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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information (1 of 3)

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

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

Lifespan Waiver

C. Type of Request: new

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

○ **3 years** ◉ **5 years**

☐ **New to replace waiver**

Replacing Waiver Number:

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: (mm/dd/yy)

Draft ID: **ME.026.00.00**

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

Regular Waiver

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

10/01/26

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so

that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

1) Non-Emergency Medical Transportation (NET) services – previously approved and effective through April 1, 2028.
2) Community Resource Coordination (CRC) that includes Community Transition Case Management services – submitted concurrently with this application.

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

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

☐ **section 1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Maine's Home and Community Based Services (HCBS) Across the Lifespan for Individuals with Intellectual Disabilities or Autism Spectrum Disorder Waiver (Lifespan Waiver) offers eligible participants age 14 years and older and their families the opportunity to tailor services to the participant's phase of their lifespan, living situation, individually identified goals and assessed needs including health, safety, risk planning and risk mitigation needs. Lifespan Waiver services are offered primarily in private homes and integrated community settings, including places of employment, as well as in certain types of provider-owned and/or operated settings, including residential settings.

The goals for this waiver include:
1) Offering flexibility to respond to changing needs of participants across their lifespan;
2) Ensuring more seamless transitions as the need for services changes over the course of a participant's lifespan;
3) Expanding access to HCBS to youth ages 14-17;
4) Focusing on independence and inclusion including a focus on early planning for services for youth and for their transition to adulthood;
5) Coordinating the full range of Medicaid and non-Medicaid services and supports for participants, including unpaid natural and community supports;
6) Incorporating innovations in service delivery such as technology solutions to address challenges in the direct service workforce;
7) Employing alternative payment methods to promote quality, efficiency and economies of scale;
8) Increasing access to competitive integrated employment (CIE) opportunities (as defined in this waiver) and effective services and supports to enable waiver participants to obtain and maintain CIE;
9) Expanding opportunities for self-direction; and
10) Strengthening family and other natural supports to maintain community living and facilitate full community integration.

For the purposes of this waiver, CIE means employment that occurs in one or more competitive integrated setting(s), which meets the specific requirements set forth in 34 C.F.R. §361.5 (c) (9) including:
A. ensuring compensation is the higher of the federal, state or locally established minimum wage for the location where the participant works and includes eligibility for the level of benefits provided to other employees in similar positions at that location;
B. occurring in one or more location(s) typically found in the community that are not disability-specific settings;
C. enabling the participant to interact with co-workers and customers to the same extent as a person without a disability filling a similar position;
D. for wage employment, ensuring the employer of record is the business or organization ultimately benefitting from the work done by the participant;
E. offering the participant an individualized position in which the participant has the opportunity to interact with the public, and with other employees who are not individuals with disabilities, to the same extent as employees in comparable positions who are not individuals with disabilities; and
F. presenting, as appropriate, opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

The Lifespan Waiver will operate Statewide and concurrently with two 1915(b)(4) waivers: one providing NET and one implementing selective contracting for Community Resource Coordination (CRC) - the Lifespan Waiver case management service.

Maine's Department of Health and Human Services (DHHS) is committed to ensuring all waiver participants have a choice of qualified providers for Lifespan Waiver services. The state's contracted network of willing and qualified providers is responsible for delivering Lifespan Waiver services, except CRC services. CRC services will be available through a limited network pursuant to a 1915(b)4 waiver application submitted concurrently with this application.

The waiver design and service array assists the State in ensuring compliance with the federal HCBS Settings requirements (42 CFR 441.301(c)), the Americans with Disabilities Act (ADA), and this waiver. The state is also committed to ensuring quality program implementation and service delivery through robust training, technical assistance, and best practice sharing among providers as well as support of peer-to-peer learning among participants, family members, and internal and external partners.

The state proposes a phase-in approach for managing participant enrollments over the five-year waiver cycle as detailed in Appendix B-3. Further, the state projects new enrollees to the Lifespan Waiver over the five-year waiver cycle may come from the following sources:
1. additional legislative appropriations;
2. the option for participants in Sections 21 (ME.0159) and 29 (ME.0467) Waivers to voluntarily transition to Lifespan starting one year after Lifespan opens; and

3. attrition slots and associated funding transitioned to Lifespan from Sections 21/29 which will be closed to new admissions as of the date admissions begin in this Lifespan Waiver.

Slots will transfer when voluntary transfers from Section 21/29 enroll in Lifespan and at the end of each fiscal year through technical amendments that always ensure no reduction in total Statewide slots available across the three waivers. Participants who are enrolled in ME.0159 or ME.0467 as of the date Lifespan opens, and who choose to voluntarily transfer to the Lifespan Waiver when this option becomes available, will have their funding and their slot transition with them to the Lifespan Waiver, even if the program is at maximum capacity as specified in Appendix B-3. Those participants who transition to the Lifespan Waiver therefore would not take up the allocated slots specified in Appendix B-3 of this waiver.

3. Components of the Waiver Request

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

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

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

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

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

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

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**

◉ **Yes**

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

◉ **No**

○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified

provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

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

The State utilized the following strategies to secure public input and engagement during the development of the Lifespan program.
1) The Department convened a stakeholder workgroup which met 10 times between January and June 2023 and discussed a range of topics related to the waiver.
2) The Department conducted a participant experience survey in early spring of 2023 of participants with ID and Autism on the waiting lists for HCBS.
3) In June 2023, the Department developed and presented in two separate virtual public forums a preliminary “Concept Paper” describing the Lifespan Waiver. The Department accepted public comments on the “Concept Paper” through July 2023 following the virtual public forums.
4) The Department hosted a series of engagement sessions with providers (5 in-person sessions) and participants, family members/guardians, advocates (5 in-person and 2 virtual sessions), in various locations across the State in September 2023.
5) Between October and December 2023, the Department convened additional workgroup sessions for interested parties.
6) In May 2024, the Department hosted a series of engagement sessions with providers (6 in-person sessions) and participants, family members/guardians, advocates (6 in-person sessions), in various locations across the State.
7) During the summer of 2023, and the fall of 2024, the Department, with its contractor for the development of Lifespan Waiver reimbursement rates, held public and provider input sessions leading up to rate study implementation.
8) In spring 2025, the Department held a public comment period on the proposed Lifespan Waiver rate methodologies and rates for services.

In accordance with 42 CFR § 441.301, the State must solicit public comment on any proposed waiver application. The State conducted Tribal Consultation on July 3, 2025, and again on February 6, 2026, and posted a proposed 1915(c) waiver application to its Section 24, Home and Community Based Services Across the Lifespan for Individuals with Intellectual Disabilities or Autism Spectrum Disorder Waiver (Lifespan Waiver) on the Office of MaineCare Services’ website on April 14, 2026. The State sent a provider notice regarding this application and posted a notice in five (5) newspapers with the highest circulation on April 14, 2026. Interested parties could email and request a hard copy to be mailed or picked up in any regional DHHS office in the State. Comments on the proposed changes were accepted until 11:59 PM, May13, 2026.

The State received timely comments from ( ) Commenters ranging from ( ) to ( ) to ( ) to ( ). The State includes a summary of comments and the State’s responses, including whether and why the State altered the proposed waiver application as a result of the comments.

Any interested party could go into any regional DHHS office or contact OMS or OADS for a printed copy of the Notices and/or 1915(c) Lifespan Waiver application. A printed copy could also be obtained by calling Heather Bingelis at (207) 624-6951 or via email at heather.bingelis@maine.gov.

The active link used to post the waiver renewal application is: (LINK)

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

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

7. Contact Person(s)

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

Last Name: Leet

First Name: Thomas

Title: Long Term Services and Supports Manager

Agency: Office of MaineCare Services

Address: 109 Capitol St

Address 2:

City: Augusta

State: **Maine**

Zip: 04330

Phone: **Ext:** ☐ **TTY**

Fax: (207) 287-1864

E-mail:

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

Last Name: Fales

First Name: Derek

Title:

Agency:

Address:

Address 2:

City:

State: **Maine**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Probert

First Name: Michelle

Title: Director

Agency: Office of MaineCare Services

Address: 109 Capitol Street

Address 2:

City: Augusta

State: **Maine**

Zip: 04330

Phone:

(207) 287-2093 **Ext:** ☐ **TTY**

Fax:

(207) 287-1864

E-mail:

Michelle.Probert@maine.gov

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Due to character count limit in Brief Waiver Description:
As the single State Medicaid Agency for Maine, the Office of MaineCare Services (OMS) is responsible for the administration of the Medicaid Program and this waiver. This authority can be found at the following link: https://www1.maine.gov/sos/cec/rules/10/144/ch101/c1s001.docx (MaineCare Benefits Manual (MBM) Ch I, Section 1, General Administrative Policies and Procedures). OMS delegates day-to-day operational authority of this waiver to the Operating Agency: DHHS Office of Aging and Disability Services (OADS).

For the purposes of this waiver the State uses the terms “the Department”, “DHHS” and “the State” interchangeably to mean any department, division, office or entity that falls under the purview of the Commissioner of Maine’s Department of Health and Human Services. The State references specific divisions or entities (e.g. “the Office of MaineCare Services (OMS)” or “the Office of Aging and Disability Services (OADS)” within the application accordingly and as needed.

Due to character count limit in App C, Sub-a, First PM. Denominator: Total number of provider agencies reviewed whose staff are required to have a license or certification and meet other waiver requirements prior to providing waiver services.

App G sub-a PM #6:
Numerator: Number of QA referrals by APS to Disability Quality Assurance (DS QA), where DS QA determines corrective action is required and for which corrective action has been completed within State-determined timeframes. Denominator: QA referrals by APS to Disability Quality Assurance (DS QA), where DS QA determines corrective action is required.

Due to Character count limit in Appendix I-2.d.
The Department and its professional advisors regard the maintenance of adequate clinical and other required financial and product-related records as essential for the delivery of quality care. In addition, providers should be aware that comprehensive records, including but not limited to treatment/service plans, progress notes, product and/or service order forms, invoices, and documentation of delivery of services and/or products provided are key documents for post-payment reviews. In the absence of proper and comprehensive records, no payment will be made and/or payments previously made may be recouped.

Once an overpayment has been identified and is finally determined, a Notice of Debt is sent over to the Maine Department of Health and Human Services’ Service Center for collection. The Service Center will arrange for the repayment of the debt with the provider. The Service Center recoups in a variety of ways including lump sum payment, installment payment plans, or offsetting against future Medicaid reimbursement.

The State of Maine DHHS Service Center and the State of Maine Claim Processing System are programmed to ensure FFP recoupments. Annual audit reviews are part of the State of Maine Single Audit and cash management.

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

Providers delivering Personal and Home Assistance, Community Supported Living, Respite Breaks and Opportunities, Home-Based Independent Living Skills, Private Dute Nursing and Remote Monitoring and On-Call Response services must comply with Maine DHHS EVV system standards and requirements for these services.

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Office of Aging and Disability Services (OADS)

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

As the Medicaid Agency, OMS retains ultimate authority and oversight of the waiver and administration of the Medicaid program including responsibility for development of State policy that governs implementation and reimbursement for this waiver. This authority can be found in MBM, Ch.I, Section 1, General Administrative Policies and Procedures at the following link:
https://www1.maine.gov/sos/cec/rules/10/144/ch101/c1s001.docx

OMS manages provider enrollments in the MaineCare program and executes the Medicaid provider agreements. OMS coordinates, reviews and approves communication with CMS including renewals and amendments and the associated quality and requisite annual reporting for this waiver. OMS retains responsibility over the following assurances and sub-assurances in this waiver:
Appendix A – Waiver Administration and Operation;
Appendix I – Financial Accountability; and
Appendix J – Cost Neutrality Demonstration.

OMS delegates day-to-day operational authority of the waiver to OADS. OADS is the operating agency for all services provided to the target group. This delegation means OADS is responsible for meeting the following assurances and sub-assurances:
Appendix B – Participant Access and Eligibility;
Appendix C – Participant Services;
Appendix D – Participant Centered Service Planning and Delivery;
Appendix E – Participant Direction of Services;
Appendix F – Participant Rights;
Appendix G – Participant Safeguards; and
Appendix H – Quality Improvement Strategy.

The Directors of the OMS and OADS report directly to the Commissioner of DHHS. The two agencies maintain a Memorandum of Agreement (MOA) that delineates the agencies' respective responsibilities for the administration and operation of this waiver. The MOA is reviewed annually and may be amended periodically upon mutual written agreement of the agencies. Representatives from the OMS Policy Unit and OADS Operations Team meet weekly to discuss this waiver and corresponding rule, and associated policies and procedures to ensure the highest quality services and supports. Additionally, OMS and OADS managers and directors meet monthly to discuss the overall quality improvement strategy and resolve any issues that have been escalated by staff or stakeholders.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

DHHS contracts with transportation brokers to organize and provide non-emergency medical transportation services under a 1915(b) waiver that operates concurrently with this waiver.

DHHS contracts with a professional information and technology services organization in the operation of the State's Medicaid Management Information System (MMIS) called Maine Integrated Health Management Solution (MIHMS).

DHHS contracted with an actuarial and rate setting consulting firm for assistance with developing a framework for rate setting, conducting a rate study, designing alternative payment methods, and establishing the initial annual monetary amounts for each enrollment group.

DHHS contracts with a professional services organization for completion of the Supports Intensity Scale – Adult Version®, SIS-A® needs assessments for waiver participants.

DHHS contracts with selected provider agencies to deliver CRC and Community Transition Case Management services under a 1915(b)(4) waiver that operates concurrently with this waiver.

DHHS contracts with a professional services firm for quality assurance and quality improvement, including the development of quality standards and compliance and quality review mechanisms, as well as licensing rule updates.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

OOMS is responsible for assessing the performance of the NET broker, the professional information and technology services organization in the operation of MMIS, and actuarial/rate setting vendors. OMS has dedicated positions to manage the associated contracts for each entity.

OADS is responsible for assessing the performance of the professional services organizations that conduct level of care assessments and the agencies awarded contracts to deliver CRC, which includes Community Transition Case Management services. OADS has dedicated positions to manage the associated contracts for each entity.

Appendix A: Waiver Administration and Operation

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

OMS has a dedicated position managing the contract with the transportation brokers for the 1915b NET waiver (Me.19). The contract includes monthly reporting performance measures outlined in the 1915b waiver. The OMS contract manager reviews the reports submitted by the broker monthly for compliance with performance metrics and contractual obligations.

OMS maintains a service level agreement for the MMIS contract that is reviewed and monitored monthly.

For the actuarial and rate setting contract, this contractor is involved in only one of the 12 functions of A-7 (establishment of Statewide rate methodology), and the final decision on rate implementation lies with OMS and the State of Maine Legislature after the contractor completes each contracted rate study. When conducting a rate study, the contractor follows a prescribed process for evaluating rates that includes collecting data from a variety of sources including State policies, provider and stakeholder input, published sources (e.g., Bureau of Labor Statistics wage data, IRS mileage rates), and special studies. Members of the OMS Rate Setting Unit and OADS are involved in all provider meetings and responses to provider comments. The Rate Setting Unit oversees the contract (including oversight and assessment) between the contractor and OMS.

OADS has a dedicated position managing the contract with the vendor conducting SIS-A assessments. The contract outlines performance measures and deliverables. Additionally, OADS uses a verification process based on the SIS-A, including its supplemental medical and behavioral modules, to confirm that individuals meet the threshold for exceptional medical or behavioral support needs.

OADS has a dedicated position managing the contract with CRC provider agencies. The contract outlines performance measures and deliverables.

For the contract related to quality assurance and quality improvement, there is a detailed contract with a schedule of deliverables that is monitored in accordance with the timeliness in the contract.

Appendix A: Waiver Administration and Operation

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

government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which

each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
#1 Number and percent of annual Quality Reports submitted by OADS to OMS, in the correct format and timely. Numerator: Number of Quality Reports submitted by OADS to OMS, in the correct format and timely. Denominator: Number of Quality Reports required by OMS.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
#2 Number and Percent of OMS/OADS waiver quarterly monitoring meetings during which the waiver quality assurance and quality improvement activities are discussed. Numerator: Quarterly OMS/OADS meetings during which waiver quality assurance and quality improvement activities are discussed. Denominator: Number of OMS/OADS quarterly meetings held.

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

OMS and OADS identify issues through inter-agency meetings, scheduled audits of provider enrollment activities and requirements, periodic claims audits, site reviews, and review of grievances. OMS operates a Provider Relations (PR) Unit to address and resolve any concerns or problems that may arise with processing claims. Providers will contact their PR Specialist for problems associated with the claims processing system. OMS documents all contact between the PR and the provider directly within the MMIS system.

Additionally, OMS and OADS meet bi-weekly to discuss deficiencies and remediation activities, waiver policies and associated renewals/amendments and rule changes.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	**Included**	**Target Sub Group**	**Minimum Age**	**Maximum Age**	
				Maximum Age Limit	**No Maximum Age Limit**
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	14		☒
	☐	Developmental Disability			☐
	☒	Intellectual Disability	14		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage: 150

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

The State applies the individual cost limit to all applicants seeking waiver entrance by using the results of the SIS-A assessment which is required for every applicant seeking enrollment in the Lifespan Waiver to determine their supports need level. The support needs levels, in order from lowest to highest support needs, are: 1, 2, 3, 4, M (exceptional medical needs) and B (exceptional behavioral needs).

To assure the health and welfare of those individuals with a support needs level 1,2, or 3, the State reviewed SIS assessments completed for existing ME.0159 and ME.0467 waiver participants between March 2023, and December 2024, and identified 833 participants whose SIS assessments placed them in support needs levels 1, 2, or 3 (347 in level 1, 308 in level 2 and 178 in level 3).

The State then looked at the corresponding cost of the current services, including case management, for these same participants. For FY24 the average annual cost of services for the 833 participants was 36.5% of the Individual Cost Limit specified in B-2-a of this waiver. As a result, the State concluded that for any Lifespan applicant with a support needs level of 1, 2 or 3, the annual projected cost of services will not exceed the Individual Cost Limit for this waiver, thus affirming, in advance of waiver entrance, these individuals' health and welfare can be assured within the individual cost limit for this waiver.

