-time” or “intermittent” basis or otherwise no less than twice per month.
- Medical Eligibility Requirements for Psychotropic Medication Services: in-home psychotropic medications if he or she meets ALL of the following requirements:
  - Has a severe and disabling mental illness that meets the eligibility requirements set forth in Section 17; and
  - Requires psychotropic medication administration or monitoring; and
  - Not receiving psychotropic medication services under any other Sections of the MBM; and
  - Home health services shall not be provided if services are available and safely accessible to the member on an outpatient basis.

**Covered Services**
- Skilled Nursing Services;
- Home Health Aide Services;
- Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services;
- Medical Social Services;
Non-Routine Medical Supplies.

Limitations
- Services delivered under this Section shall not duplicate any other services delivered to the member (See 40.06 for listing).

Non-Covered Services
- Parenting skills training;
- Nursing services, physical therapy, and occupational therapy exercises that may be carried out by the member, or family member or friend who is trained, willing and able to safely perform the service after receiving instruction from the appropriate home health care professional;
- Services provided by a personal care attendant;
- Laboratory services;
- Blood glucose monitoring;
- Routine foot care;
- Homemaking services and chore services;
- RN supervisory visits made for the purpose of supervising home health aide services to the member;
- Nursing evaluation visits, unless skilled observation and assessment by a licensed nurse would result in a change of the treatment of the member;
- Visits made solely to remind the member to follow instructions;
- Services that can be appropriately provided by other community resources;
- Respite services;
- Venipuncture;
- Custodial care;
- A monthly injection;
- Monthly catheter change, beyond the acute phase.
Ch. II - Section 50: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

Definition

- ICF-IID Nursing Facility: To assist each member to reach his or her maximum level of functioning capabilities, an ICF-IID Nursing Facility provides, under an agreement with the Department of Health and Human Services, twenty-four (24) hours, seven (7) days a week, of licensed nurse supervision of coordinated health treatment and rehabilitative services for persons who have Intellectual disabilities or persons with related conditions (See Section 50.01-11 for definition of “persons with related conditions”).

- ICF-IID Group Home Facility: An ICF-IID Group Home Facility provides a supportive and protective setting and twenty-four (24) hour, seven (7) days a week, of non-nursing supervision for persons who have an intellectual disability or persons with related conditions (See Section 50.01-11 for definition of “persons with related conditions”). The facility must assure the coordination of health and rehabilitative services to assist each member in reaching his or her maximum level of functioning capabilities.

Eligibility

- General MaineCare eligibility. The eligibility determination process is administered by the Office of Family Independence (OFI);
  - The Department or the Department’s authorized agent must determine the individual’s medical eligibility, as described in Section 50.06; and
  - Individuals must be diagnosed by a physician as having an intellectual disability or a related condition, which is manifested before the person reaches age twenty-two (22); and
  - Individuals must require active treatment of ICF-IID services, as defined in this Section. An individual’s eligibility cannot be based merely on his/her diagnosis.

Eligibility for Care in an ICF-IID Nursing Facility:

- Documented evidence of nursing needs that require at least eight (8) hours per day of licensed nurse supervision;
- There must be a medical, psychological, and social evaluation and a plan of care;
- One (1) or more of the following criteria must apply to a member:
  - Plan of care requires the skills of a licensed nurse; and/or
  - Tube feedings that require professional nursing judgment, observation and care; and/or
  - Medical needs that require constant licensed nursing evaluations, judgments, and interventions, i.e. suctioning; and/or
  - Certain injectable medicines that require licensed nursing observation, supervision, or administration; and/or
  - Uncontrolled seizures that require licensed nursing observation, supervision, or administration.
Eligibility for Care in an ICF-IID Group Home Facility:

- Physician must certify that the member is not in need of eight (8) hours or more per day of nursing care;
- A member must require the services provided in an ICF-IID Group Home Facility, but cannot have care needs that require the presence of a licensed nurse for supervision for eight (8) hours or more per day;
- One (1) or more of the following criteria must apply to the member in order for the member to be eligible to receive care in an ICF-IID Group Home Facility. The member must:
  - Need assistance in personal care such as oral hygiene, care of skin, personal grooming and bathing; or
  - Exhibit or has exhibited deviation from acceptable behavior; or
  - Require some personal supervision; or
  - Require some protection from environmental hazards; or
  - Require supervision while participating in diversion and motivational activities both in the facility and in the community; or
  - Require assistance with medications that are of a routine nature and can be administered by qualified group home facility personnel; or
  - Require assistance due to aphasia.
- If a member residing in an ICF-IID Group Home Facility has medical needs that require twenty-four (24) hour nursing supervision, he or she may continue to reside in the facility if the following conditions are met. The member must:
  - Have a medical care plan developed in accordance with State licensing and Federal certification regulations; and
  - Be in a facility where twenty-four (24) hour licensed nurse in-house coverage is provided; and
  - Obtain approval from the DHHS before twenty-four (24) hour nursing services are provided; and
  - The member's medical condition must be expected to be temporary.

Covered Services

- Routine Services, Supplies, and Equipment Included in Regular Rate for Reimbursement;
- Supplies and Equipment for Which the Department may be Billed by a Supplier or Pharmacy;
- Physical Therapy (PT) and Occupational Therapy (OT) services and consultations;
- Speech and Hearing Services;
- Dental Services;
- Pharmacy Services;
- Other Services: an order from a licensed medical practitioner legally qualified to order services for members, is required for all other types of services provided in an ICF-IID, unless the MaineCare Benefits Manual specifically does not require an order;
• ICF-IID Developmental Training Program.

Non-Covered Services
• Maintenance therapy PT and OT;
• Private room (single bed), telephone, television, and authorized bed hold days services;
• Vocational or academic type services;
Introduction
This Section of the MaineCare Benefits Manual consolidates what were previously four separate Sections; Section 58 Licensed Clinical Social Worker, Licensed Clinical Professional Counselor and Licensed Marriage and Family Therapist Services; Section 65 Mental Health Services; Section 100 Psychological Services; and Section 111 Substance Abuse Treatment Services. This Section consolidates all Outpatient Services into one Section.

Eligibility
• Individuals must meet the eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member’s eligibility for MaineCare, as described in MaineCare Benefits Manual, Chapter I, prior to providing services.

Covered Services
• Crisis Resolution Services;
• Crisis Residential Services;
• Outpatient Services;
• Family Psycho-educational Treatment;
• Intensive Outpatient Services;
• Medication Management Services;
• Neurobehavioral Status Exam and Psychological Testing;
• Children’s Assertive Community Treatment (ACT) Service;
• Children’s Home and Community Based Treatment;
• Collateral Contacts for Children’s Home and Community Based Treatment;
• Opioid Treatment;
• Interpreter Services;
• Children’s Behavioral Health Day Treatment;
• Tobacco Cessation Treatment Services.
Limitations

• Only services included in the Individual Treatment Plan (ITP) will be reimbursed;

• Some services in this section require prior authorization:
  ➢ Crisis Residential;
  ➢ Children’s Assertive Community Treatment;
  ➢ Children’s Home and Community Based Treatment;
  ➢ Collateral Contacts for Children’s Home and Community Based Treatment;
  ➢ Opioid Treatment when a member has reached his/her lifetime cap of twenty-four (24) months;

• Crisis resolution-A treatment episode is limited to six (6) face-to-face visits over a thirty (30) day period;

• Crisis Residential Prior authorization for up to 7 (seven) consecutive days, beginning with the date of admission must be obtained for all medically necessary Crisis Residential Services;

• Limitations to Outpatient Services (as outlined in 65.05-5);

• Intensive Outpatient Services must be delivered for a minimum of three (3) hours per diem three (3) days a week;

• Medication Management Services. Medication management limits for reimbursement are as follows:
  ➢ For adults, up to one (1) hour is allowed for the Comprehensive Assessment of medication management;
  ➢ For children, up to two (2) hours is allowed for the Comprehensive Assessment of medication management;
  ➢ All subsequent sessions for medication management and evaluation are limited to thirty (30) minutes;

• Limitations to Psychological Testing (as outlined in 65.08-8);

• For the purposes of Collateral contacts for Children’s Home and Community Based Treatment, MaineCare reimburses only up to forty (40) units or ten (10) hours of billable face-to-face collateral contacts per member per year of service;

• Opioid Treatment Reimbursement for methadone maintenance treatment for addiction to opioids is limited to twenty-four (24) months per lifetime, except as permitted through prior authorization. Only treatment after January 1, 2013 will count toward the limit.

Non-Covered Services
Refer to the MaineCare Benefits Manual, Chapter I, “General Administrative Policies and Procedures”, for a general listing of non-covered services including academic, vocational, socialization or recreational services and custodial services and associated definitions that are applicable to all Sections of the MaineCare Benefits Manual. Additional non-covered services related to the delivery of mental health services are as follows:

• Homemaking or Individual Convenience Services;
• Transportation Services- Costs related to transportation services are built into the rates for all services by allocation of non-personnel costs;
• Case Management Services;
• Adult Community Support/Adult Day Treatment Services;
• Financial Services- Any services, or components of services of which the basic nature is to provide economic services to the member, such as financial or credit counseling are not covered under this Section;
• Driver Education and Evaluation Program (DEEP) Evaluations;
• Comparable or Duplicative Services as outlined in 65.07-7.
**Ch. II - Section 96: Private Duty Nursing and Personal Care Services**

**Definition**
Private Duty Nursing (PDN) and Personal Care Services (PCS) are those covered services provided to an eligible Member, as defined in this Section, when determined to be medically necessary, when prior approved, and in the best interest of the Member according to the orders and written plan of care reviewed and signed by a licensed physician. With the exception of those medically necessary services that are prior authorized for children under the age of 21, all services provided are not to exceed the cost limits set forth in Section 96.03.

**Eligibility**
An individual is eligible to receive services as set forth in this Section if he or she meets the *general* MaineCare eligibility requirements (financial), the *specific* MaineCare eligibility requirements, and the *medical* eligibility requirements for the applicable level of care.

- **General Eligibility Requirements:** Individuals must meet the financial eligibility criteria as set forth in the *MaineCare Eligibility Manual*. Some Members may have restrictions on the type and amount of services they are eligible to receive;
- **Specific Eligibility Requirements:**
  - Only individuals under age 21 are eligible for Level IV under this Section;
  - Individuals of any age are eligible for all other Levels of care;
- **Medical Eligibility Requirements** as outlined in 96.02-4.

**Covered Services**
- Private Duty Nursing Services;
- Personal Care Services;
- Venipuncture Only Services (Level VII);
- Medication and Venipuncture Services (Level VI);
- Care Coordination Services;
- Skills Training.

**Limitations**
- Skills training shall not exceed 14.25 hours annually including any hours needed for initial instruction;
- Care Coordination shall not exceed 18 hours annually.
**Non-Covered Services**

- Services for which the cost exceeds the limits described in this Section, except as described in 96.03(A);
- Psychiatric nursing services, except as described under Section 96.04(A);
- Those services that can be reasonably obtained by the Member outside his/her place of residence;
- Unless qualified for the “special circumstances nursing” (see Section 96.04(B), nursing services when provided by the Member’s husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father in law, mother in law, son in law, daughter in law, brother in law, sister in law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit;
- Personal care services provided by a spouse of the Member, the parents or stepparents of a minor child, or a legally responsible relative;
- Homemaker and chore services not directly related to medical necessity. Homemaker and chore services are covered in this Section only as authorized by the Assessing Services Agency in the plan of care when required;
- Services in an ICF-MR, nursing facility or hospital;
- Services to Members receiving any Home and Community Benefits for the Elderly, or Adults with Disabilities (nursing and personal care services are covered under these waiver benefits);
- Escorting Members outside of the home, except as described in Section 96.01-3 or 96.04(C);
- Custodial care or respite care;
- Except for those services delivered under Level IX, personal care services delivered in an Adult Family Care Home setting or other licensed Assisted Living Facility that is reimbursed for providing personal care services It is the responsibility of the AFCH or assisted living provider to deliver personal care services;
- Personal care services may not be provided to Members receiving Home and Community Benefits for Persons with Mental Retardation or Home and Community Benefits for the Physically Disabled. Personal care services are covered services under these Waivers. These Members may receive nursing services only under this Section;
- Supervisory visits made for the purpose of supervising home health aides, certified nursing assistants or personal care assistants;
- Services which are not approved by the plan of care; or
- Services in excess of 40 hours per week, provided by an individual PSS, home health aide or certified nursing assistant, for an individual Member.
**Ch. II - Section 97: Private Non-Medical Institution**

**Definition**
A Private Non-Medical Institution (PNMI) is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, personal care, and treatment services to four or more residents in single or multiple facilities or scattered site facilities.

The following details services in Chapter III, Section 97:
- Appendix B—Substance Abuse Treatment Facilities;
- Appendix C -- Medical and Remedial Treatment Services Facilities;
- Appendix D -- Child Care Facilities;
- Appendix E -- Community Residences for Persons with Mental Illness;
- Appendix F -- Non-Case Mixed Medical and Remedial Facilities.

**Eligibility**
- Eligible for MaineCare services;
- Documentation of medical necessity required (See Section 97 for medical necessity criteria for each type of facility).

**Covered Services**
**Possible covered services, not all apply, check with the individual PNMI to see what they offer**
- Physician services
- Psychiatrist services
- Psychologist services
- Psychological examiner services
- Social worker services
- Licensed clinical professional counselor services
- Licensed professional counselor services
- Dentist services
- Registered nurse services
- Licensed practical nurse services
- Psychiatric nurse services
- Speech pathologist services
- Licensed alcohol and drug counselor services
- Occupational therapy services
- Other qualified mental health staff services;
- Other qualified medical and remedial staff services
- Other qualified alcohol and drug treatment staff services
- Personal care services
- Other qualified child care facility services
- Other qualified licensed treatment foster care provider services
- Interpreter services
• Nurse practitioner services
• Physician assistant services
• Clinical consultant services
• Physical therapy services

**Limitations**
- Reimbursement shall be made for direct services, collateral contacts, and certain supportive services when there is not a direct encounter with the member, only as described in Chapter III, Principles of Reimbursement for PNMI, Section 2400, and when provided by qualified staff members;
- Bed-hold days are not reimbursable;
- Reimbursement shall not be made for Private Non-Medical Institution services provided out of state unless the services are medically necessary, and are not available within the State and prior authorization (as described in this Section and Chapter I, of the MaineCare Benefits Manual) has been granted;
- Non-Duplication of Services;
- Services that are part of the PNMI rate may not be billed to MaineCare separately by other providers including Personal care services and Private Duty Nursing;
- PNMI providers must coordinate their services with all other MaineCare services, including but not limited to case managers providing services outside the residential setting, in accordance with the provisions of Chapter II, Section 13, of the MaineCare Benefits Manual, Targeted Case Management Services.

**Non-Covered Services**
- Private Room telephone, television, room and board, etc.;
- Personal Care Services Provided by a Family Member.
Ch. II - Section 102: Rehabilitative Services (for individuals with acquired brain injuries)

Purpose

The purpose of this rule is to cover rehabilitative services for eligible members who have sustained a brain injury. This section does not include coverage for services for people with brain injuries that are congenital or induced by birth. Rehabilitative services are specialized, interdisciplinary, coordinated, and outcomes focused. The services are designed to address the unique medical, physical, cognitive, psychosocial, and behavioral needs of members with acquired brain injuries. Limitations apply; services are appropriate if there is the potential for rehabilitation and the expectation of functionally significant improvements in the member’s status, or in certain cases where services are necessary because their withdrawal would result in the member’s measurable decline in functional status.

Eligibility

- Financial eligibility;
- Medical Criteria:
  - A diagnosis of brain injury;
  - Member is not receiving acute hospital rehabilitation services;
  - Member is not receiving intensive rehabilitation NF services;
  - If receiving services in a nursing facility setting that are not intensive rehabilitative NF services, member must meet all of the following:
    - Clinical evaluation documents rehabilitation potential; and
    - Requires licensed/certified services to continue improvement; and
    - Limited or no other access to rehabilitative services; and
    - Expresses a desire to move to a less restrictive setting; and
    - Discharge to a less restrictive living arrangement has been identified in the discharge potential section of the Minimum Data Set (MDS) (which is conducted by the NF) and active planning for discharge is documented in the member’s NF plan of care.
  - Meets the requirements of one of the following three Covered Services:
    - Intensive Integrated Neuro-rehabilitation; or
    - Neurobehavioral Rehabilitation; or
    - Community/Work Reintegration or Self Care/Home Management Reintegration;
- Member must have each item in the Brain Injury Assessment Tool (BIAT) rated by clinicians to indicate the level at which the member being evaluated experienced problems during the last two (2) weeks.

**Covered Services**
- Clinical Assessment Services;
- Intensive Integrated Neuro-rehabilitation;
- Neurobehavioral Rehabilitation;
- Self-Care/Home Management Reintegration;
- Community/Work Reintegration.

**Limitations**
- Does not include coverage for services for people with brain injuries that are congenital or induced by birth;
- Services are limited to a combination of no more than eighteen (18) hours (72 units) per week;
- A member may not receive coverage for services under this Section if he or she is involved in acute hospital rehabilitation services;
- A member may not receive coverage for services under this Section if he or she is receiving intensive rehabilitative NF services;
- Services must not duplicate services delivered under any other Section of the MBM, including but not limited to: Section 97, Private Non-Medical Institution Services; Section 12, Consumer Directed Attendant Services; Section 22, Home and Community-Based Waiver Services for the Physically Disabled; Section 19, Home & Community Benefits for the Elderly and for Adults with Disabilities; Section96, Private Duty Nursing & Personal Care Services; Section 68, Occupational Therapy Services; Section 85, Physical Therapy Services; Section 109, Speech and Hearing Services; Section 111, Substance Abuse Treatment Services; Section 17, Community Support Services; Section 24, Day Habilitation Services for Persons with Intellectual Disabilities; Section 26, Day Health Services; and Section 65, Behavioral Health Services;
- MaineCare will only reimburse for initial clinical assessment services up to eight (8) hours (32 units) of service, per member, per occurrence of acquired brain injury. MaineCare will reimburse Clinical Reassessment for up to eight (8) hours (32 units) per year;
- MaineCare will reimburse for a covered service provided in an individual or a group session. A "group" must not exceed four (4) members per each licensed or certified clinician or other qualified staff person. When group services are provided, a brief notation must be made for each member in his or her medical record.
Non-Covered Services

- Services that are primarily vocational, custodial, academic, socialization, or recreational are not covered.
Ch. X – Section 3: Katie Beckett Benefit

Summary
This section describes basic provisions of the Katie Beckett benefit that reimburses services for certain children who meet Social Security criteria for disability, but are otherwise not eligible for MaineCare services. This rule supplements other sections of the MaineCare Eligibility and MaineCare Benefits Manuals.

Eligibility
The member must be:

- Age 18 and under (up to age 19);
- Meet Social Security Administration criteria for disability as determined by the Department;
- Not eligible for MaineCare under any other category;
- Reside in the community (not in a medical institution);
- Need in-patient care provided by a hospital, nursing facility, psychiatric hospital, or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) but not reside in one of these facilities;
- Have an initial face-to-face medical assessment to determine if the child meets medical eligibility;
- Meet financial and any other additional eligibility criteria as required by the MaineCare Eligibility Manual.

Covered Services
This is a financial eligibility program - looks only at consumer's income and excludes family income/assets. Once consumer is found eligible for MaineCare under the Katie Beckett program they can receive MaineCare funded programs. They don't necessarily provide a service; it just determines them eligible for MaineCare.
Navigating the Transition from School to Adult Life

Transition Checklist:

Prior to the start of the 9th Grade

____ Have conversations with your child and family about what he/she would like to do after high school.
____ Present ideas of possible post-school outcomes at last IEP before transitioning to high school.

During High School

____ Continue to have conversations with your child concerning post-school dreams and desires.
____ Annually update Transition Plan to reflect post-school outcomes (Transition Plans are only required for individuals who have IEP’S).
____ Have an updated Triennial review fully completed no later than 2 years prior to exiting school.
____ Obtain the Summary of Performance report at graduation or shortly after (Only required for individuals who have IEP’s)

Post-Secondary Education

____ Research institutions of higher learning with your child.
____ Research 504 plans and how to access them if your child has an IEP.
____ When visiting schools visit the Office of Disability Services at each institution and determine eligibility requirements for each.

Upon Acceptance to an Institution of Higher Learning

____ Contact the Office of Disability Services
____ Visit the Office of Disability Services prior to starting school. Bring along the report of the last Triennial Review and the Summary of Performance.

Employment

At age 14 and older

_____ Visit your local Career Center and determining what services might help your child access employment.

_____ Obtain work experience for you child. This can be done through school, Career Center Services, or through Vocational Rehabilitation.

Three years prior to exit from school

_____ Obtain information about Vocational Rehabilitation Services

_____ Invite the Vocational Rehabilitation Counselor to the IEP meeting.

Two years prior to exit from school

_____ Make a referral to Vocational Rehabilitation.

Independent Living

Two years prior to 18th birthday

_____ Families should gather information regarding adult services.

_____ DHHS Community Case Manager should be invited to attend the IEP meeting.

By 17 ½ years old

_____ Start the process of applying for MaineCare and DHHS services.

Guardianship

By age 17

_____ Schools are required to inform a student of his/her rights that will transfer to the child upon reaching 18 years old (Only for those who have IEP’s).

_____ Parents/families should inform themselves on the levels of guardianship to determine if it should be pursued

Prior to the person reaching age 18

_____ Applications for guardianship should be completed prior to the person reaching 18 years of age.
Youth Transition Process
Office of Children and Family Services
To
Office of Aging and Disability Services

Youth Referred to Transition Committee
Transition Committee Reviews Information Presented
OADS Staff Starts Transition Process and Documents Meeting for Youth Record
Committee Discusses Youth’s Adult Service Needs

Adult Services Decision (MH, DS, BVR, etc)

TCM enters Note documentation of contact with youth & family (Documents Work)

TCM Prepares for Referral to OADS (Secures Current Evaluations, Completes EIS Electronic OADS

OADS Staff Starts Transition Process and Documents Meeting for Youth Record

90 Day Eligibility Clock Starts (if needed)

TCM makes Referral To OADS After Age 17

OADS Intake Confirms Information Record & Additional Information
OADS Complete Review of all EIS Assessment and Demographic Information

OADS Intake Requests or Arranges Addition Psychological or Medical Evaluation

OADS Intake Secures Permission to Treat from guardian or youth if over age 18 and no guardian

OADS Intake Updates EIS Record, Enters Notes as Needed

OADS Intake Request Eligibility Decision

Office of Children and Family Services
To
Office of Aging and Disability Services

Application for Home and Community Comprehensive and the Support Waivers may be made at Age 18 by Young Adults who have either a Children TCM or Assigned Adult TCM

90 Day Letter Extending Intake Sent

District Supervisor Eligibility Decision

TCM Prepares for Referral to OADS (Secures Current Evaluations, Completes EIS Electronic OADS

TCM makes Referral To OADS After Age 17

OADS Intake Closes Intake Process – TCM assumes responsibility

Refer to OADS Community Liaison to connect Youth to TCM in EIS

Eligible – Guardian/family/youth instructed as to choosing adult TCM

Ineligible – Supervision talks with guardian/family regarding other service options