Maine’s Appendix K

Operational Guidance for HCBS Waivers

Sections 18, 20, 21, and 29

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# Introduction

This operational guide is intended for providers of waiver services in Sections 18, 20, 21, and 29 only. Guidance for Section 19 waiver services will be provided in a separate document.

The Centers for Medicare and Medicaid Services (CMS) has approved the following temporary changes to Maine’s Home- and Community-Based Services 1915(c) waiver programs to plan for and address the impacts of COVID-19 on community living, workforce, and service delivery. These changes include temporarily raising the limit(s) and expanding the scope for some services; increasing some rates, particularly those impacting direct staff; increasing individual waiver budgets, if needed; and providing greater administrative flexibility so providers can adapt to extraordinary operating conditions. These exceptions are designed to ensure members are healthy and safe and receive the right amount of services to support their needs during this pandemic.

Appendix K remains in effect until 30 days after the State of Maine has declared that the statewide emergency has ended, or February 28, 2021, whichever comes sooner. Services will transition to pre-emergency levels during the final 30 days that the Appendix K is in effect. Please see Return to Pre-COVID-19 Services below for details on how this will occur.

This document should be read in conjunction with other COVID-19 information published by the Department of Health and Human Services, which includes the Maine Center for Disease Control (CDC), and any guidance issued by other federal and state authorities. This recognizes providers’ responsibility to comply with Executive Orders, local municipality orders, and directions from health officials regarding management and control of COVID-19. Our understanding of the pandemic continues to evolve, and people should always refer to the latest information available on the Department’s COVID-19 response [webpage](https://www.maine.gov/dhhs/oads/Coronavirus-COVID-19.shtmlhttps%3A/www.maine.gov/dhhs/oads/Coronavirus-COVID-19.shtml).

Please see guidance for supporting members during this pandemic in [Appendix A](#_Appendix_A).

# Guide for Determining if Appendix K Applies

All service-related changes contained in this operational guide may only be implemented for members impacted by COVID-19. Changes beyond those directly related to COVID-19 will not be authorized consistent with this guidance. ***During this emergency, health and safety activities for individuals and families are paramount.***

The following questions provide a guide for determining whether requests and authorizations will be covered under Appendix K. If, after reviewing this guide, it is determined that the requested change is as a result of the emergency, the Appendix K Operational Guidelines will specify the options for changes in services and service settings.

***What change(s) occurred for the member as a result of COVID-19?***

The member’s needs must be related to one or more of the questions listed below:

**Changes Related to Services**

1. Was the member receiving day services, such as Community Support, in a setting that closed due to the orders to "shelter in place" and/or CDC advisory for social distancing?
2. Was the member receiving community-based services, such as Community Support, Work Support, or Career Planning, that could not be provided due to the orders to "shelter in place" and/or CDC advisory for social distancing?
3. Was the member employed and using waiver services, such as Work Support or Employment Specialist Services, but is currently not able to work as a result of COVID-19 "shelter in place" requirements and/or CDC advisory for social distancing?
4. Is the provider unable to provide staffing at pre-COVID-19 required levels due to overall shortages of staffing and inability to secure additional staff as a result of the COVID-19 situation?
5. Is the member’s family choosing to not allow direct support workers (DSWs) into their home as part of social distancing?
6. Is the member’s family temporarily providing services that were provided by an agency prior to the emergency?
7. Is the member’s direct support worker unable to provide services due to caring for a family member affected by closure of schools or daycare programs as a result of COVID-19?
8. Is the member’s direct support worker unable to provide services due to caring for a family member diagnosed with COVID-19?

**Changes Related to Health**

1. Is the member isolating at home or quarantined due to potential exposure to someone diagnosed (presumptive or confirmed) with COVID-19?
2. Was the member diagnosed with COVID-19 and required to receive services from different people or in an alternative location?
3. Was the member’s caregiver or a person with whom they live diagnosed (presumptive or confirmed) with COVID-19?
4. Is the member’s direct support worker isolating at home or quarantined due to exposure to someone diagnosed (presumptive or confirmed) with COVID-19?
5. Was the member’s direct support worker diagnosed (presumptive or confirmed) with COVID-19?

# Person-Centered Planning

Members and guardians (as applicable) will work with their Case Manager/Care Coordinator to determine what supports they might need during this period through the person-centered planning (PCP) process. One of the many challenges associated with the COVID-19 emergency is that it may not be possible to provide direct care as it normally would be. Case Managers/Care Coordinators will work closely with members, guardians, and providers (a.k.a. “Planning Team”) to ensure close coordination and communication.

**Plan Development and Planning Team Meetings:** Planning Team meetings and contacts related to the person-centered planning process may be completed via phone, videoconferencing, or other electronic communication that enables direct contact with the member, guardian (if applicable), and any service providers as needed in accordance with HIPAA requirements.

If the impact of COVID-19 has resulted in program closures, modifications to the Person-Centered Plan/Care Plan (Plan) to meet a member’s needs and circumstances may be completed minimally with the member/guardian (if applicable) and Case Manager.

### Annual Service Planning

Annual Plans may be renewed for an additional twelve (12) months if the member/guardian believe that current services are appropriate and do not require modification; a meeting is held via phone, videoconferencing, or other electronic communications; and the provider(s) agree to continue to provide the services in the current plan.

Case Managers or Care Coordinators will create a new version of the annual PCP in the Enterprise Information System (EIS) and document all agreements and plan approval.

**For Sections 21 and 29**

If, after meeting, the Planning Team determines the annual PCP should not be renewed, but requires updating, the Case Manager will create a “new version” for the annual PCP to reflect:

1. Changes (additions/updates) in services and supports necessary to meet the member’s needs and desires.
2. Any measures put in place to mitigate harm or risk directly related to the COVID-19 emergency.
3. Changes to the PCP Service Description, Goals, and Planning Narratives.

Annual Person Centered Planning shall be conducted with timeframes consistent with the [COVID-19 Person Centered Planning (PCP) Frequently Asked Questions (FAQ- Question #5)](https://www.maine.gov/dhhs/oads/docs/covid-19/covid-19-pcp-faq.pdf).

### Plan Modifications

Plans should be modified (by creating a “new version”) as the needs of a member change and at the member’s/guardian’s request. If a member still has a need for a service but is not currently accessing the service due to COVID-19 related impacts (e.g. program closure), the Case Manager/Care Coordinator will capture this in a note attached to the Plan. If a service remains medically necessary and the member still wishes to receive the service, it should remain in the Plan.

It is not necessary to modify an existing Plan with authorized services (e.g. Community Support, Work Support, Career Planning, Home Support-¼ Hour) to reflect the member’s decision to receive services via telehealth. A modification to the plan is only necessary if the “Description of Service” or “Goals” to be delivered via telehealth for the respective service will differ from what is captured in the current Plan.

Plan modifications are needed to reflect other changes in how services are delivered, when new services are added, or for new service locations. Documentation must include the need for the change; when the change occurred/will occur; a description of the scope of the change; changes to the member’s health and safety; temporary address, if applicable; and criteria for adjustment back to before the emergency began.

For Sections 21 and 29, changes to an existing PCP shall be conducted according to the [COVID-19 Emergency Person Centered Planning (PCP) Process](https://www.maine.gov/dhhs/oads/docs/covid-19/covid-19-emergency-pcp-process.pdf). For Sections 18 and 20, changes to an existing PCP shall be conducted following the Person-Centered Planning Process linked above with adjustments as needed for Brain Injury and Other Related Conditions waiver members.

### Retroactive Authorizations

Services can be retroactively authorized as early as March 1, 2020 if they met criteria for determining if Appendix K applies according to the guidance above. However, the member’s service plan must be updated to reflect the changes in amount, duration, and/or scope within 60 days from the start date of the service. For example, a member’s Case Manager/Care Coordinator may submit a request to relocate on May 15, 2020 with a start date of March 16, 2020 in the new service location. Documentation in the Plan must specify retroactive services related to Appendix K during the COVID-19 emergency.

Providers should contact the Case Manager/Care Coordinator to discuss the need for retroactive authorizations. Certain services (e.g. home support) require clinical approval before the authorization can be granted.

No changes to a plan are required for the provider to receive the temporary 10% rate increases specified in Appendix K.

Plan Agreement: A “wet” signature is not required during the COVID-19 emergency (see [guidance](https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/Behavioral-Health-Frequently-Asked-Questions.pdf). Email/text notification may serve as proof of agreement to the PCP service plan. The email/text documenting consent must be kept in the member’s record. Provider verbal agreement with the PCP service plan is acceptable during the emergency period, if approval by email or text is not an option. Documentation of the provider’s verbal approval must be maintained in the member’s record.

Return to Pre-COVID-19 Services:

Appendix K will end when there are no longer widespread impacts caused by COVID-19. Within 30 days after the end of the State of Emergency, or by February 28, 2021, whichever comes sooner, all changes permitted under the Appendix K will end. The Department will send an official notification when that occurs. There will no longer be a need for members to maintain service changes allowable through Appendix K:

1. All existing Person-Centered Plans/Care Plans that were modified to identify changes permissible under Appendix K will revert to levels prior to being impacted by COVID-19.
2. For all annual Person-Centered Plans/Care Plans that were developed to reflect service needs related to COVID-19 impacts, it will be critical for Planning Teams to convene and conduct a post COVID-19 assessment of needs. The Plan will need to be updated (by creating a “new version”) to remove changes permissible under Appendix K. The updated plan will reflect the post COVID -19 needs/desires of the member/guardian.

# Waiver Services

The Department has temporarily increased limits on some services, allowing flexibility in program settings, adding new services for the emergency, waiving some licensing requirements, changing some billing requirements, increasing rates for some services, and modifying some provider requirements. All services provided, other than non-medical transportation, require prior authorization.

Providers must maintain sufficient documentation to ensure compliance with submitting claims for services delivered, in conformance with the Department’s CMS 1500 Billing Instructions Guide, of valid claims for reimbursement pursuant to 10-144 C.M.R Ch. 101 (the MaineCare Benefits Manual or “MBM”), Ch. II, Sec. 18, Sec. 20, Sec. 21, and Sec. 29 in accordance with any temporary changes, additions, or exceptions as approved by CMS under the Appendix K.

Office of MaineCare Services (OMS) guidance during the COVID-19 emergency is available [here](https://www.maine.gov/dhhs/oms/COVID-19.shtml). Questions about their guidance should be sent to COVID19MaineCare@maine.gov.

## Changes to Limitations for Services

The following changes to service limits are effective March 1, 2020 through May 31, 2020 and some were extended by the Department. See the [communication from 5/29](https://content.govdelivery.com/accounts/MEHHS/bulletins/28e0fd0) which describes which services have been extended.

Assistive Technology Devices for Sections 18 and 20: Remove the $6,000/year individual cost limit from the member’s annual individual cost limit. Medical necessity for device(s) must be documented and prior authorization is required.

Assistive Technology Transmission for Sections 18, 20, 21 and 29: Costs may increase up to a total of $200/month. Any increase must be to allow services delivered in alternate ways/settings, to ensure the use of personal emergency devices, or to increase data capacity for remote monitoring or another emergency service delivered electronically in lieu of face to face contact. Medical necessity must be documented and include a justification for the temporary increase that is directly related to an alternative service delivery method or the provider’s decreased staffing availability and must be documented in the member’s Plan. Prior approval for any increase is required. The increase in data transmission will be outside of the individual cost limit for Sections 21 and 29. Sections 18 and 20 removes this cost from the members’ individual cost limits.

Care Coordination for Sections 18 and 20: The Department will authorize additional units of care coordination to be delivered in accordance with the effective dates of Appendix K. A member, through an authorization request, will have an additional 100 hours/400 units of care coordination beginning March 1, 2020. If the member’s service year ends during the emergency and there are approved additional units that have not been used, those units will be added to the member’s annual units for care coordination. These additional units may only be used under Appendix K.

Quarter Hour Home Support: Services may be increased to meet the member’s documented health and safety needs in their Plan, up to a total of 16 hours/day, with prior authorization required.

Shared Living, Sections 21 and 29: Will allow up to three members to be served in a location.

Respite Services, Section 29: All limitations are waived.

Per Diem Home Support (Group Home) for Sections 18, 20, and 21: The Department recognizes that staffing challenges are exacerbated during this emergency and that staffing availability may change abruptly. Provided that the agency determines it can ensure resident health and safety, the agency may continue to be reimbursed at authorized staffing levels if staffing is maintained at 50% or more of authorized levels.

## New Services

Temporary Service – Emergency Quarantine Service: This service is primarily for individuals who need to be quarantined away from their housemates and require support 24 hours/day. Services may be provided in the member’s regular residential setting if isolation can be safely accomplished or may be provided in a temporary location approved by the Department.

This service will be limited to no more than 30 consecutive days. Members are eligible for this service beginning on the date a positive test is confirmed and ending when the member is cleared clinically to return to the general population or thirty (30) days after the service began, whichever is sooner. Please see more below in Rates. The waiver provider must:

* Submit a roster of all staff delivering this service, trainings, and status of background checks;
* Ensure that staff have successfully completed the following within the past 12 calendar months:
	+ First Aid
	+ Cardiac Pulmonary Resuscitation (CPR)
	+ Abuse/Neglect/Exploitation reporting
	+ Reportable Event reporting
	+ Agency-specific training on medication and personal care
* Ensure all medication administration is provided by a Certified Residential Medication Administrator (CRMA) or have comparable staff training delivered by the agency and submit a plan for safe administration of medication if a CRMA is not available;

This temporary service may be provided by a second agency under a sub-contractual arrangement between the member’s agency and the second agency. MaineCare will pay the member’s agency, which will pay the subcontracted agency. Final Verification of Provider Qualifications is approved by the Office of MaineCare Services’ Provider Enrollment unit.

Temporary Service for Section 20 – Shared Living: This service is currently available as a waiver service in Sections 21 and 29 and will have the same definitions and provider requirements currently defined in Sections 21 and 29. Shared Living (Adult Foster Care) is direct support and personal care (e.g. homemaker, chore, attendant care, companion) and medication oversight (to the extent permitted under State law) provided to a member in a private home by a principal care provider (Home Provider) who lives in the home. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, and social and leisure skill development that assist the member to reside in the most integrated setting appropriate to their needs. Residential habilitation also includes protective oversight and supervision. Services are provided according to the member’s Person-Centered Plan to identify health and safety needs. Residential habilitation, personal care, and protection oversight and supervision are provided so the member’s initiative, autonomy, and independence in making life choices, including but not limited to, daily activities and with whom to interact are optimized and not regimented. A member’s essential personal rights of privacy, dignity, and respect, and freedom from coercion and restraint are protected. A Provider may not have more than two people that they care for in one home. The rate is based on services provided; please see more below in Rates for Shared Living. Note that this service may have no more than two members per location. The temporary increase to three members for Sections 21 and 29 does not apply.

Services in an Acute Setting: Services may be provided in an acute setting (hospital) when the acute setting provider is willing to have agency staff assisting in the hospital and attests that it is not able to provide needed services and details the specific tasks needed. Prior authorization is required. Providers will be required to document all tasks provided to the member.

## Expanded Settings

* Services may be provided in alternate settings such as hotels, shelters, churches, or other settings approved by the Department if a member needs to be evacuated from their current residence or needs to quarantine. Department approval may be provided retroactively. All habilitative and rehabilitative supports may be provided in these settings. Community Support may be provided in one of the settings above or in the member’s home.
* Per Diem Agency Group Home for Sections 18, 20, and 21: The Department will allow added flexibility to move among settings. Providers must include staffing provided when tracking established per diem staffing ratios. Providers must use reasonable discretion in developing and reducing residential staffing patterns and ratios adequate to maintain the health and safety of all members in the setting. Services will resume to authorized levels automatically within 30 days of the end of the state of emergency or February 28, 2021, whichever is sooner.
* Service definition limitations on the number of people served in a licensed or unlicensed setting may be increased or decreased to meet the members’ health and safety needs.

The Office of MaineCare Services (OMS) and the Office of Aging and Disability [Services](https://www.maine.gov/dhhs/oads/docs/covid-19/Employment-Guidance-and-Telehealth.docx) (OADS) must approve temporary residential placements and locations. Providers will not be required to enroll the temporary locations. Claims will be submitted at the currently authorized service location. The [link to OMS guidance temporary/alternative settings can be found here](https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/Alternate-Settings-Final-Guidance-05282020-3.pdf).

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## Telehealth

Providers should refer to MaineCare’s telehealth [guidance](https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/03232020-Telehealth-Guidance.pdf.) to determine what services may be delivered via telehealth in order to meet members’ needs. Specific guidance about these services will be released as separate documents from this guidance.

* [[Community Support guidance](https://www.maine.gov/dhhs/oads/docs/covid-19/Community-Support-Guidance-and-Telehealth.docx)](https://www.maine.gov/dhhs/oads/docs/covid-19/Community-Support-Guidance-and-Telehealth.docx)
* [[Work Support guidance](https://www.maine.gov/dhhs/oads/docs/covid-19/Employment-Guidance-and-Telehealth.docx)](https://www.maine.gov/dhhs/oads/docs/covid-19/Employment-Guidance-and-Telehealth.docx)
* [[Quarter Hour Home Support guidance](https://www.maine.gov/dhhs/oads/docs/covid-19/Home-Support-Guidance-and-Telehealth.docx)](https://www.maine.gov/dhhs/oads/docs/covid-19/Home-Support-Guidance-and-Telehealth.docx)

**COVID-19 and Community Support, Work Support, and Career Planning Telehealth Guidance in Congregate Settings:** The Department expects that waiver members may receive per diem services (Home Support- Agency Per Diem, Family-Centered Support, or Shared Living) as well as telehealth Community Support, Work Support, or Career Planning services. In Section 21, the per diem rate for Home Support- Agency Per Diem varies, as the rate methodology includes weekly authorized support hours. Should a Section 21 member receive a service delivered via telehealth in a Home Support- Agency Per Diem setting, that time may still be counted by the Home Support- Agency Per Diem provider towards the actual support hours delivered that week. During any given hour when a member receives services via telehealth in a Home Support- Agency Per Diem setting, the Home Support- Agency Per Diem Provider continues to be required to provide protective oversight and supervision.

**Supporting Waiver Members in the Use of Telehealth:**

The Department expects that waiver members will have direct support to access services remotely. This includes direct support professionals and personal support specialists in group home settings supporting members in the set up and use of electronic devices and equipment. Some members need direct support in the use of telehealth technology so they can receive the benefits of services delivered remotely.

**Licensing**

Providers may continue to provide services in locations after the expiration of the current license. Providers will be required to submit renewal/reapplication within 60 days of the emergency end date.

Sections 18, 20, and 21 will waive limitations on the number of people served in licensed or unlicensed settings to meet members’ health and safety needs.

**Billing** for Care Coordination for Sections 18 and 20 can be accumulated and billed over the course of seven days.

**Rates**

Temporary rate increases are in effect from March 1, 2020 through May 31, 2020. Rates are temporarily increased by 10% on the services listed below. The increase is intended for emergency-related costs including, but not limited to: excess overtime or premium pay to ensure enough direct care workers to cover staffing needs, infection control supplies, and other additional or unanticipated service costs. Providers will be asked to report to the Department, within 30 days of the end of the emergency, how the temporary increase was expended, including the percentage allocated to direct care staffing costs. The Department expects that providers will expend at least 80% of the increase on direct care costs. The rate setting methodology is not changed for the 10% increase. Providers who are subject to the service tax will have to pay tax on the additional revenue from this temporary rate increase.

Services receiving the 10% temporary increase are:

* **Section 18 Brain Injury**
	+ Work Support – Individual
	+ Care Coordination
	+ Home Support Level II Home Support Level III, Increased Neurobehavioral Home Support Level I
* **Home Support Remote Section 20 Adults with Other Related Conditions**
	+ Work Support – Individual
	+ Care Coordination
	+ Personal Care Services
	+ Home Support – Quarter Hour
	+ Home Support - Remote
	+ Home Support – Per Diem
* **Section 21 Adults with Intellectual Disabilities or Autism Spectrum Disorder**
	+ Work Support – Individual
	+ Shared Living – one member served
	+ Shared Living – one member served, increased level of support
	+ Career Planning
	+ Home Support – Agency Per Diem
	+ Home Support – Agency Per Diem with Medical Add On
	+ Family Centered Support – One member served
	+ Family Centered Support – One member served, increased level of support
	+ Family Centered Support – Two members served
	+ Family Centered Support – Two members served, increased level of support
	+ Family Centered Support – Three members served
	+ Family Centered Support – Three members served, increased level of support
	+ Family Centered Support – Four members served
	+ Family Centered Support – Four members served, increased level of support
	+ Family Centered Support – Five members served
	+ Family Centered Support – Five members served, increased level of support
	+ Home Support – Quarter Hour
	+ Home Support – Quarter Hour with Medical Add on
	+ Community Support
	+ Crisis Intervention Services
* **Section 29 Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder**
	+ Work Support—Individual
	+ Shared Living – one member served
	+ Respite Services – per diem
	+ Career Planning
	+ Home Support – Quarter Hour
	+ Community Support
* **Shared Living – Modified Rate for more than One Member. This service is only available under Sections 20, 21 and 29.**
	+ For 2 people (Sections 20, 21, and 29), the rate increases to 75% of the one-member rate for each member served.
	+ For 3 people (Sections 21 and 29 only), the rate increases to 60% of the one-member rate for each member served.

Emergency Transitional Services for waiver members with COVID-19 rate is based on the Department’s current Emergency Transitional Housing (ETH) contracted service rate of $27.72 per hour. This rate does not include funding for room and board, and it may not duplicate another service.

## Modifications of Provider Qualifications

Modifications are applicable to all waivers, unless otherwise indicated, until the emergency has ended but not to exceed the effective end date for Appendix K.

* Hiring - The Department will:
	+ Waive the minimum age limitation to those 17 years and older through the period of the emergency to increase the prospective hiring pool, but not to exceed the effective end date of Appendix K;
	+ Waive the educational requirement of a high school diploma or GED through the period of the emergency, but not to exceed the effective end date for Appendix K;
	+ Allow relatives or spouses of members to provide care when hired by the provider agency or when established as a contractor with the provider agency;
	+ Family caregivers, friends, and guardians may also be hired or contracted by an agency to provide support during the emergency;
	+ The provider agency must ensure services are provided in the member’s Plan and must maintain documentation to include relatives or spouses providing services.
	+ Training and certification changes are in effect for the emergency period and all trainings and certifications that are temporarily waived must be completed by the effective end date of Appendix K or by February 28, 2021, whichever is sooner.
	+ Waive training requirements for members’ relatives and spouses to begin providing services, but training and certification must be completed by the end date for Appendix K.
	+ Waive background checks for prospective staff, and orientation and initial training are suspended until they can be safely provided no later than the end of Appendix K. Staff with expiring/expired credentials in the administration of medication may continue to dispense medication during the emergency period with documentation to submit a progression in action steps to obtain recertification.

To allow redeployment of direct care and clinical staff to needed service settings during the emergency, staff qualified under any service definition in the waiver may be used for provision of any non-professional service under another service definition. Professional services exempt from this include nursing assessments and other nursing services.

# Reimbursement of Relatives, Friends and Guardians

Relatives/Family caregivers, spouses, friends, and guardians can only be reimbursed by an enrolled Home and Community Based Services provider in which the person-centered plan and prior authorization(s) outline what service will be delivered and any changes in how the service shall be delivered following the guidance contained in this document and the approved Appendix K and subsequent amendments to the Appendix K.

* The provider is obligated to ensure accurate and adequate reimbursement to the category of individuals now allowed to provide services under the authority of the Appendix K.
	+ A provider may only bill for services provided, relatives/family caregivers, spouses, friends, and guardians cannot be paid a service intended to provide relief or support for themselves (a shared living provider cannot be paid both community support and the per-diem shared living service).
* The provider must collect and maintain documentation to support the claim and payment for services authorized. Documentation may be collected and maintained electronically or in paper form by providers and must be produced upon request by the Department.
	+ For services authorized using a 15 minute-based unit, the provider must document:
		- The date of the documentation.
		- The day, month and year the service was provided.
		- The start and stop times with a.m. and p.m. designations.
		- Service name or description (for example, Group Home Supports).
		- The name, signature and title (Direct Support Professional), if any, of the person providing the service. This documentation verifies services were delivered.
* Claim for payment(s) must be consistent with the quality of care and follow the current reimbursement options available within the MaineCare Benefits Manual for Section(s) 18, 20, 21 and 29.
* The person-centered plan and prior authorization request must both be consistent with how a provider chooses to pay a individual in the waiver(s) fee-for-service delivery system.
	+ - * Example: A provider may contract with an individual in the same capacity as providers currently contract with third parties to deliver services in the event of agency staffing shortfalls.
			* Example: A provider may hire an individual and treat the individual as any employee of the agency.

# Level of Care Assessments/Reassessments

For Sections 18 and 20, all assessments may be conducted via telehealth to protect members’ health and safety. The Initial Level of Care assessment may be completed telephonically or by other remote technology.

All Annual Level of Care reassessments can be conducted up to 30 days late for all four waivers, including the DS Comprehensive/Support HCB Waiver assessments in EIS (aka “BMS-99”) for Sections 21 and 29.

# Provider Policies Regarding Visitors

**Provider owned and operated settings where waiver services are provided** may prohibit/restrict visitation in line with CMS and CDC guidance for congregate living settings. Restriction of visitation within CMS and CDC guidance does not need to be justified in the member’s PCSP. Please see the Home and Community Living recommendations in the Introduction section above Appendix A at the end of this guidance.

**Critical Incident Management** – Please see Reportable Events guidance and FAQ [here](https://www.maine.gov/dhhs/oads/docs/covid-19/covid-reportable-events-tracking-04062020.docx) and instructions for reporting abuse, neglect, or exploitation [here](https://www.maine.gov/dhhs/oads/aps-guardianship/how-to-report.html).

# Appendix A

What service Providers can do to lessen the impact of the novel coronavirus (COVID-19) restrictions in congregate (group home) settings:

* Create a routine. Routines give everyone a sense of safety.
	+ The group home housemates can create their routines.
	+ Set up a daily planner so everyone knows what is going to happen that day. When people are feeling stressed, knowing what is happening helps. Remember to consider everyone’s communication skills – you may need to make it a visual schedule.
	+ Make a time each day for standard daily exercise. It is important to keep physically active and have some time outside as much as safely possible and following any health official guidance.
* Use social stories to help people understand changes in routine and communicate their feelings. For example:
	+ What the coronavirus (COVID-19) restrictions mean to me.
	+ Things I would like to do during this time.
	+ How I can stay healthy?
	+ What happens if I get sick?
	+ What I can do to help others in the house feel better?
	+ Encourage all to share their social stories to create a better understanding of what is happening and how everyone is feeling.
* Use easy-to-read and plain language documents about coronavirus (COVID-19) to increase people’s understanding of what is happening.
* Create zones in the home for different activities around people’s interests (for example, meditation, dancing, and so on). This will also allow for everyone to have their own space when staying at home.
* If people feel unwell or are not feeling themselves, help them contact their health care Provider to obtain health services using telehealth.
* Staff need to draw on the best of their skills to get to know the people they support by documenting their likes and dislikes and coming up with ways to communicate.
	+ Make sure all staff have read each person’s Person-Centered Service Plan.
* Staff should also be sensitive to the ways they communicate the need for social distancing (such as asking vs. telling a person to go to their room). Build on relationships each housemate has with key staff and help members understand what is going on and why. This is a time build common awareness and consideration, and not to compromise people’s rights.
* Ensure staff are trained in infection prevention and control as appropriate.
* Respond to requirements for self-quarantine, self-isolation or COVID-19 illness among people living in a group home or staff in accordance with CDC guidelines and instructions as issued.
* Develop and implement emergency preparedness plans to ensure critical supports and services continue to be provided to people with disabilities, while reducing risk of exposure to COVID-19 of both members receiving services and staff.
* Ensure all members are supported to access relevant and up to date information in a format they can understand.
* Ensure members, guardians, families and staff receive information about any changed practices or service delivery to respond to COVID-19.

# Home and Community Living

It is important to maintain social connections while physically distancing. Strategies to do this might include:

* Think about increasing opportunities for sharing, choice, engagement and interaction:
	+ Discussing with members in a group home how to manage what gets viewed, listened to, or seen on the TV or other electronic media in common areas.
	+ Developing a roster for cleaning or cooking.
	+ Holding more frequent house meetings.
	+ Scheduling regular phone or video chats with family and friends, and for those who need support ensure support to access technology to continue connections.
	+ Positioning furniture in the house to allow for interaction while still physically distancing.
	+ Spending time outside (if possible) to interact with neighbors from a distance.