For applicants whose SIS support needs level is 4, M or B, the State could not conclude that the annual cost of Lifespan services will remain within the Individual Cost Limit for entrance to the Lifespan waiver due to a lack of comparable data. Consequently, the State expects these individuals' health and welfare cannot be assured within the cost limit in advance of waiver entrance. For these applicants OADS trained staff will initiate the development and costing of a Person-Centered Service Plan (PCSP) in order to ascertain the number of waiver services that the person may require (in addition to State Plan and the other services and supports available to the person) to meet the person's needs. If the total annual cost of the identified Lifespan Waiver services in the PCSP is within the Individual Cost Limit as confirmed by OADS, the applicant will continue the enrollment process.

If the total cost of the PCSP is projected to be above the Individual Cost Limit, OADS staff will first work with the applicant to consider:
1. accessing services or supports to meet needs through a non-waiver source;
2. substituting a less expensive waiver service for a more expensive waiver service if both services can effectively address the same need and/or goal (e.g., Remote Monitoring rather than overnight awake staffing; Shared Living rather than Residential Habilitation; Paid Co-Worker Supports rather than Work Supports-Individual job coaching); or
3. other viable options identified during the development of the initial PCSP.

If the listed options have been exhausted and the annual projected cost for services does not fall within the Individual Cost Limit, OADS must inform the applicant of the option to submit a Request for Exception to the Individual Cost Limit. This includes assisting the applicant, as needed, to prepare and submit this request to OADS, on the OADS-approved Request for Exception to the Individual Cost Limit form, along with the PCSP.

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

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

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

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

Participants may be authorized to receive additional services that exceed the cost limit identified in Section B-2-a. If the participant receives additional services under the State Plan, any limits on those services are applicable to the participant.

The State complies with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134 and maintains policies and procedures to receive and process Title II modification requests, including requests to modify financial limitations pursuant to the ADA.

Additionally, participants applying to receive services under this waiver and participants currently receiving services under this waiver may submit a Request for Exception to the Individual Cost Limit. The following describes the State's criteria and procedures for authorizing additional services that exceed the Individual Cost Limit through a request for exceptions process. This process ensures that applicants and participants receive appropriate and adequate services and supports in the most integrated setting consistent with the ADA and the health and safety requirements outlined in this waiver

Prior to Enrollment:
As described in Appendix B-2.b. of this waiver, OADS staff support the applicant to first consider a range of options for remaining within the Individual Cost Limit if the total cost of the PCSP exceeds the Individual Cost Limit. Once the applicant exhausts the other options, OADS staff inform the applicant of and support the applicant to submit the OADS-approved Request for Exception to the Individual Cost Limit form along with the PCSP.

OADS, or its Authorized Entity, may approve a Request for Exception to the Individual Cost Limit for enrollment so long as the exception(s) included in the written request are fully documented within the applicant's initial PCSP, and the written request meets all of the below criteria:
1. he requested service(s) is a Covered Service(s) that the applicant is otherwise eligible to receive.
2. The applicant reasonably requires exception to the Individual Cost Limit to achieve or maintain community living, and failure to grant this exception will place the applicant at serious risk of institutionalization.
3. The assessed need(s) for which the exception is requested cannot be met with a service or combination of services (through this waiver or the State Plan), natural supports, and other public/private services.
4. The PCSP must document the individual needs.
5. The exception to the Individual Cost Limit will ensure the applicant's needs will be met in the most integrated setting where their needs, including their health and welfare, can be appropriately met.

OADS shall issue a written decision ("Decision") on the Request for Exception to the Individual Cost Limit within sixty (60) days of receipt of a completed request. OADS, or its Authorized Entity, reserves the right to request additional information when needed to render a Decision. The CRC must retain the Decision in the applicant's record.

OADS, or its Authorized Entity, may deny an applicant's Request for Exceptions if the OADS has previously denied a substantially similar Request for Exceptions from the applicant, or if the applicant has previously been denied a reasonable modification under the Americans with Disabilities Act for a substantially similar request, unless new information is available regarding the participant's need for the requested Exception.

Additionally, OADS, or its Authorized Entity, may deny a Request for Exception to the Individual Cost Limit (even if the applicant demonstrates the need for the Exception to live in the most integrated setting appropriate to their needs) if OADS determines that any or all of the below applies:
1. The applicant's health and safety cannot be assured in the community even if the Exception to the Individual Cost Limit is granted.
2. The Exception to the Individual Cost Limit would fundamentally alter these HCBS waiver services.

An applicant may appeal the Decision within sixty (60) calendar days through the OMS appeals process as detailed in Chapter I, Section 1 of the MBM and described in Appendix F of this application.

Subsequent to Enrollment:
Subsequent to enrollment the participant must follow the same procedure outlined above if the total cost of their PCSP exceeds the Individual Cost Limit. The CRC supports the participant to first consider other options to meet the Individual Cost Limit and, once exhausted, submit their Request for Exception. Further, the Department utilizes the

same process, decision criteria and timelines when reviewing Requests for Exceptions and rendering a Decision.

If the Department denies a Request for Exception to the Individual Cost Limit, the CRC supports the participant to access a combination of other MaineCare State Plan services (including consideration of ICF-IID), state funds, and informal supports to meet additional needs. The waiver provides for the authorization of additional services to address time-limited or other needs for additional services in order to support the participant until alternative arrangements are made.

A participant may appeal the Department's Decision on a Request for Exception to the Individual Cost Limit, or a request to renew this type of exception, within sixty (60) calendar days through the Department's MaineCare appeals process as detailed in Chapter I, Section 1 of the MBM and described in Appendix F of this application.

In all cases, filing a Request for Exceptions is neither a waiver of nor a substitute for the Participant's right to an administrative hearing on an appeal under Chapter I, Section 1; to file a grievance under 14-197 C.M.R. ch. 8; or to file a complaint pursuant to 34-B M.R.S. § 5611.

All exceptions are subject to Utilization Review.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	680
Year 2	1073
Year 3	1466
Year 4	1859
Year 5	2252

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

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
To support adults aged 18 years and older who are not currently receiving other HCBS.
To support young adults in transition from children's PNMIs
To support transition-age youth ages 14-17 to ensure successful transition to adulthood at age 18.
To support moves from institution to community
To respond to incapacitated or dependent adults at risk of abuse, neglect and/or exploitation and other adults in emergency situations facing serious health and/or safety risk

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

To support adults aged 18 years and older who are not currently receiving other HCBS.

Purpose *(describe):*

This capacity is reserved for adults aged 18 years and older who are not currently receiving other HCBS to support access to services.

Describe how the amount of reserved capacity was determined:

This reserved capacity is based on the projected elimination of the waitlist for and closure of new enrollments to ME.0467 (MBM, Section 29) as of the effective date of this waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	45

Waiver Year	Capacity Reserved
Year 2	58
Year 3	58
Year 4	58
Year 5	58

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

To support young adults in transition from children's PNMIs

Purpose *(describe):*

This capacity is reserved for young adults, ages 18-21, whose placements in children's in-state PNMIs are ending due to the individual reaching age 21 or which are determined by DHHS to not be sufficiently meeting their needs.

Describe how the amount of reserved capacity was determined:

The reserved capacity is based on CY2023 out-of-state placement of five (5) individuals in 18-21 age range plus approximately eight (8) individuals annually who transition from in-state children's PNMI settings to adult waiver when their children's placements come to an end at age 21.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

To support transition-age youth ages 14-17 to ensure successful transition to adulthood at age 18.

Purpose *(describe):*

This capacity is reserved for youth, ages 14-17, to support successful transition to adulthood and adult services that continue to support community living, development of skills for independence and achievement of employment and community inclusion.

Describe how the amount of reserved capacity was determined:

The reserve capacity is based on data from school special education enrollment, data from the Office of Child and Family Services and the Office of Behavioral Health Services' behavioral health home data.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	500
Year 2	200
Year 3	200
Year 4	200
Year 5	200

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

To support moves from institution to community

Purpose *(describe):*

This capacity is reserved for those adults who currently reside in an in-state institutional setting (i.e., ICF/IID, nursing facility, in-patient psychiatric hospital; other in-patient hospital) who would rather and are able to receive their services in the community OR adults who have been placed out-of-state, by DHHS, in a residential setting who would rather and are able to receive their services in-state and in the community.

Describe how the amount of reserved capacity was determined:

Recent history indicates that there are approximately six (6) adults per year in-state who may choose to move from an institutional setting (ICF/IID, state in-patient psychiatric hospital, or long-term Nursing Facilities; or other in-patient hospital) to a community setting. Additionally, recent history indicates the State has approximately eleven (11) adults placed in out-of-state placement.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	8
Year 2	8
Year 3	8
Year 4	8
Year 5	8

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

To respond to incapacitated or dependent adults at risk of abuse, neglect and/or exploitation and other adults in emergency situations facing serious health and/or safety risk

Purpose *(describe):*

This capacity is reserved to meet the needs of incapacitated or dependent adults who are in circumstances that present a substantial risk of abuse, neglect and/or exploitation in accordance with 22 M.R.S. §3473(1.a) and other adults who are in an

emergency situation facing serious health and/or safety risk determined by DHHS based on evidence submitted to substantiate the emergency as defined 22 M.R.S. §3473.

Describe how the amount of reserved capacity was determined:

The number reserved is an average based on the State's data for those incapacitated or dependent adults found to be in circumstances that present a substantial risk of abuse, neglect and/or exploitation and other adults in emergency situations facing imminent health and/or safety risk in recent years.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	117
Year 2	117
Year 3	117
Year 4	117
Year 5	117

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

All applicants that wish to be enrolled will be required to have a SIS-A assessment within three years prior to enrollment.

OADS selects entrants to the waiver from among financially and medically eligible applicants based on the category of reserve capacity they qualify for and the date of their application. An applicant qualifying for a reserve capacity category described in this waiver receives an offer of enrollment in order of the earliest application date. For any participant on the Section 29 (ME.0467) or Section 21 (ME.0159) waiting list prior to the opening date of Lifespan, their date of application shall remain the same for the purposes of determining their placement on the Lifespan Waiver waiting list. If a participant is on both the Section 21 and Section 29 waiting list, the earliest application date will be used. If there is more than one participant with the same date of application, the participant with the highest support needs, as determined by the SIS-A assessment, will be prioritized first.

OADS will send a letter to the applicant and their guardian notifying them of a waiver opening. The applicant has thirty (30) days from receipt of the letter to respond to OADS regarding their intent to enroll in the waiver. If the applicant or guardian fails to respond to the offer with thirty days, OADS will withdraw the offer. In order to accept the offer, the participant or guardian submits a signed choice letter documenting their decision to enroll in the waiver rather than receive institutional care. If the participant or guardian declines the offer but expects to need and want Lifespan services in the future, OADS notifies the participant in writing that their date of application will be changed to the date they declined the offer and they will be kept on the Lifespan waiting list.

New applicants will be added to the Lifespan waiting list if the reserve capacity category for which they qualify is full or other applicants that qualify for the same reserve capacity category and have earlier application dates are waiting to be admitted to the waiver.

The above process excludes those voluntarily transitioning from Section 21 (ME.0159) or Section 29 (ME.0467). Beginning in Year Two of the Lifespan Waiver, participants who are already enrolled in ME.0159 or Me.0467 may voluntarily transition to the Lifespan Waiver. These transitions are not subject to the Lifespan waiting list, application date order, or reserve capacity categories, because the participant is already receiving HCBS services through an existing 1915(c) waiver.

Prior to transition, participants will receive assistance comparing the benefits and requirements of their current waiver to those of the Lifespan Waiver to support an informed choice. To ensure continuity of services, the PCSP planning team must convene to develop the participant's Lifespan PCSP, as described in Appendix D.

Participants who transition will transfer their existing HCBS enrollment and funding from Section 21 or Section 29 to Lifespan. As part of its annual technical amendments, the State will adjust the unduplicated counts for Section 21, Section 29, and Lifespan to reflect these transfers. No net increase in overall HCBS enrollment will occur as a result of transitions.

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 10/01/26

a. The waiver is being (select one):

- (●) **Phased-in**
- ( ) **Phased-out**

b. Phase-In/Phase-Out Time Schedule. *Complete the following table:*

Beginning (base) number of Participants: 0

Phase-In/Phase-Out Schedule

Waiver Year 1	Waiver Year 2
Unduplicated Number of Participants: 680	**Unduplicated Number of Participants: 1073**

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Oct	0	56	56
Nov	56	57	113
Dec	113	56	169
Jan	169	57	226
Feb	226	56	282
Mar	282	57	339
Apr	339	56	395
May	395	57	452
Jun	452	56	508
Jul	508	57	565
Aug	565	57	622
Sep	622	58	680

Month	Base Number of Participants	Change	Participant Limit
Oct	680	32	712
Nov	712	33	745
Dec	745	34	779
Jan	779	32	811
Feb	811	33	844
Mar	844	33	877
Apr	877	32	909
May	909	33	942
Jun	942	33	975
Jul	975	32	1007
Aug	1007	33	1040
Sep	1040	33	1073

Waiver Year 3

Month	Base Number of Participants	Change	Participant Limit
Oct	1073	32	1105
Nov	1105	33	1138
Dec	1138	34	1172
Jan	1172	32	1204
Feb	1204	33	1237
Mar	1237	33	1270
Apr	1270	32	1302
May	1302	33	1335
Jun	1335	33	1368
Jul	1368	32	1400
Aug	1400	33	1433
Sep	1433	33	1466

Waiver Year 4

Unduplicated Number of Participants: 1859

Month	Base Number of Participants	Change	Participant Limit
Oct	1466	32	1498
Nov	1498	33	1531
Dec	1531	34	1565
Jan	1565	32	1597
Feb	1597	33	1630
Mar	1630	33	1663
Apr	1663	32	1695
May	1695	33	1728
Jun	1728	33	1761
Jul	1761	32	1793
Aug	1793	33	1826
Sep	1826	33	1859

Waiver Year 5

Unduplicated Number of Participants: 2252

Month	Base Number of Participants	Change	Participant Limit
Oct	1859	32	1891
Nov	1891	33	1924
Dec	1924	34	1958
Jan	1958	32	1990
Feb	1990	33	2023
Mar	2023	33	2056

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Apr	2056	32	2088
May	2088	33	2121
Jun	2121	33	2154
Jul	2154	32	2186
Aug	2186	33	2219
Sep	2219	33	2252

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five
☒	☒	☒	☒	☒

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Oct	
Phase-in/Phase-out begins	Oct	1
Phase-in/Phase-out ends	Sep	5

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ◉ **Section 1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.

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

- ◉ **No**
- ○ **Yes**

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

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

- ☒ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☒ **Pregnant Women (42 CFR § 435.116)**
- ☐ **Infants and Children under Age 19 (42 CFR § 435.118)**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- ☒ **Optional state supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage: [ ]

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

Specify:

• Children with Non-IV-E Adoption Assistance as specified in §435.227
• Former Foster Care Children as specified in §435.150
• Children Aged 14 to 20 years of age as specified in §435.222
• Adult Group as specified in §435.119

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- (●) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

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

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

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

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals**

with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

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

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

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

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the state plan**

    Specify:

- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage: 300

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

The person conducting the assessment must meet the standard of Qualified Intellectual Disability Professional (QIDP) as outlined in 42 CFR 483.430(a). Specifically, the individual must have a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and/or psychology. In addition, the individual must have at least one year of experience working directly with persons with Intellectual Disability or other developmental disabilities.

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

The BMS-99 is the assessment instrument used to determine the level of care (LOC).

Initial Evaluation: The participant submits the completed LOC (medical eligibility) instrument (Form BMS-99), to OADS. The QIDP reviews the information for LOC determination.

Reevaluation: On an annual basis the CRC submits an updated LOC (medical eligibility) instrument (Form BMS-99) for QIDP review through the OADS's client data system for reevaluation. The reevaluation process does not differ from the initial evaluation process. The QIDP reviews the BMS 99 to ensure a participant maintains LOC criteria for waiver services.

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

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

ICF-IID LOC criteria are identified on the medical eligibility instrument utilized in this program (form BMS-99). In 1999, this assessment form was submitted to CMS for comparative analysis of this form and the form used for admission to an ICF-IID and determined that the outcomes of the evaluation are equivalent.

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

The reevaluation process is the same.

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

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

Specify the other schedule:

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

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

Specify the qualifications:

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

Maine's electronic database system generates a tickler notification to the Community Resource Coordinator and supervisor as well as an overall report of upcoming reevaluations. This will occur with a 60-day advance notice.

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

OADS and the CRC provider will maintain these records for a minimum period of five years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and Percent of initial applicants with documentation where evaluation for LOC was provided and reviewed by QIDP. Numerator: Total number of initial applicants with documentation where an evaluation for LOC was provided and reviewed by QIDP. Denominator: Total number of initial applications received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic database system

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-

assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants with a level of care redetermination completed within 12 months of the previous level of care determination. Numerator: Number of waiver participants with a level of care determination completed within 12 months of their previous level of care determination. Denominator: Number of waiver participants scheduled for a re-evaluation reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic database system

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:
electronic database system

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

As part of the discovery and remediation process the OADS quality management team will conduct reviews on all initial level of care assessments and re-evaluations to ensure timeliness and the use of the approved waiver tool and processes. When a problem is identified, OADS quality management will report the issue to OADS senior management for corrective action, if appropriate. OADS senior management will determine corrective action that effectively addresses any individual or systemic problems. The quality management team will continue to monitor on a quarterly basis to ensure that the issue has been resolved. At the end of each quarter, the quality management team will document findings, recommendations and improvements and report to both OMS and to OADS senior management.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

After an individual receives notification of a funded offer, the OADS staff, who assisted with the waiver application, will be responsible for educating the individual/guardian, if applicable, on this waiver’s services and service provision options and alternatives to include waiver and institutional services. Additionally, the OADS staff will be responsible for informing the individual/guardian about their freedom of choice between all feasible service options. The individual/guardian signs the “Choice Letter for Waiver Services” if waiver enrollment is desired. An electronic copy of this document is kept in the participant’s electronic record.

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

The Freedom of Choice forms are stored in the electronic database record.

Appendix B: Participant Access and Eligibility

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

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

CRCs are informed of OADS resources to support participants and their guardians with limited English proficiency. Support includes interpreters for all interactions between the CRC and participants/guardian. Interpreter Services are covered in the MBM, Ch. I, 1.06-2 Interpreter Services. All waiver service providers must comply with Ch I, Section 1, General Administrative Policies and Procedures, of the MBM. This includes ensuring that LEP persons are afforded the opportunity to have interpreters at scheduled meetings, when services are delivered, and to support with written correspondence.

Waiver service providers must deliver services in a way that fits each participant's communication needs. This includes using age-appropriate language, offering translation or interpretation for people who don't speak English well, providing American Sign Language interpretation, and supporting people who use communication devices.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Co-Worker Supports**		
Statutory Service	**Community and Relationship Connecting**		
Statutory Service	**Community Resource Coordination (CRC)**		
Statutory Service	**Facility-Based Day Program Services**		
Statutory Service	**Home Support Agency Per Diem**		
Statutory Service	**Personal and Home Assistance**		
Statutory Service	**Respite Breaks and Opportunities**		
Supports for Participant Direction	**Financial Management Services**		
Supports for Participant Direction	**Supports Brokerage**		
Other Service	**Assistive Technology**		
Other Service	**Behavioral Support Consultation**		
Other Service	**Benefits and Work Incentive Counseling**		
Other Service	**Career Planning**		
Other Service	**Community Connections Assistance**		
Other Service	**Community Supported Living**		
Other Service	**Community Transition Case Management**		
Other Service	**Community Transportation**		
Other Service	**Employment Exploration**		
Other Service	**Family Empowerment and Systems Navigation**		
Other Service	**Home-Based Independent Living Skills Training**		
Other Service	**Housing Counseling**		
Other Service	**Housing Start-Up Assistance**		
Other Service	**Individual Goods and Services**		
Other Service	**Integrated Employment Path Services**		
Other Service	**Job Coaching**		
Other Service	**Job/Career Development Plan and Outcome**		
Other Service	**Minor Home Modifications**		
Other Service	**Occupational Therapy (Maintenance)**		
Other Service	**Peer Specialist Services**		
Other Service	**Physical Therapy (Maintenance)**		
Other Service	**Private Duty Nursing**		
Other Service	**Remote Monitoring and On-Call Response Service**		
Other Service	**Self-Employment Start-Up Plan and Outcome**		
Other Service	**Shared Living**		

Service Type	Service		
Other Service	Speech Therapy (Maintenance)		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Co-Worker Supports

HCBS Taxonomy:

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

Service Definition *(Scope):*

Co-Worker Supports is an employment service, set up and overseen by a qualified Employment Specialist, allowing on-the-job assistance from trained co-workers or supervisors instead of an outside job coach. The Employment Specialist, employer and participant sign a written agreement using an OADS-approved form that explains what supports will be provided, by whom and how payment will work.

The employer and the participant agree upon one or more co-workers or supervisors to provide the needed on-the-job supports to the participant. The selected co-worker(s) and/or supervisor(s) providing the on-the-job support must pass a background check.

The Employment Specialist trains the selected co-worker(s) or supervisor(s) based on the participants needs for on-the-job support and checks in regularly to make sure the supports are working. The Employment Specialist provider is paid for setting up the service, monthly oversight and reimbursing the employer for the cost of the employer-provided support. A participant accesses this service when they want help from co-workers rather than an outside job coach, or when an outside job coach is not available or feasible in the workplace. Co-Worker Supports only pays for extra help during work hours related to the participant's assessed needs for additional help. Assessed needs are determined using an OADS-approved job supports assessment form. This service does not pay for normal training, supervision, or help that every employee receives as part of employment.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation

is not the responsibility of the provider.

Co-Worker Supports must be provided in person and cannot be delivered virtually.

Time billed for this service, including the Employment Specialist's in-person oversight, cannot be billed at the same time (i.e., same hour or 15-minute unit) as any other in-person waiver service.

Because co-workers provide the job supports, any personal care the participant needs at work is authorized separately and cannot be billed during the same time as Co-Worker Supports.

If the trained co-workers are not available and the participant needs help learning or meeting job expectations, Job Coaching services may be added to fill the gap, but it cannot duplicate Co-Worker Supports. When Job Coaching is billed, any personal care during that time is included in the Job Coaching Service.

Co-Worker Supports can be provided only in jobs that meet the definition of CIE. It cannot be used in provider-owned or operated work settings, and it cannot be used for volunteer positions. The employer who is reimbursed cannot be a Vocational Rehabilitation provider, an AbilityOne contractor, or a waiver service provider.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Co-Worker Supports

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

The Employment Specialist must obtain and maintain a Department-approved Employment Specialist Certification is required.

The Department makes available an approved list of certifications on its website.

Other Standard *(specify):*

The Employment Specialist must:
1. Successfully complete a department-approved Employment Specialist Certification program prior to working with a participant.
2. Successfully complete the Work and Benefit Navigator training within the first year of employment.
3. Be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
4. Have at least one (1) year of experience working with individuals with disabilities.
5. Complete six (6) hours of Department-approved continuing education every twelve (12) months.

The Employment Specialist must also complete the following Department-approved trainings, within the first six (6) months from date of hire and every thirty-six (36) months thereafter.
1. Reportable Events System (14-197 C.M.R. ch. 12) and Adult Protective Services System (14- 197 C.M.R. ch. 12)
2. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5).
3. Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury (14-197 C.M.R. ch. 1).
4. Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).

The Employment Specialist must be trained upon hire and annually thereafter on the HCBS Global Rule.

The Co-Worker must:
1. Be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
2. Pass a criminal background check as described in this waiver.
3. Complete training with the Employment Specialist before supporting a participant.

In order to provide transportation in their own or an agency vehicle, the Employment Specialist or Co-Worker must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver’s License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver’s license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90) days). At any point should the participant’s status change and they are in in arrears of child support payment(s), said driver’s approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Vehicle registration and inspection must be current and valid.
E. Automobile liability insurance must be in effect.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee’s personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years

thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Community and Relationship Connecting

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community and Relationship Connecting is a short-term service that helps the participant build new relationships and connections in their community and take part in community life with less paid help over time. All activities must follow the participant's preferences and goals in the PCSP. Service activities themselves must occur in typical community locations used by people without disabilities.

The provider helps the participant meet people with shared interests, join community groups or activities, and volunteer in roles that give back to the community. The provider includes reviewing current relationships, visiting new places and events and learning about local groups. This also includes skills training to build and maintain relationships, understand expectations when joining groups or volunteering, manage personal money in the community, travel safely, use phones and other technology appropriately, and stay safe in community settings. The provider may also help the participant use technology or adaptive aids to stay connected and be more independent. The cost of devices is not included in this service rate.

Services must not occur in the participant's private home or in a provider-owned or provider-controlled settings, except for brief use of a "hub" (such as the home or a nearby provider site) to meet or provide needed personal care that cannot happen in the community. The provider may deliver services in a 1:1 or 1:2 ratio.

The Service Implementation Plan (SIP), as described in Appendix D of this waiver, must include fading strategies to reduce

paid support over time by building natural supports and participant skills and duration of the service (not to exceed six months). On-going skills training and development is available through Community Connections Assistance services.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

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

The limit for any combination of Community Connection Assistance, Community and Relationship Connecting, and Facility-Based Day Program services must not exceed 32 hours per week (Monday through Sunday).

Facility-Based Day Program services are further limited to no more than 4 hours of direct support per day (from Monday to Friday). The remaining authorized hours may be used for Community Connection Assistance and Community and Relationship Connecting services, consistent with the service definitions.

Time during which the provider is not actively engaged in delivering services, such as time waiting for transportation, is not reimbursable and does not count against these limits.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community and Relationship Connecting

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:
A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within six (6) months of hire.
B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.
C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.
D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90) days. At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any

employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, DLC and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Community Resource Coordination (CRC)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Resource Coordination (CRC) is the comprehensive case management service under the Lifespan Waiver, assisting participants and their families to access, coordinate, and monitor needed services and supports. CRC coordinates Lifespan Waiver services with Medicaid-funded services, other publicly funded programs, community resources, and natural

supports so that services are non-duplicative, person-centered, and aligned with the participant's goals, needs, and vision for a good and full life. Active coordination includes ongoing monitoring of waiver and non-waiver services to ensure they are appropriate, effective, and focused on measurable outcomes.

The CRC completes a comprehensive assessment using OADS-approved tools and methods with the participant, people who know the participant well, and staff from other involved programs. Using this assessment, the CRC works with the participant, and the participant's guardian or involved family when needed, to identify the participant's goals, vision for a good and full life, needed services and supports, and health and safety needs. The CRC then helps the participant connect to natural supports, publicly funded services, and community resources that support these goals. The CRC also explains the option to self-direct certain services, the roles of the Support Broker and FMS agency, and the participant's rights, including the right to choose among qualified providers.

The CRC coordinates the PCSP planning process and develops, carries out, and maintains the PCSP in accordance with MBM, Ch I, Section 6, Global HCBS Waiver Person-Centered Planning and Settings Rule (the HCBS Global Rule) and other requirements. The PCSP must show the participant's current goals and needs and their longer-term vision beyond the coming year, including likely transitions and future service needs.

The CRC incorporates and monitors any necessary Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications in partnership with the PCSP planning team. When a health or safety need is identified in the PCSP and the participant chooses not to address it, the CRC must talk with the participant about possible risks and other options. The CRC must document the discussion and the participant's informed choice in the PCSP.

The CRC helps the participant understand the annual monetary allocation for their grouping, which services can be used within that monetary limit, and when an exception to the monetary limit can be requested based on individual need. The CRC must make sure the PCSP is updated at least once a year and whenever the participant asks for a change or has a major change in their life, so that the plan continues to address the participant's goals and health and safety needs.

For participants who self-direct services, the CRC provides ongoing support and monitoring to confirm that the participant is effectively served by, and satisfied with, their Support Broker and FMS agency.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

CRC caseloads are limited to participants in the Lifespan Waiver. Within each CRC agency, the average caseload per CRC is limited to twenty-seven participants. Supervisors may temporarily take on a CRC's caseload when needed. CRCs may not temporarily take on other types of case management or services billed under different service categories.

CRC may be provided to participants who are temporarily out of state when services are needed for ongoing monitoring. The CRC agency is responsible for monitoring service delivery to show that participants are receiving the services and supports in their PCSPs.

CRC is authorized and billed as a per-member-per-month (PMPM) service. The CRC must base the amount and frequency of monthly contacts on the needs and goals of the participant as outlined in the PCSP. At a minimum and prior to monthly billing, the CRC provider must ensure:
1. The CRC conducts at least one (1) meaningful contact (in person, by telephone, or by secure video) with the participant and documents the contact in OADS' data management system.
2. The CRC conducts an in-person visit at least once every quarter. At least two (2) of the required quarterly in-person visits must take place in the participant's place of residence. The quarterly in-person contacts must be documented in OADS' date management system.

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

This service is limited to one PMPM unit.

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Resource Coordination (CRC)

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

Minimum Requirements

A. Bachelor's Degree from an accredited educational institution in Social Work, Psychology, Education, Human Development, Nursing, Rehabilitation, or directly related human services field and a minimum of two (2) years' experience in providing support services and/or (paid or unpaid) direct care to clients/families with disabilities or providing support services in a directly related human service field.
B. In accordance with DLC's Home and Community Support Services Agency Licensing Rule (10-144, C.M.R. Ch 108) and OADS' Certification Requirements for Agencies Seeking to Provide Community Based Targeted Case Management for Adults with IDD and ASD rule (14-197, C.M.R. Ch. 10), CRCs must receive the following trainings within 6 months of hire and annually thereafter:
1. Person-centered practices. (Example: Learning Community for Person-Centered Practice and the LifeCourse Nexus);
2. Discovery;
3. Employment First training ;
4. Social role valorization; and
5. Alternatives to guardianship, including supported decision making.
C. Department-approved training (equivalent to the current Target Case Management (TCM) training).
Supplemental Trainings include one or more of the following:
1. Building Community and Relationships Training 10-12 hours
2. Work and Benefit Navigator Training (MMC/BCS) 6 hours
3. Employment training for CRCs
4. START training (Care Coordinator and Case Manager Training by the National Center for START Training)
D. In addition to the Department-approved CRC training the CRC must complete the following Department-approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months.
1. Reportable Events System (14-197 C.M.R. ch. 12) and
2. Adult Protective Services System (14-197 C.M.R. ch. 12) and Child Protective Services Training (in accordance with 22

M.R.S. §4011-A
3. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism Spectrum Disorder in Maine (14-197 C.M.R. ch. 5).
4. Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury (14-197 C.M.R. ch. 1).
5. CRCs, regardless of capacity and prior to provision of service to a participant, must be trained upon hire and annually thereafter on the HCBS Global Rule.
6. CRCs, regardless of capacity and prior to provision of service to a participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have automobile liability insurance in effect.

Supervisors must meet all requirements of the CRC position.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1. Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, DLC and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Facility-Based Day Program Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Facility-Based Day Program services support a person to maintain and increase skills outside their home in a setting that meets the HCBS Global Rule. The service is built around the person's needs, goals, interests, and choices, as written in their PCSP. The service is not a residential service and does not replace where the person lives.

The service takes place in settings that are not the person's home or another residential program.

Staff support the person to explore interests, try new activities, and learn about places, groups, and roles in the community. As part of the service, the person is supported to have real experiences in community settings that match their interests, strengths, learning goals, and relationship goals. When services happen in regular, non-disability-specific community places, staff help the person have positive interactions, avoid isolation, and build valued roles and real connections.

Service activities in non-disability-specific community places may include volunteering, career and employment exploration (going to events, job clubs and local businesses), health and wellness activities, and learning how to take part in community life. Through these activities, the person can build skills like social and communication skills, planning and organizing, using money, getting around, participating and contributing, and using technology or adaptive equipment to be more independent. This service may help the person learn about employment, but it does not help the person get a competitive, integrated job and does not include other vocational work tasks. Volunteering may not be done in for-profit businesses or organizations, except hospitals and nursing homes.

Facility-Based Day Program services can also support people who are retired, especially those age 55 or older who no longer want to work. The service can adjust schedules to allow more rest and support the person to take part in hobbies, clubs, senior centers, and other community activities that are meaningful to them.

Additional Standards:
1. When providing supports outside the facility (in the community), the maximum staffing ratio is 1 staff for up to 3 participants (1:3). You cannot combine groups to make bigger groups (for example, 2 staff for 6 people or 3 staff for 9 people is not allowed).
2. Providers will not be reimbursed for any time when the participant is away from the provider's setting unless the participant is accompanied by a provider staff member.
3. Facility-Based Day Program services may not be primarily recreational, transactional, or event-based.
4. Providers must keep detailed and accurate records in 15-minute increments, showing:
o When the participant is in the provider's setting and receiving services
o When the participant is outside the setting

o Which staff member is accompanying the participant or small group (if applicable)
o Which other participants are receiving services with them (if applicable)
5. Providers may not charge any extra reimbursement for any visitors of the participant.
6. Facility-Based Day Program services cannot be provided in any of the following places:
o PNMI
o Residential Habilitation (Home Support Agency Per Diem) setting
o Shared Living setting
o Community Supported Living setting
o Foster home
o Hospital
o Any other institutional setting
7. A participant may not receive Facility-Based Day Program services while they are enrolled in high school and school is in session.
8. Facility-Based Day Program services may not be provided at the participant's place of employment during the time the participant is scheduled to be working.
9. Administrative tasks and indirect supports (such as supervision, planning, and documentation) are included in the rate for this service and cannot be billed separately.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

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

The limit for any combination of Community Connection Assistance, Community and Relationship Connecting, and Facility-Based Day Program services must not exceed 32 hours per week (Monday through Sunday).

Facility-Based Day Program services are further limited to no more than 4 hours of direct support per day (from Monday to Friday). The remaining authorized hours may be used for Community Connection Assistance and Community and Relationship Connecting services, consistent with the service definitions.

Time during which the provider is not actively engaged in delivering services, such as time waiting for transportation, is not reimbursable and does not count against these limits.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Facility-Based Day Program Services

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:

A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.

B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4.DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.

C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.

D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another

DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for the MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the with OMS and receive approval from OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, DLC and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Home Support Agency Per Diem

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Home Support Agency Per Diem is residential habilitation, congregate living in a provider owned or controlled residential setting where a minimum of two and maximum of six participants receive individually tailored support that assists participants with acquiring, retaining, and/or improving skills related to living in the community. Services are developed in accordance with the assessed needs and goals of the participant and include support to foster independence and encourage development of a full life in the community, based upon goals defined in the PCSP and what is important to and for the participant, as documented in their PCSP. Services include adaptive skill development and assistance with Activities of Daily Living (ADLs); instrumental Activities of Daily Living (IADLs); community inclusion; transportation; social and leisure skill development. Home Support Agency Per Diem also includes protective oversight and supervision tailored to each participant based on need as identified in the SIS-A support needs assessment and the comprehensive assessment and documented in the PCSP.

The provider managed setting is integrated in and facilitates the participant's full access to the greater community including opportunities to seek employment and work in competitive, integrated settings; engage in community life, control personal resources, and receive services in the community with the same degree of access as participants without disabilities. A participant's essential personal rights of privacy, dignity, and respect, and freedom from coercion and restraint are protected. Participant initiative, autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact are optimized and not regimented. Participant choice regarding services and support, and whoever provides them, is facilitated.

Providers are reimbursed on a per-diem basis for Home Support Agency Per Diem so long as each participant's health, safety, and participant needs/goals for which the service is authorized are addressed, consistent with each participant's PCSP. Further, at all times where the provider is not using OADS-approved remote monitoring with on-call response, the provider assures that at least one qualified staff person is onsite (in the same setting as participants receiving services in that setting) at all times (24/7) and available to respond immediately when any participant requests or requires support, including during overnight hours.

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

Home Support Agency Per Diem includes the delivery of direct support for the participant when the participant is not present only when the activities and actions meet the scope of the service and when documented within the participant's PCSP to meet a specific and identified need. These activities, as listed in a) through d) below, are included in the established authorization. Providers must clearly document the delivery of these activities in the participant's record:

A. Services when the participant is in the same location: activities and time spent by Home Support providers whenever the staff and the participant are in the same physical environment but not in close proximity (e.g. staff waiting for a participant during a medical appointment or a home visit), for Home Support services.

B. Professional Consultations for the participant: activities and time by Home Support providers for scheduling appointments and consulting with physicians, dentists, medical personnel, therapists, clinicians, or employers to meet a specified need within the participant's PCSP, medical plan or behavioral plan (e.g. collaborating with a physician or

therapist regarding a medication or treatment intervention).

C. Home Visits & Family Reunification: activities and time spent by Home Support providers for the purposes of, as specified in the participant's PCSP, arranging participant's home visits and participation in family events and/or family reunification. This includes transporting a participant to their parent's, guardian's, or friend's home for visits; returning a participant to their home; and any time spent during such visits with the participant.

D. Habilitative Skill Building for Home and Work: activities and time spent by Home Support providers that support the participant in practicing specific learned skills, including safety and enhancing independence in the community as identified within the PCSP.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

A minimum of two (2) and a maximum of six (6) participants may reside together in an OADS-approved Home Support Agency Per Diem setting. Section 21 (ME.0159) Waiver participants can reside with Lifespan waiver participants in the same setting so long as the number of participants in a given setting does not exceed this maximum.

Remote Monitoring and On-Call Response services may not be delivered in a Home Agency Per Diem setting. Payments are not made for room and board, the cost of facility maintenance, upkeep, or improvement.

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

This service is authorized on a monthly per diem basis and billed 350 days per year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Support Agency Per Diem

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:

A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.

B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2.Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.

C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.

D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for

license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Personal and Home Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

Personal and Home Assistance provides ongoing, individualized support to a participant in their own home so they can live safely and as independently as possible. This includes assistance with basic self-care routines and home-management activities such as:
• personal care (bathing, dressing, eating, toileting, mobility, and following medication routines as directed;
• household routines such as meal preparation, cleaning, laundry, shopping, budgeting and paying bills, and using phones or other communication devices;
• support to use adaptive strategies, communication tools, or problem-solving approaches that improve daily functioning;
• support to practice positive or replacement behaviors identified in the participant's Positive Behavior Support Plan when this level of support is assessed as needed;
• support to explore or take part in pre-vocational or work-related activities when this fits the participant's goals.

This service is intended to complement natural supports—it adds to the support a participant already receives from family, friends, or other unpaid supports, and does not replace them except to the extent relief of natural supports who provide a home to the participant is necessary to sustain those natural supports and the living arrangement.

This service is different from Home-Based Independent Living Skills Training. Independent Living Skills Training is short-term and focused on learning a specific task so the participant can later do it without paid support. Personal and Home Assistance is used when a participant needs ongoing support to complete daily routines and they can't rely on natural supports or technology to otherwise stay safe at home. The participant's PCSP describes the goals and supports this service will address within the scope of this definition, including any health and safety needs. Providers deliver support in ways that promote independence whenever possible.

If a participant is temporarily outside Maine, Personal and Home Assistance may continue only when it is necessary to meet essential daily living or health and safety needs and no other support is available during the trip. Personal and Home Assistance services may not be delivered for more than 14 calendar days consecutively per calendar year.
This service may not be delivered in a provider-owned or controlled setting.

The service can be delivered to no more than three people at a time in the same home. If the service is provided in a group, the provider must bill the group rate.

If the Department, or its Assessing services Agency (ASA), (or the physician for participants under age 21) determines that a participant, based upon their health status, requires more than one staff member to perform a specific ADL task, then this can be authorized and specified in the PCSP.

For participants under the age of 21, EPSDT must be used first. This service may be authorized only to address needs not addressed by EPSDT services available to the participant.

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

Personal and Home Assistance may not exceed 84 hours per week. Units of service that were not provided to a participant in any week cannot be carried over into subsequent weeks.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal and Home Assistance

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:

A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.

B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.

C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in

accordance with Department procedures.

D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:

A. Must be at least eighteen (18) years of age.

B. Must have a current and valid Driver's License based on state of residence.

C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.

D. Must have a current and valid vehicle registration.

E. Must have current and valid vehicle inspection.

F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Providers delivering Personal and Home Assistance services must follow Electronic Visit Verification (EVV) system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

OMS Provider Enrollment conducts verification at enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal and Home Assistance

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

The participant or Authorized Representative must verify that each prospective employee is at least seventeen (17) years of age.

The participant or Authorized Representative must submit minimum qualification documentation to the FMS to generate a background check and for record-keeping purposes.

The participant or Authorized Representative sets the standards for and conducts the training of each employee under Self-Direction. The participant or Authorized Representative must maintain documentation that the employee received adequate orientation to assure that the employee can meet the needs of the participant and demonstrate competency in all required tasks.

Any employee may be a family member of the participant.

If an Authorized Representative directs services on behalf of the participant, the Authorized Representative may not be paid to deliver this service.

If the guardian is acting as the Authorized Representative on behalf of the participant, the guardian may not be paid to deliver this service.

Personal and Home Assistance services must comply with the Department’s EVV system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker’s record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Breaks and Opportunities

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite Breaks and Opportunities provide short-term support to a participant who lives with family or other natural supports. This service is used when the unpaid people the participant lives with—such as family members or friends—need a temporary break and are not able to provide their usual support, care, or supervision for a limited period of time. Shared Living providers are not considered natural supports for this service.

This service can be provided:

A. In the waiver participant's home and home community; or

B. In the private home of the Respite Breaks and Opportunities service provider and in the local community surrounding that setting, if the service is delivered through self-direction and the Employer of Record approves this;

C. In a Shared Living setting that has no more than two (2) existing Shared Living participants;

D. In a Home Support Agency Per Diem setting of no more than six (6) beds; or

E. During the participant's travel away from their home and home community.

The service helps sustain the family or natural support arrangement so the participant can continue living with the people they choose and supports the participant to maintain their usual routines and relationships and, if they want, to take part in new activities or meet new people with the respite provider. Respite should not interrupt the participant's normal life. When the participant wants to keep their regular schedule such as employment, school, community activities, or visits with friends—respite supports are arranged so those routines continue.

Respite is usually planned ahead of time, but it can also be used in unexpected situations. If an unplanned situation becomes a crisis, respite may be used to give the family time to address the situation while keeping the living arrangement stable. The priority in a crisis is to prevent the loss of the participant's natural home and support arrangement. If all reasonable efforts to sustain that arrangement have been tried and do not work, respite may be used for a short period while an alternative living arrangement is identified. Any alternative must be the least restrictive, most integrated option possible and aimed at avoiding hospitalization or institutional placement.

Respite may be provided during a temporary out-of-state stay only when it is necessary to meet the participant's daily living or health and safety needs and no other support is available. This service may not be provided in institutional settings or in settings that do comply with the HCBS Global rule. The Respite Breaks and Opportunities setting must closely resemble the setting in which the participant resides.
Only relatives who are not living with the participant may provide this service if qualified.

This service cannot be used if the participant receives Shared Living services. Respite for Shared Living providers is a component of that service and included in the daily rate paid to the Oversight Agency.

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

This service shall be limited to no more than 216 hours of service per person per calendar year with the authorization for each participant based on assessed need and reflected in the PCSP.
Respite may not be delivered for more than 14 calendar days consecutively per calendar year.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Breaks and Opportunities

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:

A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.

B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.

C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.

D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and

any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Providers delivering Respite Breaks and Opportunities services must comply with the Department's EVV system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Breaks and Opportunities

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

The participant or Authorized Representative must verify that each prospective employee is at least seventeen (17) years of age.

The participant or Authorized Representative must submit minimum qualification documentation to the FMS to generate a background check and for record-keeping purposes.

The participant or Authorized Representative sets the standards for and conducts the training of each employee under Self-Direction. The participant or Authorized Representative must maintain documentation that the employee received adequate orientation to assure that the employee can meet the needs of the participant and demonstrate competency in all required tasks.

Any employee may be a family member of the participant.

If an Authorized Representative directs services on behalf of the participant, the Authorized Representative may not be paid to deliver this service.

If the guardian is acting as the Authorized Representative on behalf of the participant, the guardian may not be paid to deliver this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker's record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Financial Management services are a critical support for self-direction. The participant must receive Financial Management services in order to access self-direction in this waiver. This service includes:

A. Training the participant and Authorized Representative and employees on the roles of the FMS in self-direction and the FMS's responsibilities to the participant, Authorized Representative and employees;
B. Providing the participant or Authorized Representative with skills training on their responsibilities in exercising employer

and/or budget authority consistent with the rules and limits associated with authorized covered services;
C. Informing the participant that the Department does not require employers to offer health insurance coverage, but they may negotiate a stipend or wage adjustment to assist their employees with the costs of procuring benefits (e.g., healthcare insurance).
D. Enrolling Employer/Employer-of-Record and employees in the payroll processing system and training those enrolled on how to use the system;
E. Processing payroll for employees including withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
F. Conducting required background checks for potential employees as well as verifying other applicable state and federal requirements for employees;
G. Tracking of the participant's spending for the approved Individual Goods and Services (IGS) with the Department-approved Spending Plan Tool and making regular reports on spending available to the participant/Authorized Representative and CRC;
H. Tracking changes or additions to the list of IGS on the Department-approved Spending Plan Tool and ensuring the participant has available, accrued funds prior to approving and procuring IGS;
I. Making financial transactions on behalf of the participant within the scope of covered services under Self-Direction and within the specific service authorization(s) and budget of the participant;
J. Providing a monthly financial report to the participant/Authorized Representative and CRC which includes projected and actual spending to ensure the participant stays within the individual budget based on approved service authorizations; and
K. Assisting the participant with resolving employee questions and complaints and remediating as appropriate.

Payments for services must not be made directly to a participant, either to reimburse the participant for expenses incurred or enable the participant to directly pay a service provider or employee.

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

1. Must be at least eighteen (18) years of age.
2. Must have graduated from high school or acquired a GED.
3. Must have a background check completed consistent with this waiver.
4. Must have an adult protective and child protective record check.

OADS-approved providers must meet expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, quality management, compliance with all HCBS Settings requirements, and compliance with federal Internal Revenue Service (IRS) codes.

FMS providers must use an electronic platform that is HIPAA compliant and ensures accessibility and efficiency for the participant to engage in Self-Directed services.

Providers must demonstrate high quality customer service to effectively and efficiently support the participant and Authorized Representative choosing Self-Direction including, but not limited to, the ability to process timesheets and payroll, manage and disburse payments for the participant's Individual Goods and Services budget (and monthly reports to the participant and Authorized Representative for the same), and other needed management functions.

Staff must meet the same qualifications as specified above when delivering the service remotely or via telehealth. The provider must ensure all personnel are acting within the scope of license or certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Providers must enroll with the Office of MaineCare Services (OMS) and receive approval from the OADS. Oversight of provider enrollment activities is a shared responsibility of OMS and OADS. The application and other information and materials are shared and reviewed by a number of entities within DHHS including PIU, finance/rate-setting, Division of Licensing and Certification (DLC), and OADS. The OMS Provider Enrollment unit completes the final verification.

Enrollment as an FMS provider is open to all willing and qualified providers.

Frequency of Verification:

The OMS Provider Enrollment conducts verification at enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Supports Brokerage

HCBS Taxonomy:

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

Service Definition *(Scope):*

Supports Brokerage is the delivery of support and information to ensure that the participant/Authorized Representative understands how Self-Direction works in this waiver and can effectively carry out the responsibilities involved with self-direction.

Through this service, the Supports Broker must provide easily understandable information and support to the participant/Authorized Representative that address:
1. Requirements and best practices for recruiting, managing and directing employees within the scope of Self-Direction;
2. Individual choices and options available to the participant/Authorized Representative under Self-Direction;
3. The process for requesting a change to the PCSP and the self-directed budget;
4. How to monitor use of services and the Self-Direction budget over time to keep within authorization and budget limits; and
5. Other information and topics pertinent to the participant and/or family in managing and directing services.

Duties of the Supports Broker include, but are not limited to, teaching, coaching, and advising the participant/Authorized Representative about the responsibilities of being an employer, managing their personal budget, and implementation of their PCSP. The PCSP must identify the types of the assistance the Supports Broker furnishes to the participant/Authorized Representative. The Supports Broker is selected by and works on behalf of and under the direction of the participant/Authorized Representative.

Supports Brokerage includes:
A. Offering support, including effective communication and problem-solving strategies, to enable the participant or Authorized Representative to recruit, hire, train, and manage employees as independently as possible.
B. Supporting the participant in person-centered service planning for Self-Directed services.
C. Completing community mapping, in accordance with the Department-approved Support Broker curriculum, of all services and supports available to participant in their community of choice.
D. Working closely with the Case Manager and the FMS to ensure the PCSP identifies the mix of services (community services, VR, Education, State Plan, Provider-Managed services and Self-Directed services) and natural supports to maximize the participant’s flexible individual budget of Self-Directed services.
E. Supporting and monitoring the participant or Authorized Representative in carrying out their employer responsibilities including educating, managing and scheduling employees.
F. Supporting the participant or Authorized Representative to project and track costs associated with Self-Directed services including staffing, wages, and allowable IGS, using the Department-approved Spending Plan Tool.
G. Supporting the participant or Authorized Representative, in coordination with the FMS with monitoring their spending using the Department-approved Spending Plan Tool.
H. Assisting the participant in identifying immediate and long-term needs related to Self-Direction and assisting the participant in developing strategies to meet those needs.
I. Supporting the participant/Authorized Representative to request adjustments to the PCSP as needed and ensuring those authorized adjustments are reflected in the updated Spending Plan Tool.
J. Supporting the participant/Authorized Representative in ensuring employees comply with the Department’s EVV system

standards and daily documentation requirements.
K. Reporting overutilization/scheduling of more staff than the budget can cover to the OADS resource coordinator.

If an Authorized Representative directs services on behalf of the participant, the Authorized Representative may not be paid to deliver this service or any other waiver service. If the legal guardian or legally responsible individual is acting as the Authorized Representative on behalf of the participant, the legal guardian or LRI may not be paid to deliver this or any other waiver service.

Supports Brokerage is not duplicative of and does not prohibit the participant's receipt of CRC or FMS services.

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

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

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Support Broker
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Independent Support Broker

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

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

When the State allows Remote/Via Telehealth as a service delivery method, staff must meet the same qualifications as

specified above.

In order to provide transportation staff must meet the following requirements:

A. Must be at least eighteen (18) years of age.

B. Must have a current and valid Driver's License based on state of residence.

C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose causefor license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3.Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.

D. Must have a current and valid vehicle registration.

E. Must have current and valid vehicle inspection.

F. Must have in effect automobile liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Independent Support Brokers must enroll with the Office of MaineCare Services (OMS) and receive approval from the OADS. Oversight of provider enrollment activities is a shared responsibility of OMS and OADS. The application and other information and materials are shared and reviewed by a number of entities within DHHS including PIU, finance/rate-setting, Division of Licensing and Certification (DLC), and OADS. The OMS Provider Enrollment unit completes the final verification.

Frequency of Verification:

The OMS Provider Enrollment unit conducts verification at enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

The OADS-approved FMS will ensure Support Brokers meet the following minimum qualifications:

Agency-Employed or Subcontracted Staff Qualification and Training:
1. Must be at least eighteen (18) years of age.

2. Must have graduated from high school or acquired a GED or equivalent.
3. Must have a background check in accordance with this waiver.
4. Must have an adult protective and child protective record check.
5. Must have completed Department-approved Support Brokerage Training.
6. Must have at least 1-year community experience supporting people with disabilities and demonstrated knowledge of community services, MaineCare services, person-centered planning, business processes, Home and Community Based Services, health and social services systems, problem solving and positive engagement and interpersonal skills.

When the State allows Remote/Via Telehealth as a service delivery method, staff must meet the same qualifications as specified above.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90) days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

Staff must also complete the following Department approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months:
1. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
2. Adult Protective Services (10-149, Ch. 1)
3. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
4. Grievance Training (14-197, Ch. 8).

Finally, any staff providing direct care must be trained on the HCBS Global Rule (10-144 C.M.R. Chapter 10, MBM Chapter 1, Section 6).

The FMS agency must:
1. Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

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

Service Definition *(Scope):*

Assistive Technology (AT) includes resources that directly assist a participant in the selection, acquisition, or use of an AT device or adaptive aid for purposes other than remote monitoring. An AT device means adaptive aids or a piece of equipment, or a product system, whether acquired commercially or through specialized supplier, which may be modified or customized, and is used to increase, maintain, or improve functional capabilities of the participant. This service includes three components (A, B, and C) described below.

A. AT Assessment and Training includes the following:

1. Evaluation of the AT and adaptive aid needs of a participant, which includes a functional evaluation of the anticipated impact of the AT and adaptive aids. The evaluation and functional assessment also include necessary training and support for the participant in the typical environment(s) where the participant currently spends or plans to spend time.
2. Coordination and use of AT and adaptive aids, in conjunction with therapies or other services in the service plan.
3. Training or technical assistance for the participant, and, where appropriate, the PCSP team, family members, guardian, advocate(s), or Authorized Representative of the participant.
4. Training or technical assistance for anyone who is or will be expected to assist or communicate with the participant through the use of AT or adaptive aid(s) including providers of services and supports and/or people who are otherwise directly involved in the life of the participant.
5. Assistance and support in determining where to place necessary devices and monitors in coordination with the participant and guardian, as applicable. Cameras will not be installed in places where privacy is warranted including bedrooms and bathrooms.

The AT Assessment component is Provider-Managed only.

B. AT Devices and Adaptive Aids includes the following:

1. Purchasing, leasing, or otherwise acquiring AT devices and adaptive aids for the participant; and
2. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing AT devices or adaptive aids.

C. AT Transmission:

This component is the fee associated with the data transmission required for the AT Devices. This includes reimbursement to increase data capacity of the AT Device associated with data transmission (e.g. Increased iCloud storage capacity). This component service cannot be used for recurring utility expenses, including internet connectivity.

AT Transmission can be Provider-Managed or Self-Directed. This component may be provided to participants who are temporarily located outside of the state when such services are determined to be necessary.

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

The annual limit for assistive technology services or equipment is $10,000.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

To conduct an AT Assessment as set forth in the Service Description, a staff must be Occupational Therapist, Speech Language Pathologist

Certificate *(specify):*

To conduct an AT Assessment as set forth in the Service Description, a staff must be:
1.Rehabilitation Engineering Technologist (RET) or;
2.Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North American (RESNA).

Other Standard *(specify):*

To conduct AT training as set forth in the Service Description, a staff must meet the qualifications to perform an AT Assessment or must be employed or contracted and trained by the vendor of the AT device or adaptive aid.
Minimum requirements for equipment may include compliance with local and state codes, Underwriters Laboratories, FCC, NFPA, Life Safety Code or ADA.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all qualifications and

training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1. Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Support Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service provides consultation, training, and technical assistance to the individuals (unpaid natural support and paid direct care workers) who provide support to the participant with behavioral support needs. This service teaches and trains members of the participant's team to implement evidence-based, positive behavior support strategies and interventions to support the participant to effectively live in and engage with their community, to effectively maintain safety across all settings, and to effectively engage in and maintain relationships with essential natural support and direct care workers.

The qualified professional delivering Behavioral Support Consultation Service's conducts a functional assessment and develops the positive and/or modifying behavioral health support plans with the participant and the PCSP team. The functional assessment identifies the participants behavioral support needs as well as the evidenced-based strategies and interventions for addressing the participant's behavioral support needs. The strategies must be evidenced-based and conform with 34-B M.R.S. ch. 5, §5605.

Behavioral Support Consultation services include:
A. Consultation to develop positive and/or modifying behavioral health support plan based on the participant's assessed needs and their own goals and vision for a good life.
B. Training and instruction for staff and natural supports to implement strategies across settings as identified on the positive and/or modifying behavioral health support plans.
C. Ongoing consultation for monitoring implementation and effectiveness of the positive and/or modifying behavioral health support plans including recommendations for revising the positive and/or modifying behavioral health support plans to assure progress with achieving desired outcomes.

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

OADS may authorize up to 24 hours (96 fifteen-minute units) per quarter (three months).

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☒ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Consultation

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Licensed Clinical Social Worker (LCSW), or a Licensed Clinical Professional Counselor (LCPC), Licensed Psychological Examiner or Licensed Clinical Psychologist, certified psychiatric clinical nurse specialist

Certificate *(specify):*

Board Certified Behavior Analyst (BCBA)

Other Standard *(specify):*

All providers, agency or independent, must comply with 34-B M.R.S. §5605, Rights and basic protections of a person with

an intellectual disability, autism or an acquired brain injury as well as DHHS Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5). Additionally, providers must be trained on an OADS-approved Positive Behavior Supports training curriculum.

The provider agency must ensure all contracted employees are qualified to deliver this services and acting within the scope of their license. The provider agency must verify licensure and certification and retain documentation of the same.
The provider agency must conduct background checks in accordance with Appendix C-2 of this waiver.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for the provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll in the MaineCare program with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. Final approval and verification is completed by OMS Provider Enrollment.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Consultation

Provider Category:

Individual

Provider Type:

Individual Practitioner

Provider Qualifications

License *(specify):*

Licensed Clinical Social Worker (LCSW), or a Licensed Clinical Professional Counselor (LCPC), Licensed Psychological Examiner or Licensed Clinical Psychologist, certified psychiatric clinical nurse specialist.

Certificate *(specify):*

Board Certified Behavior Analyst (BCBA)

Other Standard *(specify):*

All providers, agency or independent, must comply with 34-B M.R.S. §5605, Rights and basic protections of a person with an intellectual disability, autism or an acquired brain injury as well as DHHS Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5). Additionally, providers must be trained on an OADS-approved Positive Behavior Supports training curriculum.

The Independent provider must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for the provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The independent practitioner must enroll in the MaineCare program with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. Final approval and verification is completed by OMS Provider Enrollment.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Benefits and Work Incentive Counseling

HCBS Taxonomy:

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

Service Definition *(Scope):*

Benefits and Work Incentive Counseling is a service that helps participants prepare for and succeed in jobs in the community or start their own community businesses to earn a competitive wage.

The goal is to help participants earn more and become more financially independent; while ensuring they remain eligible for services they need to sustain community living. The service helps participants understand the benefits they are receiving and explains what work incentives are available, how to use them, and how working might affect benefits.

This service gives participants (and guardians/family, if applicable) information about programs like SSI, SSDI, Medicaid, Medicare, housing help, food assistance, and other supports. It also teaches participants how to report income and follow the rules for public benefits, including Social Security programs. This service is for participants who are thinking about working, looking for work, already working, or trying to advance in their career.

Benefits and Work Incentive Counseling is a distinct service and is not intended to duplicate the activities of other supported employment services offered under this waiver.

Benefits and Work Incentive Counseling include the following components:

1. Introductory information to participants of minimum working age who are not currently employed in CIE.
2. Initial benefits counseling and analysis for a participant of minimum working age who is actively considering or seeking CIE, or career advancement in CIE.
3. Assistance with development of a Social Security Plan for Achieving Self-Sufficiency, (PASS Plan) or Impairment Related Work Expense (IRWE).
4. Supplementary benefits counseling for a participant of minimum working age, evaluating a CIE job offer/promotion or CIE self-employment.
5. Problem solving for a participant of minimum working age, to maintain CIE.

This service may be provided to participants who are self-employed or considering/seeking self-employment. It must be delivered in a community setting, the provider's office, or the participant's home when doing so does not duplicate services already provided in the home. The service must be provided on a 1:1 basis.

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

The limits for each component are based on what is generally accepted as the amount of time needed to deliver that type of support. The components used and the hours applied must be justified by the participant's desired goals and employment circumstances and agreed upon with the participant.

Benefits and Work Incentive Counseling services are limited in the following ways:

A. Introductory general education is limited to participants of minimum working age who are not currently employed in CIE for a total of four (4) hours of service. This component of service can be reauthorized once per waiver year with a minimum 365-day interval between services.

B. Initial benefits counseling and analysis for a participant, of minimum working age who is actively considering or seeking CIE, or career advancement in CIE is limited to up to twenty (20) hours per authorization. This service may be authorized no more than once every two (2) years and only if circumstances have significantly changed since the prior authorization, warranting a new analysis.

C. Assistance with development PASS Plan or IRWE is limited to a total of fifteen (15) hours of service to cover all necessary steps involved for submission to, and approval by, the Social Security Administration (SSA). This component of service may not be authorized more than once every three (3) years and only if the participants' circumstances warrant a change and SSA approval is likely.

D. Supplementary benefits counseling is limited to six (6) hours of this component up to three times per year.

E. Problem-solving services are limited to eight (8) hours per work-related issue up to four (4) times per year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits and Work Incentive Counseling

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

In order to deliver this service, the staff must receive certification as a Certified Community Work Incentives Coordinator (CWIC) or Community Partner Work Incentives Counselor (CPWIC) from the SSA. Additionally, CWICs and CPWICs must meet annual continuing education requirements set forth and renewed by SSA.

Other Standard *(specify):*

In addition to the requisite certification issued by SSA, staff must successfully complete state-specific benefits and work incentives training through the State's Learning Management System (LMS).

Staff must also complete the following Department-approved trainings, within the first six (6) months from date of hire and thereafter every thirty-six (36) months.
1. Reportable Events System (14-197 C.M.R. ch. 12) and Adult Protective Services System (14- 197 C.M.R. ch. 12)
2. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5).
3. Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury (14-197 C.M.R. ch. 1).
4. Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).

Staff must be trained upon hire and annually thereafter on the HCBS Global Rule.

The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1. Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. Final approval and verification is completed by OMS Provider Enrollment.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Career Planning

HCBS Taxonomy:

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

Service Definition *(Scope):*

Career Planning is a time-limited person-centered, comprehensive employment planning and direct support service. It is service to engage a participant in identifying a career direction and developing a plan for achieving CIE. The service provides assistance to obtain or advance in CIE. Career Planning assists in identifying skills, priorities, and capabilities determined through an individualized discovery process. As needed, the provider will make a referral to Benefits and Work Incentive Counseling, and if needed, a referral for an AT Assessment to increase independence in the workplace and/or for development of experiential learning opportunities and career options consistent with the participant's skills and interests.

Career Planning and information gathered will be used in the application to Vocational Rehabilitation, which will be completed at day thirty (30) of service. When career exploration identifies an interest in competitive, integrated self-employment, the participant will have the opportunity to explore similar businesses and determine potential steps necessary to develop a business. The outcome of this service is the participant's stated career objective and a career profile. The participant will be able to use this "career profile" (as documented on the Department-approved forms) to further their employment goals.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

The service must take place in the community and may not take place in a provider office setting or a provider owned or controlled setting. Services cannot be used to create a plan for volunteer positions or employment in businesses owned and operated by a provider of waiver or Vocational Rehabilitation services.

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), (17).

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

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Career Planning

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Department-approved Employment Specialist Certification and Maine Career Planning Certification

The Department makes available an approved list of certifications on its website.

Other Standard *(specify):*

1. Successfully complete an Employment Specialist Certification and Maine Career Planning Certification before working alone with a participant.
2. Successfully complete the work and benefit navigator training within the first year of employment.
3. Be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
4. Have at least one (1) year of experience working with individuals with disabilities.
5. Complete six (6) hours of Department-approved continuing education every twelve (12) months.

Staff must also complete the following Department-approved trainings, within the first six (6) months from date of hire and thereafter every thirty-six (36) months.
a. Reportable Events System (14-197 C.M.R. ch. 12) and Adult Protective Services System (14- 197 C.M.R. ch. 12)
b. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5).
c. Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury (14-197 C.M.R. ch. 1).
d. Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).

Staff must be trained upon hire and annually thereafter on the HCBS Global Rule.

In order to provide transportation staff, in their own or a provider agency vehicle, must meet the following requirements:
1. Must be at least eighteen (18) years of age.
2. Must have a current and valid Driver's License based on state of residence.
3. Must maintain an acceptable driving history. This means the driver must not:
a. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
b. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
c. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
4. Vehicle registration and inspection must be current and valid.
5. Automobile liability insurance must be in effect.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1. Complete the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Career Planning

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Employment Specialist Certification and Maine Career Planning
The Department makes available a list of approved certifications on its website.

Other Standard *(specify):*

The participant or Authorized Representative must verify that each prospective Employment Specialist meets the following minimum qualifications:
1. Staff must be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.

2. Have at least one (1) year of experience working with individuals with disabilities.
3. Hold and maintain a valid Department-approved Employment Specialist Certification and Maine Career Planning Certification.
4. Have successfully completed the Department-approved Work and Benefit Navigator Course.

The participant or Authorized Representative must submit minimum qualification documentation to the FMS to generate a background check and for record-keeping purposes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker's record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Connections Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Connections Assistance provides ongoing support to the participant to maintain and deepen relationships and

participate more fully in community life. The service focuses on helping the participant increase skills for community involvement and increase connections with others, such as friends, neighbors, members of their local community and coworkers (outside of work). The combination of increased skills (including increased use of technology when applicable) and increased connections with natural (unpaid) supports enables the participant to rely less on paid staff.

Community Connections Assistance may include help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that occur outside the home. services take place in integrated community settings where the participant can be active, involved, and/or contribute alongside others.

This service can also be provided in a workplace where the participant is employed, interning, or apprenticing toward CIE and needs personal assistance but does not require job coaching under Supported Employment. It may also be provided in post-secondary education settings—such as college or Comprehensive Transition and Post-Secondary (CTP) programs—when personal assistance is needed and not available through another funding source.

Community Connections Assistance may include help with personal needs that occur outside the home, such as eating, toileting, grooming, or other supports needed for work, education, or community participation. It can also include help with communication, scheduling, and follow-through to promote independence in community settings.

Staff may assist participants in maintaining and deepening acquaintances and friendships, joining community groups, and participating in community events and activities. With the participant’s consent, staff may also train natural supports or coworkers to provide limited assistance that would otherwise be provided by paid staff.

Assistive technology and adaptive aids may be used in conjunction with this service to increase independence and community involvement. The cost of these items may be covered under another Lifespan service if not already available through another program or funding source.

Community Connections Assistance may be provided in staffing ratios of 1:1, 1:2, or 1:3 Regardless of staffing ratio, the maximum group size is three participants. A provider hub or community venue may be used when needed for staff breaks, meals, personal care, or when community activities are canceled.

This service is provided outside of the participant's or family’s private residence, other residential living arrangement, and for the self-directing participant, their employees place of residence except when these locations are used as a hub as defined in this service definition.

This service must not duplicate other services delivered to the participant and delivery will not overlap with the delivery of other services in this waiver. Face-to-face delivery of the service may not be billed during the same period of time (e.g., the same hour or 15-minute unit) that another face-to-face service is billed.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

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

The limit for any combination of Community Connection Assistance, Community and Relationship Connecting, and Facility-Based Day Program services must not exceed 32 hours per week (Monday through Sunday).

Facility-Based Day Program services are further limited to no more than 4 hours of direct support per day (from Monday to Friday). The remaining authorized hours may be used for Community Connection Assistance and Community and Relationship Connecting services, consistent with the service definitions.

Time during which the provider is not actively engaged in delivering services, such as time waiting for transportation, is not reimbursable and does not count against these limits.

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency
Individual	Self-Directing Employer or Authorized Representative

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Connections Assistance

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:
A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.
B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.
C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.

3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.
D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. Final approval and verification are completed by OMS Provider Enrollment.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Connections Assistance

Provider Category:

Individual

Provider Type:

Self-Directing Employer or Authorized Representative

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N?A

Other Standard *(specify):*

The participant or Authorized Representative must verify that each prospective employee meets the following minimum qualifications:

1. Staff must be at least seventeen (17) years of age.
2. Completion of no-cost OADS training on supporting community relationships and involvement (4 hours).

The participant or Authorized Representative must submit minimum qualification documentation to the FMS to generate a background check and for record-keeping purposes.

The participant or Authorized Representative sets the standards for and conducts the training of each employee under self-direction. The participant or Authorized Representative must maintain documentation that the employee received adequate orientation to assure that the employee can meet the needs of the participant and demonstrate competency in all required tasks.

Any employee may be a family member of the participant.

If an Authorized Representative directs services on behalf of the participant, the Authorized Representative may not be paid to deliver this service.

If the guardian is acting as the Authorized Representative on behalf of the participant, the guardian may not be paid to deliver this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker’s record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Supported Living

HCBS Taxonomy:

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

Service Definition *(Scope):*

Community Supported Living (CSL) is a comprehensive service that provides skill building, training, and assistance so the participant can live in a home the participant owns or controls. The home can be owned by a private or public landlord or the participant. The participant must have a standard lease or other legally enforceable residency agreement with the same rights and responsibilities as any tenant in the community. The home may not be the residence of a paid or unpaid primary caregiver. The participant may live alone or with housemates they freely choose, with or without disabilities and with or without waiver services. If multiple waiver participants share the home, each may receive CSL.

CSL focuses on helping the participant build and use skills needed to live and remain in their own home. CSL helps the participant do as much as possible on their own, while getting help from family, friends, housemates, and as necessary, the CSL provider, when they need it. The participant is in charge of their own home and life as much as possible, with the right kind of support to make that work. They build skills, make choices, and handle daily routines as much as possible on their own, and they use help in a planned, safe way when they need it like remote or in-person coaching and support from staff, AT, or support from friends/housemates/family.

CSL may also include oversight of self-administered medication or medication administration, and health maintenance tasks, when allowed by law.

CSL is intended for participants who, with teaching, AT, natural supports, and advance planning, do not need paid staff in the home at all times, but do need reliable and unplanned/emergency access to support around the clock if something comes up. CSL is different from other residential waiver services because it provides this 24-hour on-call, as-needed support without requiring continuous staff presence. This on-call support is used when unexpected problems or crises arise. CSL includes teaching the participant what to do in an emergency. The provider will create clear step-by-step instructions that are understandable to the participant, practice the steps with the participant, and review them regularly so the participant can respond safely during emergencies.

CSL is an individual (1:1) service and may not be billed as a group service. Providers may bill CSL only for the participant who is receiving individualized CSL support at that time. Providers must not bill two or more participants for the same staff time. If staff are present in a shared home, only the time spent delivering participant-specific CSL supports to a single participant may be billed, and documentation must clearly identify the participant served and the support provided.

The participant may not receive this service for the sole purpose of companionship.

A participant receiving CSL may not also receive Home Support Agency Per Diem, Shared Living, Home-Based

Independent Living Skills Training, Personal and Home Assistance, or Community Connections Assistance.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

CSL may be used in combination with Remote Monitoring and On-Call Response when the CSL provider is not scheduled to be on site. When Remote Monitoring and On-Call Response is used with CSL, the CSL provider must act as the on-call in-person responder.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Supported Living

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:

A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.

B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. DSPs must complete recertification training as approved by the Department to maintain active certification status.
3.DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.

C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.

D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and

any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Providers delivering Community Supported Living services must comply with the Department's EVV system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Case Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transition Case Management is a time-limited service to help a participant move from an institutional or

correctional setting to a waiver setting, to a private home or to an independent living setting. The provider must meet with the participant before the transition to find out what they need, develop a clear plan that secures and coordinates services and resources needed for a successful move. This includes coordinating items and services that may be available through Housing Start-Up Assistance.

The service may also be provided virtually when the participant is temporarily out of state to support the participant to return to Maine.

Costs for this service may occur before the participant is enrolled in the waiver, but the provider may bill for the service only after waiver enrollment.

The average caseload for a CRC is 27 participants per CRC. A CRC's caseload may include only participants enrolled in the Lifespan Waiver.

In some situations, a CRC may offer to drive a participant to a scheduled meeting or appointment. This is optional and occasional and does not replace NET, or Community Transportation services under this waiver, or any other available transportation services.

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

A participant may receive up to 180 days of this service prior to enrollment in the Lifespan Waiver. This service cannot be provided after the person is enrolled in the waiver. All claims for this service must be submitted in the first month of the person's waiver enrollment.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Case Management

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

Minimum Requirements

A. Bachelor's Degree from an accredited educational institution in Social Work, Psychology, Education, Human Development, Nursing, Rehabilitation, or directly related human services field and a minimum of two (2) years' experience in providing support services and/or (paid or unpaid) direct care to clients/families with disabilities or providing support services in a directly related human service field.
B. In accordance with DLC's Home and Community Support Services rule (10-144 Ch 108) and OADS Certification Requirements for Agencies Seeking to Provide Community-Based Targeted Case Management for Adults with IDD and ASD rule (14-197 CMR Ch. 10) CRCs must receive the following trainings within 6 months of hire and annually thereafter:
1. Person-centered practices. (Example: Learning Community for Person-Centered Practice and the LifeCourse Nexus);
2. Discovery;
3. Employment First training ;
4. Social role valorization; and
5. Alternatives to guardianship, including supported decision making.
C. Department-approved training (equivalent to the current Target Case Management (TCM) training).
Supplemental Trainings include one or more of the following:
1. Building Community and Relationships Training 10-12 hours
2. Work and Benefit Navigator Training (MMC/BCS) 6 hours
3. Employment training for CRCs
4. START training (Care Coordinator and Case Manager Training by the National Center for START Training)
D. In addition to the Department-approved CRC training the CRC must complete the following Department-approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months.
1. Reportable Events System (14-197 C.M.R. ch. 12) and
2. Adult Protective Services System (14- 197 C.M.R. ch. 12)
3. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5).
4. Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury (14-197 C.M.R. ch. 1).
5. CRCs, regardless of capacity and prior to provision of service to a participant, must be trained upon hire and annually thereafter on the HCBS Global Rule.
6. CRCs, regardless of capacity and prior to provision of service to a participant, must be trained upon hire on the Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

Supervisors must meet all requirements of the CRC position.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1. Complete the enrollment process for MIHMS including the Provider Agreement.

2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transportation provides rides for non-medical trips. It helps participants access integrated places and resources in their integrated community of choice—such as jobs, adult school sites, volunteer sites, places of worship, stores, banks, and activities with friends and family specified in the PCSP. If needed for health and safety, an escort may go with the participant.

The provider may deliver this service only when the participant is not going to a MaineCare covered service at the destination. It may be authorized when free or low-cost options are not available, or when paying out-of-pocket would cause a financial hardship.

This service does not replace NET, which covers rides to medical visits or other Medicaid covered services. Community Transportation is not reimbursed when transportation during the service is included as a component of the rate paid for the service.

Community Transportation may be provider-managed or self-directed. When Community Transportation is If provider-managed, staff members delivering Community Transportation must meet the direct service provider qualifications that have been specified for the service.

This service may be provided to participants who are temporarily located outside of the state for travel to connect with family or friends or other time-limited circumstances when such services are determined to be necessary and no other means of support is available. The provider must address health and safety needs during a period of travel or temporary out-of-state stay. Community Transportation services may not be delivered for more than 14 calendar days consecutively per calendar year.

Additional Standards:
A. This service is not available when another MaineCare reimbursable service is being provided at the destination location (except Co-Worker Supports), including virtual MaineCare reimbursable services.
B. This service does not duplicate NET offered under 1915b authority as described in this waiver.
C. Residential services providers (including Shared Living) are responsible for transporting participants to access integrated places and resources in their community of choice. Community Transportation is duplicative of this service.
D. If a participant uses self-direction and drives their own car to approved services or activities, the participant may not be reimbursed for mileage. If a participant drives a vehicle owned by someone else, only the vehicle's owner can be reimbursed for mileage. Self-Directed Community Transportation uses a set monthly budget.
E. Transportation of school-aged children to and from school is not reimbursed through Community Transportation services.
F. Provider agencies cannot be reimbursed over the maximum miles allowed per month for this service.

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:
Agency
Provider Type:
OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:

A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.

B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. DSPs must complete recertification training as approved by the Department to maintain active certification status.
3.DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.

C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.

D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.

C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

The participant or Authorized Representative must verify that prospective employees meet the following minimum qualifications:
1. Employees must be at least seventeen (17) years of age.
2. Employees must have a current and valid Driver's License based on state of residence.
3. Employees must provide proof of automobile liability insurance as required by law, if using their own vehicle.

The participant or Authorized Representative sets the standards for and conducts the training of each employee under Self-Direction. The participant or Authorized Representative must maintain documentation that the employee received adequate orientation to assure that the employee can meet the needs of the participant and demonstrate competency in all required tasks.

Employees may be the participant's family members.

If an Authorized Representative directs services on behalf of the participant, the Authorized Representative may not be paid to deliver this service.

If the guardian is acting as the Authorized Representative on behalf of the participant, the guardian may not be paid to deliver this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker's record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Employment Exploration

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

Employment Exploration is a targeted, short-term service (must be completed within ninety (90 days)) that helps a participant decide whether they want to pursue CIE or self-employment. It is meant for participants who are unsure about working and want to explore the idea and includes clear information so the participant can make an informed decision. This includes:
1. what CIE and self-employment can offer, such as valued roles, learning new skills, earning wages, having more control over money, and belonging in a workplace;
2. basic information about work incentives for people who receive public benefits (like SSI, SSDI, Medicaid, or Medicare), and how to access Benefits and Work Incentives Counseling for detailed guidance;
3. a simple explanation of how employment services work, including Vocational Rehabilitation;
4. information for guardians or family members, when applicable, to support the participant's right to choose whether to pursue employment; and
5. discussion and problem-solving around any concerns, hesitations, or barriers expressed by the participant or their family/guardian.

During Employment Exploration, the provider works with the participant to understand their interests, gifts, talents, skills, strengths, and conditions for success, looking at what kinds of work might fit them. The service also identifies barriers to employment—such as concerns, skill gaps, transportation needs, benefit worries, or other challenges—and helps the participant begin to address or resolve those barriers so they can make an informed choice about next steps.

A key part of the service is learning directly from within community settings. The participant takes part in business tours, informational interviews, and/or job shadows based on their interests, skills and individual goals. Each experience includes time to schedule or arrange for the opportunity, to support the participant in preparing for each experience, and to debrief afterward and talk through what they liked, didn't like, and learned. The provider develops an Employment Profile written in plain language on an OADS-approved form. The profile summarizes what was learned about the participant's goals, interests, skills, strengths, support needs and includes possible next steps or directions for the participant to take regarding employment. The Employment Specialist shares the Employment Profile with the PCSP planning team to guide and support the participant's employment planning.

The participant may access NET to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

Additional Standard:
A. Employment Exploration is not allowable in group settings (must be delivered on an individualized, 1:1 basis) or for participants who already know they want to work in CIE.
B. Service must take place in the community and may not take place in a provider owned and controlled setting or provider office setting.
C. Other face-to-face services may not be billed when this service is delivered face-to-face.
D. If a participant is already successfully employed in CIE, services may be used to explore advancement opportunities in their chosen career, if such services are not otherwise available to the participant through Vocational Rehabilitation.
E. Career Planning may not be provided concurrently with Employment Exploration.
F. The service may not be used to explore volunteer positions or employment in businesses owned and operated by a provider of waiver or Vocational Rehabilitation services.

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

This service is paid on an outcome basis after completion of the service and submission of a completed and acceptable Department-approved report.

The outcome payment is based on an average of thirty (30) total hours and must be completed within ninety (90) days.

This service can only be authorized one time per PCSP year.

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Exploration

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Department-approved Employment Specialist Certification.

The Department makes available an approved list of certifications on its website.

Other Standard *(specify):*

The Employment Specialist must:
1. Successfully complete a department-approved Employment Specialist Certification program prior to working with a participant.
2. Successfully complete the Work and Benefit Navigator training within the first year of employment.
3. Be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
4. Have at least one (1) year of experience working with individuals with disabilities.
5. Complete six (6) hours of Department-approved continuing education every twelve (12) months.

The Employment Specialist must also complete the following Department-approved trainings, within the first six (6) months from date of hire and thereafter every thirty-six (36) months.
1. Reportable Events System (14-197 C.M.R. ch. 12) and Adult Protective Services System (14- 197 C.M.R. ch. 12)
2. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5).
3. Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury (14-197 C.M.R. ch. 1).
4. Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).

The Employment Specialist must be trained upon hire and annually thereafter on the HCBS Global Rule.

In order to provide transportation in their own or an agency vehicle, the Employment Specialist or Co-Worker must meet the following requirements:

A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2.Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90) days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Vehicle registration and inspection must be current and valid.
F. Automobile liability insurance must be in effect.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Exploration

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Employment Specialist Certification.

The Department makes available a list of approved certifications on its website.

Other Standard *(specify):*

The participant or Authorized Representative must verify that each prospective Employment Specialist meets the following minimum qualifications:
1. Staff must be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
2. Have at least one (1) year of experience working with individuals with disabilities.

3. Hold and maintain a valid Department-approved Employment Specialist Certification.
4. Have successfully completed the Department-approved Work and Benefit Navigator Course.

The participant or Authorized Representative must submit minimum qualification documentation to the FMS to generate a background check and for record-keeping purposes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker's record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Empowerment and Systems Navigation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Family Empowerment and Systems Navigation Service: Family Empowerment and Systems Navigation services are short-term supports that help families, including the participant, learn how to identify and access all of the non-waiver services and resources available to them in addition to waiver services. The service is designed for people who live with a participant

or who are directly involved in supporting them through participation on the PCSP planning team. Shared Living-related providers are not eligible for this service.

The Navigator works alongside the participant and family to look at what the participant wants and needs, as already identified through the PCSP, and to understand the family's own goals and challenges in supporting the participant with these wants and needs. The Navigator considers the whole family context—daily routines, responsibilities, barriers, and strengths—so that the guidance and resources offered fit real-life circumstances.

After this assessment, the Navigator helps the family, including the participant, learn how to find and access non-waiver services and resources that match the participant's needs and goals. This may include teaching and supporting the family with how to research available programs, services, benefits, community supports, or organizations, and then teaching the family how to learn more about those options and how to access them. The Navigator also helps the family learn and practice how to make successful connections to those resources, which may include providing "warm hand-offs" when needed. A warm hand-off means the Navigator actively supports the first steps of connection - such as helping schedule an intake, joining a call if requested, or making introductions—so the family and participant are successfully linked to the right support.

The overall goal is to empower the family, including the participant, with information, resources, and connections while building the family's ability to solve problems and find/access community resources more independently over time. The service is meant to increase confidence and skill in navigating public systems and community resources, not to create long-term dependence on the Navigator.

The Navigator may attend meetings such as school meetings, Vocational Rehabilitation services appointments, medical visits, or other planning sessions when the participant or family asks. In these situations the Navigator supports the participant and family to speak for themselves and understand their choices. The Navigator does not advocate on their behalf or make decisions for them.

The CRC is responsible for monitoring the satisfaction of the participant and family served and documents the outcomes from this service on a monthly basis in the participant's record.

Additional Standards:
A. Families will have available access to one (1) Navigator.
B. This service may not be provided as companionship and/or social support for families.
C. These services may not be provided to Shared Living Related providers as the scope of this service is the responsibility of the Shared Living oversight agency if Shared Living Related providers have a need for this service.
D. Transportation of the participant or their family members is not included in the rate and outside the scope of expectations for the Navigator delivering this service.

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

The service is limited to authorizations no longer than six months for a maximum of one authorization per year.
This service is limited to 12 units per week.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Empowerment and Systems Navigation

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

N/a

Other Standard *(specify):*

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

Staff must be family members of someone with a disability, or otherwise qualified provider of this service, who have broad knowledge of the variety of non-disability-specific programs, local community resources, organizations and groups that are available to Lifespan participants and their families.

Any staff providing direct care must:
1. Meet all applicable provider standards and background check requirements established by the Department.
2. Have an adult protective and child protective record check.
3. Be at least eighteen (18) years of age.

Prior to service delivery staff must receive the following training:
1. The service definition, expected outcomes for service delivery, reasons the service is authorized (Content provided or pre-approved by OADS)
2. At least eight (8) hours in best practices for working with families, working with participants with intellectual disabilities, family empowerment strategies and community mapping techniques.
3. Participant-specific training including PCSPs and Service Implementation Plans

Staff delivering this service must complete the following Department approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months:
1. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
2. Adult Protective Services (10-149, Ch. 1)
3. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
4. Grievance Training (14-197, Ch. 8), and Reportable Events (14-197, Ch. 12).
5. Be trained on the HCBS Global Rule (10-144 C.M.R. Chapter 10, MBM Chapter 1, Section 6).

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home-Based Independent Living Skills Training

HCBS Taxonomy:

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

Service Definition *(Scope):*

Home-Based Independent Living Skills Training is a short-term, goal-focused service that helps a participant learn skills they need to live independently at home. The service supports the participant to gain confidence while enabling them to successfully complete routine home tasks on their own and using AT or adaptive aids when helpful. The skills addressed are those the participant has identified as important for successful community living.

This service is centered on learning through teaching tailored to the individual. Staff provide step-by-step teaching of steps and skills needed to complete the desired tasks. The participant has opportunities to practice tasks in real time. Staff do not take over or complete the task for the participant. They may demonstrate or assist with parts of the task only when that support is needed to help the participant learn.

Home-Based Independent Living Skills Training supports skill achievement in the following areas:
A. Personal hygiene, self-care routines, and daily wellness habits.
B. Food and meal preparation, including simple meal planning and safe kitchen routines.
C. Home upkeep and maintenance tasks, including outdoor chores when appropriate.
D. Money management at home, such as budgeting, paying bills, making deposits or transfers, and protecting personal financial resources.
E. Using home-based communication tools, including phones, tablets, computers, or other devices used to manage daily life and stay connected.
F. Personal safety routines within the home.
G. Parenting skills, when the participant has minor children living in the home.

For each goal, the provider creates a structured teaching plan for the desired skills. The plan breaks the task into clear steps and uses evidence-based strategies, such as task analysis and systematic instruction, to support learning at a reasonable pace. When multiple staff provide this service, they use the same approach so the participant receives consistent support.

Because the service happens in the participant's home, parents, family members, or other natural supports may be encouraged to observe when appropriate. This helps them understand how the participant is building skills, reinforce progress between sessions, and support continued independence after the service ends.

Home-Based Independent Living Skills Training is different from Personal and Home Assistance. This service is time-limited and intended to help the participant learn to complete specific tasks without ongoing paid staff support. Ongoing home assistance is used when a participant has an assessed need for ongoing help to complete tasks over time.

This service does not cover any needed AT or adaptive aids that may be necessary for independent performance. If needed, these are covered through the AT and Adaptive Aids service or other sources that must be used first, if available to the waiver participant.

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

Duration of service is based on each learning goal and the participant's progress.

Authorizations are individualized and generally do not exceed 12 weeks per goal.

One additional authorization of up to 12 weeks may be approved when progress shows the participant is likely to meet the goal with continued short-term support.

This service is limited to 5 hours per week (20 units).

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Based Independent Living Skills Training

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

The participant or Authorized Representative must verify that each prospective employee meets the following minimum qualifications:
1. Staff must be at least seventeen (17) years of age.
2. Staff must complete a no-cost OADS training on supporting community relationships and involvement (4 hours).
The Department makes available a list of approved certifications on its website.

The participant or Authorized Representative must submit minimum qualification documentation to the FMS to generate a background check and for record-keeping purposes.

The participant or Authorized Representative sets the standards for and conducts the training of each employee under Self-Direction. The participant or Authorized Representative must maintain documentation that the employee received adequate orientation to assure that the employee can meet the needs of the participant and demonstrate competency in all required tasks.

Any employee may be a family member of the participant.

If an Authorized Representative directs services on behalf of the participant, the Authorized Representative may not be paid to deliver this service.

If the guardian is acting as the Authorized Representative on behalf of the participant, the guardian may not be paid to deliver this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker's record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Based Independent Living Skills Training

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:

A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.

B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2.Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.

C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.

D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

DSPs must have current CPR and First Aid Certification before working alone with a participant.

In order to provide transportation staff must meet the following requirements:

A. Must be at least eighteen (18) years of age.

B. Must have a current and valid Driver's License based on state of residence.

C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)

3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.

D. Must have a current and valid vehicle registration.

E. Must have current and valid vehicle inspection.

F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Providers delivering Home-Based Independent Living Skills services must comply with the Department's EVV system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

The service is centered on helping the participant access housing that is affordable, accessible to the extent needed, and supportive of full community inclusion. The Housing Counselor works with the participant using a service implementation plan that reflects the participant's housing goals, preferences, and support needs.

Counseling and assistance may include exploring rental and homeownership options; considering living alone or with roommates/housemates of the participant's choosing; and identifying preferred neighborhoods, housing types, and features that fit the participant's lifestyle and daily routines. The counselor helps the participant understand the full costs of housing, compare options, and determine what is financially realistic. This includes identifying income, benefits, and other resources that may be used for housing, and discussing how earned income—or changes in earned income—may affect housing affordability or eligibility for supports.

Housing Counseling may support situations where the participant lives alone or with others they choose. A non-provider third party may co-own or co-lease the housing with the participant if that person also lives in the home. Shared Living providers may not co-own or co-lease the home. If needed to qualify for a rental or mortgage, a non-provider third party may also serve as a guarantor.
Housing Counseling also includes identifying accessibility needs and supporting the participant to plan for reasonable accommodations or modifications that may be necessary now or in the future. The counselor provides practical support so the participant can search for housing, understand listings, contact landlords or sellers, evaluate options, and make informed decisions.

When the participant's goal is homeownership, the counselor assists with locating and accessing financing and with planning for ongoing costs, upkeep, and maintenance. When the participant's goal is renting, the counselor assists with locating and accessing rental subsidies or other affordability supports.

For participants who rent, the counselor helps them understand tenant rights and responsibilities. This includes reviewing leases, explaining how to request repairs or maintenance, and supporting the participant to understand and use the process for requesting reasonable accommodations or modifications. The counselor also helps the participant understand what steps to take if a complaint or dispute arises, with the goal of supporting informed self-advocacy and long-term housing stability.

Housing Counseling is time-limited but not a one-time service. A participant may access this service more than once if their housing needs change, a move becomes necessary, or new housing goals are identified. Housing Counseling focuses on obtaining and sustaining housing that the participant owns or leases. If the participant needs ongoing in-home supports after moving into their own home, those supports are provided through other waiver services.

Housing Counseling provides specialized assistance to a waiver participant to successfully obtain an integrated community living arrangement, where the waiver participant owns or leases the housing and not by any waiver agency service provider or related entity. A third party who is not a waiver agency service provider or related entity may co-own or co-lease the housing with the waiver participant, if they will live with the waiver participant (excluding Shared Living) or may act as guarantor, if necessary to enable the waiver participant to qualify for ownership or leasing.

The purpose of Housing Counseling is to provide specialized assistance to promote consumer choice and control of housing and access to housing that is affordable, accessible to the extent needed by the participant, and promotes community inclusion. Housing Counseling includes specialized counseling and assistance to the participant, based on participant needs and a service implementation plan reflecting these needs, which covers any of the following areas:
A. Exploring both home ownership and rental options.
B. Exploring both participant and shared housing situations.
C. Identifying financial resources and determining affordability.
D. Identifying how earned income, or an increase in earned income, could impact choice, access and affordability of housing

options.
E. Identifying preferences of location and type of housing.
F. Identifying accessibility and modification needs.
G. Locating available housing by educating and supporting the participant to search for available housing.
H. Identifying and assisting with access to financing if homeownership is goal.
I. Identifying and assisting with access to rental subsidies if renting is goal.
J. Educating the participant on the rights and responsibilities of a tenant, including how to ask for reasonable accommodations and modifications, how to request repairs and maintenance, and how to file a complaint if necessary; and,
K. Planning for ongoing management and maintenance if homeownership is goal.

A waiver participant who needs in-home support services to live in their own home may access these services under the waiver (e.g., Supported Living services; Home-Based Personal Assistance; Home-Based Independent Living Skills Training; Remote Monitoring and On-Call Response Service; Minor Home Modifications).

Additional Standards:
A. This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.
B. Waiver funds may not be used to purchase this service if it is otherwise available to the participant free of charge through another source.
C. This service may not be provided by an agency that delivers CRC to the participant.
D. If services are furnished to participants not yet enrolled in the waiver but returning to the community through enrollment in the waiver, the costs of such services are considered to be incurred and billable when the participant leaves the institutional setting and enters the waiver.

Such services do not duplicate Community Transition Case Management but rather provide additional specialized service focused on housing that is beyond the knowledge and skill base of the CRC.

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

Housing Counseling Services are time-limited services but are not one-time services and may be accessed more than once if needed. This service may be authorized no more than twice in a waiver year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Counseling

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

Minimum Qualifications:
Staff must have at least 2 years relevant experience in counseling people with disabilities on housing issues, developing Individualized housing plans, understanding how housing issues impact people with disabilities and can be effectively resolved for people with disabilities, and expertise in assisting participants with disabilities to find suitable housing.

Additionally, staff must:
1. Complete OADS Housing Counseling Curriculum prior to delivering services.
2.Receive training on the HCBS Global Rule (10-144 C.M.R. Chapter 10, MBM Chapter 1, Section 6).
3. Be at least eighteen (18) years of age.
4. Have graduated from high school or acquired a GED.
5. Have a background check consistent with this waiver.
6. Have an adult protective and child protective record check.

Staff delivering this service must complete the following Department approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months:

1. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
2. Adult Protective Services (10-149, Ch. 1)
3. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
4. Grievance Training (14-197, Ch. 8).

Staff providing transportation must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver’s License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1 . Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver’s license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant’s status change and they are in in arrears of child support payment(s), said driver’s approval would be revoked permanently.)
3.Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Start-Up Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Housing Start-Up Assistance is a housing service that provides short-term assistance when a participant is moving into their own home. It is for participants who are setting up a private residence that they rent or own in their own name and where they are responsible for their own living costs.

The Housing Start-Up Assistance provider must develop a SIP, as described in Appendix D of this waiver, with the participant which lists the tasks the participant needs to complete to move in, the timelines for each task, and any one-time start-up expenses that are approved in the PCSP. Housing Start-Up Assistance includes support to complete these tasks and, when needed, payment expenses that are necessary for the participant to safely move into and establish a basic household. These expenses may not constitute room and board.

Allowable expenses are limited to one-time costs needed to set up a safe, functional home. These may include:
A. Security deposits required to obtain a lease or rent a home.
B. Essential household furnishings and other items necessary to move into and live in the home such as:
- basic furniture (for example, a bed, table, chairs)
- basic household appliances necessary for move-in
- lamps and window coverings
- items for food preparation and eating
- bed and bath linens
- a first aid kit and emergency supplies.

C. Utility or service one-time, start-up fees or deposits (such as turning on electricity, heat, water, or telephone service).
D. One-time health and safety services needed before move-in, such as pest removal or a one-time deep cleaning.
E. Moving expenses needed to relocate into the new home.
F. Required accessibility adaptations that must be completed before move-in so the participant can safely enter, use, and live in the home.

Housing Start-Up Assistance is provided only when the support or expense is reasonable and necessary for the participant to establish the home, the need is clearly identified in the PCSP and move-in plan, and the participant cannot complete the move-in or afford the expense on their own. This service is used only when the needed supports or funds are not available through another program, benefit, or community resource.

Housing Start Up Assistance is a component of the Housing Counseling Service; to be referred to this service, one would need to work with their assigned Housing Counselor who would then make a referral to Housing Start-Up Assistance. Housing Start-Up Assistance needs must be documented clearly in the Housing Start-Up Service Implementation Plan. Housing Start-Up Assistance is a short-term, move-in support. It is not an ongoing housing payment, home maintenance service, or utility payment. The purpose is to remove practical and financial barriers so the participant can successfully move into housing they control and begin living there safely and independently.

Additional Standards:
A. This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.
B. This service is not available for participant's transition to a provider-owned or controlled setting.
C. Waiver funds may not be used to purchase this service if it is otherwise available to the participant free of charge through another source.
D. Housing Start-Up Assistance services do not include monthly rental or mortgage expense; food, regular utility charges; and/or recreational items.
E. When Housing Start-Up Assistance services are furnished to participants not yet enrolled in the waiver but returning to the community through enrollment in the waiver, the costs of such services are considered to be incurred and billable when the participant enters the waiver.

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

This service may be authorized for no more than one month after the participant moves into the unit.

Housing Start Up Assistance is time-limited but not a one-time service. A participant may access this service as part of Housing Counseling more than once if their housing needs change, a move becomes necessary, or new housing goals are identified. As a part of Housing Counseling, this service may be authorized, if needed, no more than twice in a waiver year. If the participant needs ongoing in-home supports after moving into their own home, those supports are provided through other waiver services.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Start-Up Assistance

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

Minimum Qualifications
Prior to service delivery, staff must:
1. Complete OADS-approved training on PCSP/SIP process and documentation requirements
2. Complete OADS approved Housing Counseling Curriculum
3. Complete training on the HCBS Global Rule (10-144 C.M.R. Chapter 10, MBM Chapter 1, Section 6).
4. Must have graduated from high school or acquired a GED.
5. Must have a background check completed consistent with Section 29 (ME.0467).10-6.
6.MMust have an adult protective and child protective record check.

Staff delivering this service must also complete the following Department approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months: Added here to align with Housing Counseling
1. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
2. Adult Protective Services (10-149, Ch. 1) Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
3. Grievance Training (14-197, Ch. 8).

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

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

Additionally, the service, equipment, or supplies must meet one or more of the following requirements:
A. Decrease the need for other Medicaid services;
B. Promote inclusion in the community; and/or
C. Increase the Participant's safety within the home environment.

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

The participant must use personal funds to purchase services, equipment, or supplies when available. When the participant does not have personal funds or funding through another source, the participant may access funds available in the budget. Availability of funds for Individual Goods and Services is contingent upon the combined cost of mandatory self-directed services, optional self-directed services, and traditional waiver services identified in the PCSP. The participant must develop a spending plan that details all service-related costs according to the participant's authorized budget limits and calculates any remaining funds available for identified Individual Goods and Services documented within the PCSP.

A participant may not "cash out" their services for the sole purpose of generating or increasing the available funds for Individual Goods and Services.

A participant may not roll over unspent Individual Goods and Services funds across fiscal years.

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

Individual Goods and Services are subject to an annual cap of ten thousand dollars ($10,000.00).

Individual Goods and Services that are not allowable:
1. Services, equipment, or supplies that are otherwise available under the waiver or State Plan including, without limitation, durable medical equipment;
2. Services, equipment, or supplies that were not previously identified in the participant's PCSP as medically necessary to meet an assessed need;
3. Services, equipment, or supplies the participant can acquire with available personal resources;
4. Services, equipment, or supplies for which the participant does not have sufficient, accrued funds in their Spending Plan, to pay for in their entirety if approved;

5. Cash Payments and gift cards;
6. Gifts or loans for Self-directed workers, family, or friends;
7. Food, beverages, or nutritional supplements;
8. Entertainment equipment or downloadable files/applications or supplies;
9. Air conditioners, heaters, fans, generators, and similar items;
10. Alcoholic beverages, tobacco products, vaping devices, or illegal drugs including Schedule I controlled substances with no federally approved medical use, in accordance with the Federal Controlled Substances Act;
11. Costs incurred by the employee associated with travel such as airfare, lodging, meals, etc. for vacations or entertainment;

12. Utility costs including internet/cable/telephone, rental costs, or mortgage payments;
13. Clothing, shoes, or other apparel;
14. Household furniture, appliances, and linens, towels, or drapes;
15. General household maintenance or repairs including electrical, plumbing, home decor supplies and related expenses;
16. Cleaning for other household members or areas of a home that are not used as part of the participant's personal care;
17. Medications vitamins, and herbal or other supplements, whether prescribed or available over-the-counter;
18. Experimental or prohibited treatments/procedures;
19. Household cleaning supplies;
20. Vehicle expenses including routine maintenance, repairs; insurance; or fuel for a personal vehicle or a vehicle belonging to a family member who performs tasks they are responsible for outside of personal care. (Mileage will not be reimbursed at an amount greater than the standard mileage rate in accordance with the Internal Revenue Service);
21. Landscaping, gardening and yard work; including equipment and supplies; lawn mowing; and snow clearing or removal
22.Pet and/or service animal care expenses including any costs related to acquisition, licensing, veterinary care (ongoing or emergent), neutering or spaying, training, food, clothing, leashes and harnesses, toys, or other costs incurred in the maintenance of the pet and/or service animal. Provided, however, that for the participant’s service animal(s) only, the participant may access IGS to purchase one session of service animal training, and subsequently one session of annual service animal re-training per service planning year;
23. Massages, manicures, pedicures or any cosmetic service or supply;
24. Recreational services and activities including related entrance fees, equipment, or supplies;
25. Room and Board costs, including meals for paid or unpaid supports providers; and
26. Any other item not specified which the Department determines does not meet the scope of service.

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

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

☐ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:

Agency

Provider Type:

Financial Management Services Provider

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

In order to administer and distribute funds for Individual Goods and Services, a provider must qualify for, and be approved as, an FMS agency. The FMS agency must administer and distribute funds for goods and services as outlined in the participant's PCSP and comply with the service description for Individual Goods and Services in Appendices C/1-C/3 and E of this waiver in its duty to screen, approve, and reimburse vendors.

The Provider Agency must attest to and retain documentation of completion of the service personnel requirements in the personnel record.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Integrated Employment Path Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Integrated Employment Path services provide short-term, community-based learning and work experiences that help a participant move toward CIE or self-employment. Through activities such as volunteering and other real-life work experiences, the participant builds general strengths, skills, and confidence that support employability. These experiences are designed to help the participant take the next steps toward getting and keeping CIE.

This service is only for participants who want to work in CIE and whose employment goal is clearly documented in the PCSP. The activities and supports must match the participant's specific career interests and CIE goal and must include strategies that support a successful transition into paid work.

These services may be authorized to complement Vocational Rehabilitation and other Lifespan services including Career Planning, Benefits and Work Incentives Counseling, Job-Career Development Plan and Outcome, and Self-Employment Plan and Outcome. If a participant does not receive any of the services listed above, this service cannot be authorized. When a waiver participant obtains individualized, CIE or self-employment, this service may only continue, if needed, for the first six months the participant is working in CIE.

Services occur in typical community locations, not in provider-owned or provider-controlled settings. The purpose is for the participant to practice in the same kinds of places where they will eventually work, alongside people without disabilities. Supports focus on building general, non-job-specific work skills that apply across many jobs.
Examples include helping the participant to

- Communicate effectively with supervisors, coworkers, and customers.
- Learn and use expected workplace routines, conduct, and professional boundaries.
- Practice appropriate dress, hygiene, and self-care for work.
- Follow directions, stay engaged in tasks, and build reliability and stamina.
- Develop problem-solving skills for workplace situations.
- Learn general workplace safety practices and how to navigate community work settings.

For participants whose goal is self-employment, the service may also support general business readiness skills such as:

- Scheduling and time management.
- Ordering supplies and managing inventory or equipment.
- Invoicing and tracking payments.
- Managing basic business accounts.
- Customer service.

Integrated Employment Path services must result in clear, measurable progress. The provider documents the knowledge, skills, and experiences the participant gains, in a way that can be added to a traditional or visual resume or portfolio. This information is shared with the participant's Employment Specialist using the DHHS report format so it directly helps with securing CIE. The expected outcome is measurable gains that contribute to obtaining and initially sustaining CIE.

Additional Standards:
A. Services may not be used to create a plan for volunteer positions or employment in businesses owned and operated by a provider of waiver or Vocational Rehabilitation services.
B. This service does not include payment for volunteer supervision or coordination rendered as a normal part of volunteering for a community organization.
C. This service will not duplicate other services provided to the participant. Face-to-face delivery of the service may not be billed during the same period of time (e.g., the same hour or 15-minute unit) when another face-to-face or virtual service is billed.
D. Service must take place in the community. The service may not take place in a provider-owned and controlled setting or provider office setting or the participant's place of residence; however, these settings are allowed as places to meet at the beginning or end of the service, as long as the service is not billed for time in these settings.

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

This service is limited to a maximum of 4 hours per day for up to two years so long as the participant is also engaged with Vocational Rehabilitation, Career Planning, Benefits and Work Incentives Counseling, Job-Career Development Plan and Outcome, or Self-Employment Plan and Outcome.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Integrated Employment Path Services

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

College of Employment Supports Certification

Minimum Qualifications for Hire:
A. 18 years of age or older
B. High school diploma or GED
C. Have at least one (1) year of experience working with individuals with disabilities.

Minimum Training Requirements:
1. Receive Job Coach Certification prior to working alone with a participant (including Job Coach training series-20 hrs., Natural Support and Fading training-5hrs, and Work and Benefit Navigator training-6hrs).
2. Complete Personal Care Matters (Open Futures Learning) prior to working alone with a participant.
3. Complete the Work and Benefit Navigator training within the first year of employment.
4. Complete training on the HCBS Global Rule (10-144 C.M.R. Chapter 10, MBM Chapter 1, Section 6).
5. Receive training on service definition and participant's PCSP
6. Job Coaches must also complete the following Department approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months:
A. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
B. Adult Protective Services (10-149, Ch. 1)
C. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
D. Grievance Training (14-197, Ch. 8).

Other Standard *(specify):*

In order to provide transportation staff, in their own or a provider agency vehicle, must meet the following requirements:

A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Vehicle registration and inspection must be current and valid.
F. Automobile liability insurance must be in effect.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Job Coaching

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual

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

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

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

Service Definition *(Scope):*

Job Coaching is individualized support from a qualified job coach that helps a participant succeed and stay in CIE or self-employment. The job coach uses job and task analysis to understand the participant's work duties, identify where support is needed, and provide the right kind of assistance so the participant can build skills, stay safe, and be successful at work. Job Coaching may be provided in person or remotely using technology, depending on what works best for the participant and the job.

Job Coaching can include support for the participant and, when needed, for supervisors or co-workers so everyone understands the participant's strengths, support strategies, and best ways to communicate. Job Coaching may also include support to help the participant report earnings to public benefit programs on time, when that is needed for work success.

Job Coaching is usually provided at the workplace, but it can also be provided in another location the participant chooses to meet with the job coach, or from the job coach's location if supports are delivered remotely. Job Coaching may be provided at home when it is directly related to self-employment tasks or to prepare for work, as long as it does not duplicate another service in the participant's plan. At minimum, Job Coaching includes monthly face-to-face contact with the participant (in person or virtual) and monthly contact with the employer.

Job Coaching is guided by a Job Coaching and Fading Plan that is based on the participant's goals, learning style, and support needs. The Job Coaching Plan focuses on helping the participant become more independent over time and on safely fading paid supports as the participant gains skills, access to effective technology and/or adaptive aids, natural supports, and customization of job duties if needed. Job Coaching strategies to allow for fading should include consideration of all of these methods for fading. The fading method(s) that are best for each participant will vary but should be identified and documented in the Job Coaching and Fading Plan. may include systematic skill-building, use of technology or adaptive aids, strengthening natural supports at work (such as supervisors and co-workers), and customizing job duties when needed to support success.
Job Coaching is provided only in CIE settings in the general workforce. The participant works alongside people without disabilities and earns at least minimum wage and no less than the typical wage and benefits paid by the employer for the same or similar work.

Job Coaching starts after the participant has obtained CIE or self-employment. Some participants may find work through their own networks or self-directed efforts; Job Coaching can still be used once employment begins if the need for ongoing support is documented in the person-centered service plan, including any health and safety needs at work.

Job Coaching may also be provided to participants who are self-employed when they need support to operate and maintain their own business. For participants with more significant or ongoing support needs, Job Coaching can be long-term, including for customized employment, when continued support is necessary to maintain the job due to changing responsibilities or life circumstances.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

Job Coaching must take place in the community and may not take place in a waiver or Vocational Rehabilitation provider managed setting, including provider office settings or provider-owned/leased businesses. Services cannot be used to create a plan for volunteer positions or employment in businesses owned and/or operated by a provider of waiver or Vocational

Rehabilitation services. This service does not include payment for the supervisory activities rendered as a normal part of the business setting.

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

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Job Coaching

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

College of Employment Supports (CES) Certification (Job Coach series -20 hrs.); Natural Support and Fading Training (5hrs); Work and Benefit Navigator Training (MMC/BCS) 6 hours;
The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program.

Minimum Qualifications:

A. 18 years of age or older
B. High school diploma or GED
C. Have at least one (1) year of experience working with individuals with disabilities.

Training Requirements:

1. Successfully complete a department-approved Job Coach Certification program, including natural supports and fading training, prior to working alone with a participant.
2. Successfully complete Personal Care Matters (Open Futures Learning) prior to working alone with a participant.
3. Successfully complete the work and benefit navigator training within the first year of employment.

4. Successfully complete training on the HCBS Global Rule (10-144 C.M.R. Chapter 10, MBM Chapter 1, Section 6).
5. Receive training on service definition and participant's PCSP
6.Job Coaches must also complete the following Department approved trainings within the first six (6) months from date of hire and thereafter every thirty-six (36) months:

a. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
b. Adult Protective Services (10-149, Ch. 1)
c. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
d. Grievance Training (14-197, Ch. 8).

Other Standard *(specify):*

In order to provide transportation staff, in their own or a provider agency vehicle, must meet the following requirements:

A. Must be at least eighteen (18) years of age.

B. Must have a current and valid Driver's License based on state of residence.

C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90) days. At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.

D. Vehicle registration and inspection must be current and valid.

E. Automobile liability insurance must be in effect.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and receive approval from the Office of Aging and Disability Services. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS Program Integrity Unit, OMS Provider Enrollment Unit, OMS Business Analytics, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Job Coaching

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Job Coach Certification.
The Department makes available a list of approved certifications on its website.

Other Standard *(specify):*

The participant or Authorized Representative must verify that each prospective Job Coach meets the following minimum qualifications:
1. Staff must be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
2. Have at least one (1) year of experience working with individuals with disabilities.
3. Hold and maintain a valid Department-approved Job Coach Certification.

The participant or Authorized Representative must submit minimum qualification documentation to the FMS to generate a background check and for record-keeping purposes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker's record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Job/Career Development Plan and Outcome

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03030 career planning

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

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

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

Service Definition *(Scope):*

This targeted service helps the participant get a job or move ahead in a job through individualized, CIE or self-employment. The provider will work with the participant to create a Job Development Plan or a Career Advancement Plan. The plan must be clear, detailed, and actionable. The provider will submit the plan to OADS. OADS will monitor the plan's implementation to support progress toward the participant's employment outcome using best practices for discovery-based job or career development.
Services include putting the plan into action and helping the participant obtain employment that matches the participant's desired outcome. Job development activities must be based on the participant's strengths, interests, and skills, and should focus on opportunities that are reasonably close to the participant.

This service may be used when the participant is not yet working in CIE, or the participant is already working in CIE and wants a promotion, and/or wants a second individualized CIE or self-employment opportunity.

When the service is focused on career advancement, the provider will develop and implement a plan that supports the participant to successfully achieve the participant's desired outcome. Career advancement goals may include increased income and improved economic self-sufficiency through a promotion or a second individualized employment or self-employment opportunity.

Payment is based on outcomes. Outcome payments are tiered by the participant's level of need, as established by the SIS-A. The provider may bill outcome payments only after submitting a Department-approved report that describes the outcome(s) achieved. The report must be sent to the CRC and the participant (and the guardian, if applicable) and must be approved.

This service must take place in the community and may not take place in a provider-owned or controlled setting, a provider office setting or the participant's place of residence. These settings may be places to meet at the beginning or end of the service, so long as the service is not billed for time in these settings.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

Job Career Development Plan and Outcome must not duplicate other services provided to the participant and face-to-face delivery of the service may not be billed for during the same period of time (e.g., the same hour or 15-minute unit) that another face-to-face service is billed. Only relatives not living with the participant may deliver this service if otherwise qualified, excluding natural or adoptive parents or an adult child by marriage or adoption.

The waiver will not cover services which are otherwise available to the participant under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). When it is determined that the public Vocational Rehabilitation (VR) program through the Division for the Blind and Visually Impaired (DBVI) and the Department of Vocational Rehabilitation (DVR) are not available to the participant in a timely manner, the participant may access waiver Work Supports-Individual.

The following are situations where OADS would consider VR or DBVI unavailable including unavailable due to being untimely:
1. the participant is determined to be ineligible for VR or DBVI services and receives written notice from VR or DBVI; or
2. the participant is competitively employed and needs assistance to transfer to a similar job; or
3. the participant is already competitively employed and solely needs extended supports to maintain the current job; or

4. eligibility determination and an Individual Plan for Employment (IPE) has not been developed and implemented within 120 days of the application date to VR or DBVI; or
5. the participant has received an offer of CIE through their personal network before implementation of the IPE, then VR and DBVI services are considered to not be available to the participant.
6. If VR or DBVI implements an order of selection, the participant may receive Employment Specialist services without a referral to VR or DBVI.

If this service is authorized, the agency must maintain documentation that the service is not timely available to the participant including any information regarding access or denial of VR and DBVI.

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

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Job/Career Development Plan and Outcome

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Employment Specialist Certification
The Department makes available a list of approved certifications on its website.

Other Standard *(specify):*

The participant or Authorized Representative must verify that each prospective Employment Specialist meets the following minimum qualifications:
1. Staff must be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
2. Have at least one (1) year of experience working with individuals with disabilities.
3. Hold and maintain a valid Department-approved Employment Specialist Certification.
4. Have successfully completed the Department-approved Work and Benefit Navigator Course.

The participant or Authorized Representative must submit documentation that prospective employees meet minimum qualifications to the FMS to generate a background check and for record-keeping purposes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker's record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Job/Career Development Plan and Outcome

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Department-approved Employment Specialist Certification
The Department makes available an approved list of certifications on its website.

Other Standard *(specify):*

The Employment Specialist must:
1. Successfully complete a department-approved Employment Specialist Certification program prior to working with a participant.
2. Successfully complete the Work and Benefit Navigator training within the first year of employment.
3. Be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
4. Have at least one (1) year of experience working with individuals with disabilities.
5. Complete six (6) hours of Department-approved continuing education every twelve (12) months.

Staff must also complete the following Department-approved trainings, within the first six (6) months from date of hire and thereafter every thirty-six (36) months.
1. Reportable Events System (14-197 C.M.R. ch. 12) and Adult Protective Services System (14- 197 C.M.R. ch. 12)
2. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5).
3. Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury (14-197 C.M.R. ch. 1).
4. Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).

Staff must be trained upon hire and annually thereafter on the Global HCBS Waiver Person Centered Planning and Settings Rule, MaineCare Benefits Manual, Chapter 1, Section 6.

In order to provide transportation in their own or an agency vehicle, staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on State of residence.

C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90) days. At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Vehicle registration and inspection must be current and valid.
F. Automobile liability insurance must be in effect.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Minor Home Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

Minor Home Modifications are physical adaptations to the private residence of the participant or the participant's family as documented in the PCSP, which are necessary to ensure the health, welfare and safety of the participant or enable the participant to function with greater independence in the home and in entering/egressing the home. These include adaptations that are not covered under other sections of the MBM.

All services shall be provided in accordance with applicable local, state or federal building codes. All providers must be appropriately licensed or certified in order to perform this service.

The State does not cover adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant.

This service is not available in provider-owned or controlled residential settings. Minor Home Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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

Minor Home Modifications are limited to a ten thousand-dollar ($10,000) limit in a five (5) year period with an additional annual allowance up to three hundred dollars ($300) for repairs and replacement per year. Minor Home Modifications that exceed five hundred dollars ($500) require documentation from a physician or other appropriate professional such as an OT, PT, or Speech Therapist, indicating that the purchase is appropriate to meet the participant's need.

Adaptations that add to the total square footage of the home are excluded from this benefit except when directly connected to completion of a permissible modification. These adaptations must be necessary for the participant to make use of the modification.

In-floor radiant heating is not allowed. General household repairs are not included in this service.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized independent service provider such as plumber, electrician, etc.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:

Agency

Provider Type:

Specialized independent service provider such as plumber, electrician, etc.

Provider Qualifications

License *(specify):*

State Licensure, if applicable

Certificate *(specify):*

Professional Certification, if applicable. Any other requirements set forth by the Department or participant if applicable.

Other Standard *(specify):*

Minimum requirements may include compliance with: Local and state building codes, Underwriters Laboratories, FCC, NFPA, Life Safety Code, or ADA.

Verification of Provider Qualifications

Entity Responsible for Verification:

OADS will perform verification of independent service providers (plumber, electrician, etc.) as needed. The provider agency is responsible for securing and maintaining documentation of independent service providers and will submit invoices to OADS for approval, prior to submitting them to MaineCare for reimbursement. The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Occupational Therapy (Maintenance)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

Occupational Therapy (Maintenance) includes direct therapy and consultation services to maintain the participant's optimal level of functioning within the participant's chosen environments. The intent is to prevent regression, loss of movement, injury and medical complications that would necessitate a higher level of skilled care.

Occupational therapy (maintenance) under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from Occupational therapy (maintenance) services in the State plan. State plan coverage limits therapies to participants with rehabilitation potential or to those participants who would experience significant physical decline putting them at risk for institutionalization.

Evaluative and rehabilitative Occupational Therapy is included in the State Plan and is not covered as a component of maintenance therapy under this waiver. The service is not available for participants under age 21, as it is covered under EPSDT. State plan services must be exhausted prior to accessing this service.

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

This service is limited to 50 hours per calendar year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Independent Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy (Maintenance)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

The provider of this service must be a Licensed Occupational Therapist, (OT/L) for Occupational Therapy Maintenance or a Licensed Occupational Therapy Assistant (OTA/L) under the supervision of a Licensed Occupational Therapist.

In accordance with 10-144 Ch. 119, Regulations Governing the Licensing and Functioning of Home Health Care Services, an Occupational Therapist employed directly or through a contractual relationship with a home health care agency may provide home health care services by virtue of possession of a current license to practice their health care discipline in the State of Maine. The professional must be employed directly by or through a contractual relationship with a home health agency.

Certificate *(specify):*

n/a

Other Standard *(specify):*

Any staff providing direct care must be trained on the Global Settings rule (10-144 C.M.R. Chapter 10, MaineCare Benefits Manual Chapter 1, Section 6).

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy (Maintenance)

Provider Category:

Individual

Provider Type:

Independent Practitioner

Provider Qualifications

License *(specify):*

The independent practitioner of this service must be a Licensed Occupational Therapist, (OT/L) for Occupational Therapy Maintenance or a Licensed Occupational Therapy Assistant (OTA/L) under the supervision of a Licensed Occupational Therapist.

Certificate *(specify):*

n/a

Other Standard *(specify):*

The independent practitioner must:

1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
2. Received approval from OADS for provision of waiver services as required in MIHMS.

Any staff providing direct care must be trained on the Global Settings rule (10-144 C.M.R. Chapter 10, MaineCare Benefits Manual Chapter 1, Section 6).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Independent Practitioner must enroll with OMS and receive approval from the OADS. Oversight and responsibility of enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by OMS Provider Enrollment, but this action represents review by staff from some or all of the following areas: PIU, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Peer Specialist Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Peer Specialist Services are short-term supports provided by a trained peer—someone who has their own lived experience of disability. The Peer Specialist uses that shared experience to help the participant build confidence, skills, and knowledge to make their own choices and direct their own life.

The participant chooses the focus of support based on goals in their PCSP. Peer Specialist services may help a participant to:
A. Lead and speak up in their PCSP planning process.
B. Learn about self-direction and decide if it is right for them.
C. Learn about CIE or self-employment and explore whether working is a goal.
D. Understand and consider different living options, including supported living or living more independently.
E. Identify and strengthen trusted people ("natural allies") they can rely on for planning, problem-solving, and decision-making.
F. Build self-determination skills in another area that is clearly named in the PCSP.

This service is provided for a limited period of time, based on what the participant needs to reach their goal. The Peer Specialist's lived experience and skills must match the participant's goals and the area(s) being supported.

Peer Specialist s support participants in ways that promote self-determination and self-esteem. This includes helping participants to:
- see their own strengths and develop a positive view of themselves and their disability;
- practice self-advocacy and make informed choices, including understanding and taking reasonable risks when that helps meet goals;
- respond to low expectations, unfair treatment, or discrimination; and
- build connections, social supports, and allies in their community.

Peer Specialist services are provided one-on-one. The Peer Specialist shares information, models problem-solving, and offers encouragement and practical support so the participant can build skills and take the lead in their own decisions.

If a participant is temporarily outside Maine, Peer Specialist services may continue only when they are still needed to support the participant's goals and there is no other way to meet the need during that time. In those situations, the service may also include support for daily living needs or health and safety related to participating in service activities while traveling or staying out of state.

A Peer Specialist may, but is not expected to, provide transportation to the participant in their own vehicle.

a. The participant may access NET for transportation to and from the MaineCare enrolled locations where this service is delivered.
b. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

The participant will have access to one (1) Peer Specialist at any given time.

These services cannot be provided for companionship purposes only.

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

This service is limited to four hours per week on average, and these services shall not be provided for more than six (6) months unless documented circumstances clearly support continuation.

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Specialist Services

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

n/a

Other Standard *(specify):*

The provider must ensure all personnel are acting within the scope of their participant license or certification.

The qualified staff delivering Peer Specialist Services must have lived experience, be hired by an enrolled provider and complete an OADS-approved Peer Specialist training. The training must prepare the Peer Support Specialist to support and advocate alongside the participant including sharing real-life experience, engaging in collaborative problem-solving, and building skills to support informed choice and self-advocacy.

The provider agency must also ensure the Peer Specialist receives provider-sponsored training in the following areas
1. HCBS Global Rule (10-144 C.M.R. Chapter 10, MBM Chapter 1, Section 6).
2. Reportable Events (14-197, Ch. 12)
3. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
4. Adult Protective Services (10-149, Ch. 1)
5. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
6. Grievance Training (14-197, Ch. 8).

The provider agency must have:
1. Completed the enrollment process for MIHMS including the Provider Agreement.
2. Received approval from OADS for provision of waiver services as required in MIHMS.

The provider must ensure that any employee or contracted individuals delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee’s personnel file.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy (Maintenance)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical Therapy (Maintenance) includes direct therapy and consultation services to maintain the participant's optimal level of functioning within the participant's chosen environments. The intent is to prevent regression, loss of movement, injury and medical complications that would necessitate a higher level of skilled care.

The service may be provided to up to three (3) participants at once. If the service is provided in a group, the provider may not be billed to a participant rate.

Services related to activities for the general good and welfare of participants, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversional or general motivation, do not constitute physical or occupational therapy for MaineCare purposes.

Evaluative and rehabilitative Physical Therapy is included in the State Plan and is not covered as a component of maintenance therapy. The service is not available for participants under age 21, as it is covered under EPSDT.

State plan services must be exhausted prior to accessing this service.

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

This service is limited to 50 hours per calendar year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Practitioner
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy (Maintenance)

Provider Category:

Individual

Provider Type:

Independent Practitioner

Provider Qualifications

License *(specify):*

Registered Physical Therapist (RPT)

Certificate *(specify):*

n/a

Other Standard *(specify):*

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity Unit review, license verification.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

The Provider Agency must attest to and retain documentation of completion of the service personnel requirements in the personnel record.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy (Maintenance)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

The provider of this service must be a Registered Physical Therapist (RPT) for Physical Therapy Maintenance.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must ensure all personnel are acting within the scope of their participant license or certification.

Any staff providing direct care must be trained on the Global Settings rule (10-144 C.M.R. Chapter 10, MaineCare Benefits Manual Chapter 1, Section 6).

The provider agency must have:
Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
Received approval from OADS for provision of waiver services as required in MIHMS.

The Provider Agency must attest to and retain documentation of completion of the service personnel requirements in the personnel record.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing

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

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

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

Service Definition *(Scope):*

Private Duty Nursing services (PDN) under the Lifespan Waiver are supplemental, physician-ordered nursing services when State Plan nursing services are exhausted. PDN services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN to a participant in their place of residence or outside the participant's residence, when normal life activities take the participant outside their residence (school, preschool, daycare, medical appointments, etc.). Reimbursement for services provided outside a participant's residence may include only authorized nursing services. Services that can be reasonably obtained by the participant outside their place of residence are not covered.

For purposes of this Section, "place of residence" does not include such institutional settings as nursing facilities, ICF-IIDs, or hospitals.

If the service is available to the participant through PNMI, EPSDT, or Section 96 Private Duty Nursing services, the Private Duty Nursing service may only be accessed when these services are exhausted and additional nursing services are required. Additional Private Duty Nursing services are based on need, as determined by the Assessing Services Agency (ASA).

Nursing services are generally not covered when provided by the participant’s spouse; 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 a grandparent or grandchild; or any person sharing a common abode as part of a single-family unit.

Special Circumstances Nursing
In limited circumstances, a relative may be paid to provide PDN services to the participant under this waiver. This “special circumstances nursing” exception allows payment to a qualifying relative only when all of the conditions in this section are met. This exception may not be used for the parent of a minor participant.

1. Physician order and direction
a. