

**State of Maine**

**Office of Aging and Disability Services**

**MaineCare Policy Summary**

**Due to ongoing changes in MaineCare Policy, this document is to be used as a reference only. Refer to the MaineCare Manual found at:** <http://www.maine.gov/sos/cec/rules/10/ch101.htm> **for complete and current information.**

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# Chapter II - Section 2: Adult Family Care Services

**Definition**

Adult Family Care (AFC) Servicesinclude 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 years or older;
* The Minimum Data Set-Assisted Living Services (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, Private Duty Nursing and Personal Care Services, 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”;
* Members receiving Section 2: Adult Family Care Services are not eligible to receive Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder or Section 29: Support Services for Adults with Intellectual Disabilities or Autistic Spectrum Disorder.

***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 2.04-1(A) (2) that is furnished directly to the member;
* Other non-covered services as described in Chapter I of the *MaineCare Benefits Manual*, including services that are primarily academic, social, vocational or custodial in nature.

# Chapter 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 (MED) form;
* A registered nurse trained in conducting assessments with the Department’s approved MED form must conduct the medical eligibility assessment;
* 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.
* Member must not be residing in a hospital, nursing facility, or Intermediate Care Facility for the Individuals with Intellectual Disabilities (ICF-IID) as an inpatient;
* Member must not reside in an Adult Family Care Home or other residential setting including a Private Non-Medical Institution, sometimes referred to as a residential care facility or supported living, regardless of payment source, (i.e. private or MaineCare);
* Member must not be receiving personal care services under Private Duty Nursing/Personal Care Services, Section 96, or be receiving any In-home Community and Support Services for Elderly and Other Adults, Section 63, or participating in other MaineCare programs where personal care services are a covered service.
* 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;

**Covered Services**

* Care Coordination Services;
* Skills Training Services;
* Personal Care Services (PCS);
* Activities of Daily Living (ADL);
* Instrumental Activities of Daily Living (IADL)
* If a single provider of personal care services is providing this service to multiple Section 12 members in a single visit, the two (2) or three (3) person modifier shall be used, as outlined in Chapter III, Section 12, “Allowances for Consumer-Directed Attendant Services”.
* Travel time only of an attendant in the course of delivering a covered service is allowed under this Section.

**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 Agencystaff, 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.

# Chapter II - Section 13: Targeted Case Management Services

**Definitions**

**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 Manager;
* Prior Authorization and Utilization Review

**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.

# Chapter II - Section 17: Community Support Services

**Definition**

Community Support Servicesis 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 of that person 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 with:
* A primary diagnosis of Schizophrenia or Schizoaffective disorder in accordance with the *Diagnostic and Statistical Manual*, 5th edition (DSM 5) criteria; or
* Another primary DSM 5 diagnosis or DSM 4 equivalent diagnosis with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders; and
* Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the LOCUS or other acceptable standardized assessment tools approved by the Department. If using the LOCUS, the member must have a LOCUS score, as determined by a LOCUS Certified Assessor, of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services (17.04-2) and ACT (17.04-3), the member must have a LOCUS score of twenty (20) (Level IV) or greater.
* 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 or other approved tools must be administered, at least annually, or more frequently, if DHHS or its Authorized Agent requires it.

***Covered Services***

* Community Integration Services;
* Community Rehabilitation Services;
* Assertive Community Treatment (ACT);
* Daily Living Support Services;
* Skills Development Services;
* Day Supports Services;
* Interpreter Services.

**Limitations**

* Reimbursement: MaineCare will reimburse only for covered services provided by agencies and individuals pursuant to Section 17.07-2.
* 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, or Assertive Community Treatment;
* Concurrent Provision of Services. The following chart reflects covered services that may, and may not, be concurrently provided to a member:

|  |  |  |
| --- | --- | --- |
| **A. Type of Service** | **B. Additional Services that May be Provided Concurrently with the Service Listed in Column A** | **C. Services that may not be Provided Concurrently with the Service Listed in Column A** |
| Community IntegrationServices | 1. Daily Living Support Services *or* Skills Development Services *or* Day Supports Services; and2. Interpreter Services | 1. Assertive Community Treatment2. Community  Rehabilitation Services3. Section 92, Behavioral Health Home4. Section 13, Targeted Case Management |
| Community Rehabilitation Services | 1. Day Supports Services; and2. Interpreter Services | 1. Community Integration Services2. Assertive Community Treatment3. Daily Living Support Services4. Skills Development Services |
| Assertive Community Treatment | 1. Daily Living Support Services or Skills Development Services or Day Supports Services; and2. Interpreter Services | 1. Community Integration Services2. Community Rehabilitation Services |
| Daily Living Support Services | 1. Community Integration Services2. Day Support Services3. Assertive Community Treatment4. Interpreter Services | 1. Skills Development  Services |
| Skills Development Services | 1. Community Integration Services2. Day Supports Services3. Assertive Community Treatment4. Interpreter Services | 1. Daily Living Supports |

* Location: Except as may be expressly provided in Section 17.04 or by federal or state statute or regulation, covered services may be provided in any community location.
* Private Non-Medical Institutions: Community Support Services, as specified in Sections 17.04-2 Community Rehabilitation Services & 17.04-3 Assertive Community Treatment 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 17-09-2(C). In order to avoid duplication of services, providers furnishing services under Sections 17.04-3 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;
* Utilization Review: DHHS or an Authorized Entity reserves the right to Review continuation of any covered services as described in this Section, applying the standards established by this Section for eligibility and for continuation of a service.
* Exclusivity of Billing: If a service may be billed under either this Section or Section 65, a Community Support Provider may bill the service under only one of those sections for a single member.
* Day Support Services: Services previously billed under this section known as or equivalent to “clubhouse” services, are defined and covered in Section 65 of the *MaineCare Benefits Manual* as “Mental Health Psychosocial Clubhouse Services.” Services provided under this policy consistent with the model of Psychosocial Clubhouse Services are considered duplicative with services offered via Section 65, and are not covered under this policy.

**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, social clubs, camps and companionship activities);
* 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;
* Refer to the *MaineCare Benefits Manual*, Chapter I for additional listings of non-covered 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.

# Chapter II - Section 18: Home and Community-Based Services for Adults with Brain Injury

**Definition**

Home and Community-Based Waiver for Adults with Brain Injury who meet criteria for care in an intermediate care facility or nursing facility and choose to live in the community with the support of this waiver.

**Eligibility**

* 18 and older;
* Has a diagnosis of acquired brain injury. {Acquired Brain Injury means an insult to the brain resulting directly or indirectly from trauma, anoxia, or vascular lesions, or infection, which is not of a degenerative or congenital nature, can produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical functioning, can result in the disturbance of behavioral or emotional functioning, can be either temporary or permanent, and can cause partial or total functional disability or psychosocial maladjustment}*. (Title 22 §3086*); and
* Has received an assessment by a qualified neuropsychologist (as defined in the *MaineCare Benefits Manual*, Rehabilitative Services, Section 102.08-5 B) and/or a licensed physician who is Board certified or Board eligible in Physical Medicine and Rehabilitation, which:
* positively indicates the individual: is not in a persistent vegetative state; is able to demonstrate potential for physical and/or behavioral and/or cognitive rehabilitation; shows evidence of moderate to severe behavioral and/or cognitive and/or functional disabilities; and
* results in specific rehabilitation goals, based upon the findings of the assessment, describing types and frequencies of therapies and expected outcomes and timeframes; and
* Has a completed Department-approved Health and Safety Assessment administered by the Department with an overall score of 0.1 or higher. The Department approved Health and Safety Assessment evaluates cognitive, physical, and behavioral needs related to a person’s brain injury. It assesses whether a person needs support for the three areas. Additionally, it assesses if the person needs cueing, direct support, or a behavioral support. Scores range from 0-1. The assessment can be found at the Department’s Brain Injury Services website: <http://www.maine.gov/dhhs/oads/disability/bi/index.shtml> The assessment was last revised: 02/25/14. The Department will only accept assessments conducted no more than three months prior to application; and
* Has completed Mayo-Portland Adaptability Inventory – 4 (or current Department approved version of the MPAI) with an item score of 3 or higher for two of the following items:
* Novel Problem Solving
* Impaired Self-Awareness
* Irritability, Anger, Aggression
* Inappropriate Social Interaction
* Fund of Information or Attention/Concentration or Memory
* 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
* The estimated annual cost of the member’s services under the waiver is equal to or less than one hundred percent (100%) of a blended rate of the statewide average annual cost of care for individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and Nursing Facility Brain Injury units, as determined by DHHS (the blended rate being the sum of 20% of the statewide average annual cost of care in an ICF/IID and 80% of the statewide average annual cost of care in a Nursing Facility Brain Injury unit); and
* Can have his or her health and welfare needs assured in the community setting as stated in § 18.04-2(D).

**Covered Services**

* Assistive Technology Device: An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of members; and
* Assistive Technology Service: A service that directly assists a member in the selection, acquisition, or use of an Assistive Technology device. Assistive Technology Services include:
* The evaluation of the Assistive Technology needs of a member, including a functional evaluation of the impact of the provision of appropriate Assistive Technology Devices and appropriate Assistive Technology Services to the member in the customary environment of the member;
* Services consisting of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology Devices for members;
* Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing Assistive Technology Devices;
* Coordination and use of necessary therapies, interventions, or services with Assistive Technology Devices, such as therapies, interventions, or services associated with other services in the Care Plan;
* Training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member;
* Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of members; and
* Transmission of data required for use of the Assistive Technology Device via internet or cable utility.
* Assistive Technology Services ***excludes*** duplicate services available under the State Plan subject to §18.06-7. The components above are subject to the following limits:
* The Assistive Technology Device and services described above in paragraphs (B) and (C) are subject to a combined limit of $6,000.00 annually.
* The services described above in paragraphs (A), (D), (E) and (F) are subject to a combined limit of 32 units (8 hours) annually.
* The data transmission utility costs described above in paragraph (G) are limited to $50.00 per month.
* Care Coordination Service - Consists of a conflict-free service that assist members in gaining access to needed waiver and State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is sought. Care Coordination Services also include responsibility for assisting the member to access and coordinate natural supports, and monitoring and assurance of the implementation of the Care Plan. This includes monitoring of the health, welfare and safety of the member. This service requires face-to-face contact between the Care Coordinator and the member, at a minimum, every thirty days. A member who has this service may not receive duplicative care coordination services including, but not limited to:
* Section 13, “Targeted Case Management Services”;
* Section 91, “Health Home Services”;
* Section 92, “Behavioral Health Home Services”;
* Or similar such services under the State Plan.
* Career Planning - A person-centered, comprehensive employment planning and direct support service that provides assistance for a waiver program participant to obtain, maintain or advance in competitive employment or self-employment at or above the State’s minimum wage. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the State’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support. This service assists in identifying skills, priorities, and capabilities determined through an individualized discovery process. This may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, development of experiential learning opportunities and career options consistent with the participant’s skills and interests. Career Planning may be used in preparation to gather information to be used as part of a referral to Vocational Rehabilitation.
* Career planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. §1401(16 and 17).
* 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. Career planning services must have the long-term goal of individual, competitive, integrated employment for which the member is compensated at or above the minimum wage. In order to receive Career Planning services, the member’s Care Plan must identify specific career goals and describe how the Career Planning services will be used to achieve those goals.
* Career Planning services can be provided within a variety of community settings such as a Career Center, the community and local business and must be documented in the Care Plan with related goals.
* Community/Work Reintegrationis an integrated clinical service to improve the member’s ability to successfully integrate into his or her current or desired community and/or work setting. The service includes compensatory interventions and treatment focused on functional improvement and reinforcement of community and work reintegration for the member. Specifically, the treatment is based on the clinical needs of the member as defined by their current Mayo Portland Adaptability Inventory. Individual functional goals are defined based on these identified needs. These treatments are provided on a 1:1 and group basis. Group services are coded with HQ and may be provided in groups up to 6 participants.
* Employment Specialist Services: Consists of services necessary to support a member in maintaining employment. Services include:
* Periodic interventions on the job site to identify a member’s opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion;
* Assistance in transitioning between employers when a member’s goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job. The need for continued Employment Services must be documented in the Care Plan as necessary to maintain employment over time; and
* For Job Development, if Vocational Rehabilitation denies services under the Rehabilitation Act and the member is unable to benefit from Vocational Rehabilitation then the member may receive Employment Specialist Services for job development. If Employment Specialist Services are used for job development, current documentation of ineligibility from Vocational Rehabilitation is required.
* Employment Specialist Services are provided by an Employment Specialist who may work either independently or under the auspices of a Supported Employment agency.
* Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. Employment Specialist Services may be utilized to assist a member to establish and or sustain a business venture that is income-producing. MaineCare funds may not be used to defray the expenses associated with the start-up or operating a business.
* A member ***may not*** receive Employment Specialist Services while enrolled in high school.
* The cost of transportation related to the provision of Employment Specialist Services is a component of the rate paid for the service and is not separately billable.
* A member ***cannot*** receive these services while working under a Special Minimum Wage Certificate issued by the Department of Labor under the *Fair Labor Standards Act*.
* Employment Specialist Services ***cannot*** be provided at the same time as Work Support Services.
* Home Support Services: There are four types of Home Support Services:
* *Home Support Services (1/4 hour) Level I* - Consist of services for a member who does not require 24/7 care; the services may be provided in the member’s home. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development that assist the member to reside in the most integrated setting appropriate to his/her needs. These supports also include personal care and protective oversight and supervision.
* *Home Support Services (Per Diem) Level II* - Consist of services for a member who requires 24/7 care typically provided in a provider- owned facility with not more than 8 members. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community as defined in the Care Plan. The Care Plan will specify the minimum number of 1:1 direct support hours a member needs on a daily basis. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs. These supports also include personal care and protective oversight and supervision.
* *Home Support Services (Per Diem) Level III* - Home Support (Residential Habilitation) Level III- Increased Neurobehavioral- consist of services for a member who requires 24/7 care typically provided in a provider-owned facility with not more than 8 members. This service is for members who have an increased clinical need relating to their behaviors associated with their brain injury. To qualify for Home Support Services Level III, a member must have at least a score of 0.5 on the Department Approved Health and Safety Assessment. The service is intended for members who are not typically successful without structured services in an individually tailored setting, and who typically are not successful in group settings. The service includes neurobehavioral treatment specific to the individual’s needs, as well as personal care and protective oversight and supervision. The Care Plan will specify the minimum number of 1:1 direct support hours a member needs on a daily basis. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs. Home Support (Residential Habilitation) Level III is an intensive neurobehavioral level of treatment. The rate for this service is all inclusive and therefore, includes the treatment of cognitive and behavioral clinical needs for the Member as part of the rate. A member who has this service may not receive Self/Home Reintegration, Work/Community Reintegration, or Work Ordered Day Club House as separate services.
* Home Support Services (Remote Support)- consist of services for a member who does not require face-to-face care but would benefit from electronic communication to ensure health and safety. The service is designed to work in concert with Home Support Services (1/4 hour) to provide habilitation support and to assist the member in achieving the most integrated setting possible and increase the member’s independence through assistive technology. Whereas members served under this waiver have limitations that inhibit their ability to communicate, control their environment, and maintain their personal safety, this service provides real-time remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, door, temperature, smoke, carbon monoxide, etc.), video cameras, microphones and speakers, as well as health monitoring equipment. This assistive technology links each member’s residence to the residential service provider. The residential service provider must have staff available 24 hours per day 7 days per weeks to deliver direct 1:1 care when needed. Two levels of emergency back-up are required for any Care Plan that includes Home Support Services (Remote Support).
* The use of this service is based upon the member’s assessed needs and the resulting Care Plan. The Care Plan must reflect the member’s and, where applicable, his or her guardian’s informed consent and commitment to the Care Plan elements including all assistive communication, environmental control and safety components. A thorough evaluation of all Assistive Technology must be completed prior to the finalization of the Care Plan with the assistance of the Care Coordinator and use of appropriate Assistive Technology consultants. The member must be provided educational support in order to fully understand the risks and benefits of all elements of the Care Plan and this must be documented and acknowledged by the member served. All assistive devices and systems must allow the member served to “opt out.” The member must be informed as to the methods for ending a service, either on a short-term basis or permanently. These options must be delineated in the member’s Care Plan. If a member served experiences a change in support needs or status, the provider must immediately adjust the direct support services to meet those needs.
* All Remote Support Services must be provided in real time. All electronic systems must have back-up power connections to insure functionality in case of loss of electric power. Providers must comply with all federal, state and local regulations that apply to its business including but not limited to the “Electronic Communications Privacy Act of 1986”.
* Any services that use networked services must comply with HIPAA requirements.
* Remote Support has two components, Monitor only and Interactive Support. Monitor only means that the member is being electronically monitored for over sight and supervision purposes. Interactive Support means that the member and the staff person monitoring the member electronically are interacting back and forth with the use of cameras or other approved devices.
* Payment is ***not*** made under this section for the cost of room and board, including the cost of building maintenance, upkeep and improvement.
* A provider may provide Home Support to more than one member at a time.
* The cost of transportation related to the provision of Home Support is a component of the rate paid for the serviceand is ***not*** separately billable.
* Non-Medical Transportation Services - Consists of services to enable members to gain access to certain Section 18 Covered Services, as specified by the Care Plan. Transportation services for Section 18 services are provided under the *MaineCare Benefits Manual*, Section 113, and “Non-Emergency Transportation Services”. Whenever possible, family, friends or community agencies, which can provide this service without charge, must be utilized.
* A provider may ***only*** be reimbursed for providing transportation when the cost of transportation is ***not*** a component of a rate paid for another service.
* Self-Care/Home Management Reintegration: An integrated clinical service to improve the member’s ability to care for him/her successfully and/or manage his/her home setting successfully. The service that includes compensatory interventions and treatment focused on functional improvement and reinforcement of self-care and home management reintegration for the member. Specifically, the treatment is based on the clinical needs of the member as defined by their current Mayo Portland Adaptability Inventory. Individual functional goals are defined based on these identified needs. Group services are coded with HQ and may be provided in groups of up to 6 participants.
* Work Ordered Day Club House - A set of services provided at a community-based facility, referred to as a “Club House,” that assist members with community reentry, the rebuilding of social relationships and the training of skills required to return to productive activity. The Work Ordered Day Club House is designed to help individuals build skills specific to a work environment.
* This Service specializes in treatment techniques for members with acquired brain injuries. Providers of Services develop and provide staff training, which focuses on the needs of individuals with an acquired brain injury identified in the Care Plan, and the specific manner in which this service will meet the member’s individual needs. The program focuses on adaptive skills and is distinct from work production objectives. These services are provided during the day through programs that are offered at facilities within the community. At the end of each day, the member returns to his/her home.
* Work Support Services **-** Intensive, ongoing supports that enable members, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting, to work in a regular work setting. Work Support Services may include assisting the member to locate a job or developing a job on behalf of the member. Work Support Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Work Support Services includes activities needed to sustain paid work by members, including supervision and training. When Work Support Services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving waiver services as a result of their disabilities and not for the supervisory activities rendered as a normal part of the business setting.
* This service is only available in the absence of a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. §§1401 *et seq*.). Members cannot receive these services while working under a Special Minimum Wage Certificate issued by the Department of Labor under the Fair Labor Standards Act.
* Documentation must be maintained in the file of each member receiving this service that the service is not available under such a program.
* Work Support Services may not be used for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
* Incentive payments made to an employer to encourage or subsidize the employer's participation in Work Support Services; or
* Payments that are passed through to users of Work Support Services; or
* Payments for training that is not directly related to an individual's Work Support Services.
* Work Support Services must be delivered on an individualized basis and not in a group format.
* The cost of transportation related to the provision of Work Support Services is a component of the rate paid for the service and is not separately billable.

**Limitations:**

* Assistive Technology Services - Limited to as described in the covered service 18-05-1. Each system or device will be revised based on medical necessity, efficiency and meets compatibility with safety needs.
* Care Coordination Services - Limited to 400 units for the first year in which the member receives services under this Section and 200 units every year after the initial year. The Care Coordination provider may not offer any other services to the member under this Section.
* Career Planning-The maximum annual allowance is 60 hours to be delivered within a six-month period. No two six month periods may be provided concurrently. Career Planning may not be provided at the same time as Home Support, Employment Specialist Services or Work Support.
* Community/Work Reintegration-A member may have up to 72 units per week of either Community/Work Reintegration, Self-Care/Home Management Reintegration or any combination of both. A member may not also access the state plan service in the *MaineCare Benefits Manual*, Section 102, “Rehabilitative Services”.
* Home Support Services:
* Home Support Services (1/4 hour) Level I - are limited to 64 units per day.
* Home Support Services (Remote Support) - are limited to 64 units per day.
* Home Support Services (Increased Neurobehavioral) Level III per diem - Members receiving this service are not authorized to have Self/Home Management Reintegration, Work/Community Reintegration, or Work Ordered Day Club House as separate services.
* Self-Care/Home Management Reintegration - A member may have up to 72 units per week of either Community/Work Reintegration, Self-Care/Home Management Reintegration or any combination of both. A member may not also access the state plan service in the *MaineCare Benefits Manual*, Section 102, and “Rehabilitative Services”.
* Work Ordered Day Club House - Members may attend Work Ordered Day Club House 3 days a week, per diem (3-5 hours a day).
* Work Support Services -Work Support Services are limited to 64 units per week, not to exceed 3328 units per service year.
* Section 18, “Home and Community Based Services for Adults with Brain Injury”, 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, spouse, or a relative of the member.
* Work Support when the member is not engaged in employment.
* Assistive Technology unless the service has been determined non-reimbursable under Section 60, “Medical Supplies and Durable Equipment”, the State Plan and/or other sections of the *MaineCare Benefits Manual*.
* Non-Duplication of Services, services as defined under this section if the member is receiving comparable or duplicative services under this or another section of the *MaineCare Benefits Manual*.
* A member may not receive services under this section if the member is in a residential treatment facility or if the member is receiving services in an institution, including, but not limited to:
* Section 2, “Adult Family Care Services”;
* Section 13, “Targeted Case Management Services”;
* Section 45, “Hospital Services”;
* Section 46, “Psychiatric Hospital Services”;
* Section 50, “ICF/IID Services”;
* Section 67, “Nursing Facility Services”
* Section 97, “Private Non-Medical Institution Services”.
* A member may not receive services if they are in another Home and Community Based Waiver such as:
* Section 19, “Home and Community-Based Benefits for the Elderly and for Adults with Disabilities”,
* Section 20, “Home and Community Based Services for Adults with Other Related Conditions”,
* Section 21, “Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder”,
* Section 22, “Home and Community Benefits for the Physically Disabled”,
* Section 29, “Support Services for Adults with Intellectual Disabilities or Autistic Disorder”
* Section 32, “Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders”.

# Chapter 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 Assessing Services Agency, using the Medical Eligibility Determination (MED) Form must complete a face-to-face assessment.
* 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 must be established within the limits set forth in Section 19.06; 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 HCB; and
* The member selected HCB as documented by a signed choice letter; and
* The health and welfare of the applicant/member would not be endangered receiving services 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; and
* Member must make themselves available for any eligibility assessment and participate to the extent needed for the assessment to be completed;
* The member must have a permanent or chronic disability or functional impairment which interferes with his/her own capacity to provide self-care and daily living skills without assistance as verified by the member’s MED form; and
* 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**

* Assistive Technology Device and Services;
* Assistive Technology-Remote Monitoring;
* Assistive Technology-Transmission;
* Care Coordination Services;
* Environmental Modifications;
* Financial Management Services;
* Home Delivered Meals;
* 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;
* Living Well for Better Health;
* Matter of Balance (Falls Prevention);
* 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 $5000 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 $3,000 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 $1,000 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 $6,000 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, Section 19 (Respite Care Services, not in the home), per Member per annual eligibility period. These costs are included as part of the Member’s monthly program cap;
* Home Delivered Meals has a limit of one meal per member, per day up to seven days per week. The cost of this service shall be included in the monthly program cap for the member.
* Living Well for Better Health: The program has a lifetime limit; a member may attend this service up to three (3) times but no more than once per calendar year. The cost of this service shall be included in the monthly program cap for the member.
* Matter of Balance (Falls Prevention): The program has a lifetime limit; a member may participate in this program up to three (3) times but no more than once per calendar year. The cost of this service shall be included in the monthly program cap for the member.
* 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 Home Delivered Meals 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;
* 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.

# Chapter II - Section 20: Home and Community Based Services 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 within the meaning of 42 C.F.R. §435.1010. A “Related Condition” must meet 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 those required for these persons. These conditions include but are not limited to Neurofibromatosis, Other Choreas, Anoxic Brain Damage, Cerebral Laceration and Contusion, Subarachnoid- Subdural and Extradural Hemorrhage following injury, Other and Unspecified Intracranial Hemorrhage following injury or Intracranial injury and unspecified nature, Muscular Dystrophy, Huntington’s, Spina Bifida or other rare developmentally- based conditions.
* 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
* Can have his or her health and welfare needs assured in the community setting;

***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
* Career Planning

***Limitations***

* Assistive Technology Services- Assistive Technology Services are limited to $6000.00 per service year;
* 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 are limited to $6,000.00 per service year. Each system or device will be reviewed based on medical necessity, efficiency and meets compatibility with safety needs;
* Community Support Services are limited to 128 units per week, for an annual total of 6,656 units per service year. The maximum weekly allowance for Work Support Services is 128 units, for an annual total of 6,656 units. When members use a combination of both services, there is a weekly limit of 128 units per week and an annual limit of 6,656 units on the total combined expenditures for the services;
* Consultation Services are limited to 64 units per service year, each type of Consultation Service;
* Employment Specialist Services are limited to 72 units per service year;
* Home Accessibility Adaptions are limited to $3,000.00 per service year;
* Home Support Services (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 is limited to 64 units per service year;
* Non-Traditional Communication Consultation is limited to 64 units per service year;
* Occupational Therapy Maintenance is limited to 8 units per week up to 416 units per service year;
* Personal Care Services are limited to 52 units per day;
* 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 6,656 units per service year. The maximum weekly allowance for Community Support is 128 units, for an annual total of 6,656 units. When members use a combination of both services there is an annual limit of 6,656 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

# **Chapter II - Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder**

***Definition***

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

**Eligibility**

Eligibility for this benefit is based on meeting all three of the following criteria:

1) The eligibility criteria for a funded opening based on priority;

2) Medical eligibility; and

3) Eligibility for MaineCare as determined by the DHHS, Office for Family Independence (OFI).

Consistent with Subsection 21.03-1, a person is eligible for services under this Section if the person:

* Is age eighteen (18) or older; and
* Has an Intellectual Disability, or Autism Spectrum Disorder, or Rett Syndrome; 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
* The estimated annual cost of the Member’s services under the waiver 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 DHHS.

**Covered Services**

* Assistive Technology-Assessment
* Assistive Technology-Devices
* Assistive Technology-Transmission (Utility Services)
* Career Planning
* Communication Aids
* Community Support
* Consultation Services
* Counseling
* Crisis Assessment
* Crisis Intervention Services
* Employment Specialist Services
* Home Accessibility Adaptations
* Home Support-Agency Per Diem
* Home Support-Family-Centered Support
* Home Support-Remote Support
* Home Support-Quarter Hour
* Non-Medical Transportation Service
* Non-Traditional Communication Assessments
* Non-Traditional Communication Consultation
* Occupational Therapy (Maintenance)
* Physical Therapy (Maintenance)
* Shared Living (Foster Care, Adult)
* Specialized Medical Equipment and Supplies
* Speech Therapy (Maintenance)
* Work Support-Group
* Work Support-Individual

**Limitations**

* MaineCare members can receive services under only one Home and Community Waiver Benefit at any one time;
* When 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 $26,640.19 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. Home accessibility adaptions that exceed 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.
* 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. Consultation is limited to sixteen and a half (16.5) hours annually, per type of consultation (Occupational Therapy, Physical Therapy, Speech, Behavioral and Psychological). Non-traditional communication is limited to sixty (60) hours annually;
* 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;
* Occupational Therapy (Maintenance) provided by an Occupational Therapist, Registered, Licensed (OTR/L) is limited to forty-eight (48) quarter hour units per year. Occupational Therapy (Maintenance) provided by an Occupational Therapist Assistant/Licensed (OTA/L) is limited to forty (40) quarter hour units per year. When a OTA/L is providing Occupational Therapy (Maintenance), it must be under the supervision of an OTR;
* 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 additional Family-Centered Support providers will be approved and enrolled 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 DHHS to continue holding the funded opening. After six (6) continuous months in a nursing facility or hospital, if the member does not resume waiver services, the member will be terminated from the waiver;
* 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 provider operated homes where a minimum of two (2) members 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 limit of 32 units per state fiscal year. Assistive Technology-Devices and services are subject to a combined limit of $6,000 annually, per state fiscal year. Assistive Technology-Transmission (Utility Services) are limited to $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;
* 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. This can be in addition to Home Support-Quarter Hour, as long as this is not duplicative.

***Non-Covered Services***

* A member receiving services under this Section 21, may not receive duplicative MaineCare services at the same time under any other sections of the *MaineCare Benefits Manual*;
* 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, state psychiatric hospital 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. This rule will not be avoided by adult adoption. Persons appointed by a probate court as legal guardian prior to and up to December 30, 2007, who are not biological family, and who are directly or indirectly reimbursed for services, may continue to receive reimbursement under this Section;
* Work Support-Individual, Work Support-Group, 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 Medical Supplies and Durable Equipment, Section 60 or other sections of the MaineCare Benefits Manual;

# Chapter 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: Member requires daily (seven (7) days per week) “Cuing” (defined in Section 26.01) for all items: 26.02-2 (A) (2), (d), (e), (f) and (g) listed below; or at least “limited assistance” (defined in 26.01) and a “one-person physical assist” (defined in 26.01) 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” (defined in 26.01) and a “one-person physical assist” (defined in 26.01) are needed for at least two (2) of the following five (5) activities of daily living listed in 26.02-2 (A) (2) above: 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***

* Refer to Chapter I, “General Administrative Policies and Procedures” for rules governing non-covered services in general. Day health services delivered to a member who is a resident in a Private Non-Medical Institution (PNMI) cannot be reimbursed under this rule.

# Chapter 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 of the *MaineCare Benefits Manual* and identified in the ITP.

***Specific Eligibility Criteria***

* The member must have a completed multi-axial evaluation with an Axis I or Axis II behavioral health diagnosis using the most recent Diagnostic and Statistical Manual of Mental Health Disorder 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); and
* 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 in (C)(1) above, 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 treatment 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; 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.

# Chapter II - Section 29: Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

**Definition:**

The Home and Community Based Benefit (HCB or Benefit) for members with Intellectual

Disabilities (ID) or Autism Spectrum Disorder (ASD) gives members eligible for this Benefit the

option to live in their own home or in another home in the community thus avoiding or delaying

institutional services. The Benefit is offered in a community-based setting as an alternative for members

who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities

(ICF/IID). The Benefit supplements, rather than replaces supportive, natural personal, family, work, and

community relationships. It does not duplicate other MaineCare services.

**Eligibility**

* Funded opening;
* Is age eighteen (18) or older; and
* Has an Intellectual Disability or Autism Spectrum Disorder or Rett Syndrome; 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
* 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;
* Home Accessibility Adaptations;
* Home Support-Quarter Hour;
* Home Support-Remote Support;
* Respite Services;
* Shared Living (Foster Care, Adult)
* Transportation Service;
* Work Support-Group;
* Work Support-Individual

***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, or Shared Living, is fifty-two thousand, four hundred and twenty-five dollars ($52,425.00).
* Employment Specialist Services are provided on an intermittent basis with a maximum of ten (10) hours (forty (40) quarter hour units) each month.
* Home Accessibility Adaptations are limited to ten thousand dollars ($10,000) in a five (5) year period with an additional annual allowance up to three hundred dollars ($300) for repairs and replacement per year. 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 one hundred dollars ($1,100.00) 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 forRespite 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 psychiatric hospital or 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 18, Home and Community Based Services for Adults with Brain Injury;
* Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities;
* Section 20, Home and Community Based Services for Adults with Other Related Conditions;
* Section 21, Home and Community Benefits for Person with Intellectual Disabilities or Autism Spectrum Disorder;
* Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations;
* Section 45, Hospital Services;
* Section 46, Psychiatric Facility Services;
* Section 50, ICF/IID Services;
* Section 67, Nursing Facility Services;
* 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;
* 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 to be delivered in a six-month period. No two six-month periods may be provided consecutively.
* Out of State Services Authorizations for services to be provided out of state will not exceed sixty (60) days of service within a given fiscal year and will not exceed sixty (60) days within any six (6) month period except as provided in 42 C.F.R. §431.52(b).

***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, psychiatric hospital, or hospital 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;
* 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.

# Chapter II - Section 40: Home Health Services

**Definition**

Home Health Services are 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 that meets the definition of a hospital, nursing facility or ICF-MR except as allowed under Section 40.01-12 and Section 40.06; 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: Community Support Services; and
* Requires psychotropic medication administration or monitoring; and
* Not receiving psychotropic medication services under any other Sections of the MaineCare Benefits Manual; 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 as defined in Section 55;
* 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 if this is the sole skilled service provided during the visit;
* Custodial care;
* A monthly injection if this is the sole skilled nursing service provided during the visit;
* Monthly catheter change, beyond the acute phase.

# Chapter II - Section 50: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

**Definition**

A facility that meets State licensing and Federal certification requirements to provide health-related care and rehabilitative services to members with Intellectual Disabilities or members with related conditions who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but require care and services above the level of room and board. There are two types of ICF's-MR: ICF-MR Nursing Facility and ICF-MR Group Home Facility. Both types must meet appropriate State licensing and Federal certification requirements.

* 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 Section 50. 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 (refer to 50.07-7);
* ICF-IID Developmental Training Program.

***Non-Covered Services***

* Maintenance therapy (repetitive services not requiring the skills of a qualified physical or occupational therapist or the use of complex and sophisticated physical or occupational therapy procedures);
* Payment by a relative of an additional amount to enable a member to obtain non-covered services such as a private room (single bed), telephone, television, and authorized bed hold days is permitted. However, the additional charge for non-covered services must not exceed the charge to individuals who privately pay. The supplement for a private room must be no more than the difference between the private pay rate for a semi-private room and a private room;
* Services may not include services of a vocational or academic nature unless the service meets the criteria in Section 50.07-8.

# Chapter II - Section 65: Behavioral Health 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 Psychoeducational Treatment;
* Intensive Outpatient Services;
* Medication Management Services;
* Neurobehavioral Status Exam, Neuropsychological Testing 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;
* Medication-Assisted Treatment with Methadone;
* Interpreter Services;
* Children’s Behavioral Health Day Treatment;
* Tobacco Cessation Treatment Services;
* Mental Health Psychosocial Clubhouse Services;
* Specialized Group 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;
* Medication – Assisted Treatment requires prior authorization 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 65.08-5)-Comprehensive Assessments, Individual Outpatient Therapy, and Group Outpatient Therapy;
* 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;
* Reimbursement for Medication-Assisted Treatment with Methadone for addiction to opioids is limited to twenty-four (24) months per lifetime, except as permitted through prior authorization. (The Department has sought and anticipates receiving CMS approval for this lifetime cap, with treatment after January 1, 2013, counting towards this 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. Therefore, separate billings to the MaineCare Program for travel time are not reimbursable;
* 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.

# Chapter 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**

* General Specific Requirements: An individual is eligible to receive services as set forth in this Section if he or she meets the general MaineCare eligibility requirements and the medical eligibility requirements.
* General MaineCare 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 (upon CMS approval);
* Skills Training (upon CMS approval).

**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 Intellectual Disabilities or Autism Spectrum Disorder. Personal care services are covered services under this Waiver. 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.

# Chapter II - Section 97: Private Non-Medical Institution Services

### 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 Services Facilities;
* Appendix D - Child Care Facilities;
* Intensive Temporary Residential Treatment (ITRT) Services;
* 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 *– Direct Service Staff***

The service must be listed in the Principles of Reimbursement in order for the service to be

reimbursable. Covered services may include, but are not limited to:

* 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**

* Collateral Contacts-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 PNMIs, Section 2400, and when provided by qualified staff members;
* Non-Duplication of Services as outlined in 97.05-2- 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;
* Out of State- 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;
* Bed-hold days are not reimbursable.

**Non-Covered Services**

* Private Room and Other Non-Covered Services- The PNMI may permit payment by a relative of an additional amount to enable a member to obtain non-covered services such as a private room, telephone, television, or other non-covered services. However, the additional charge for non-covered services shall not exceed the charge to private pay residents.
* Personal Care Services Provided by a Family Member.

# Chapter II - Section 102: Rehabilitative Services

# 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;

**Covered Services**

* Clinical Assessment Services;
* Intensive Integrated Neurorehabilitation;
* Neuro-behavioral Rehabilitation;
* Self-Care/Home Management Reintegration;
* Community/Work Reintegration.

**Limitations**

* 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***

* Refer to Chapter I, “General Administrative Policies and Procedures” for rules governing non-covered services. Services that are primarily vocational, custodial, academic, socialization, or recreational are not covered.

# Chapter 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 or its Agent;
* Not eligible for MaineCare under any other category;
* Reside in the community (not in a medical institution as defined in the MaineCare Eligibility Manual);
* 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 completed by the Department or its agent to determine if the child meets medical eligibility and if so, the type of facility the child would qualify under; and
* Meet financial and any other additional eligibility criteria for Katie Beckett coverage as required by the MaineCare Eligibility Manual.

Paul R. LePage, GovernorBethany Hamm, Commissioner

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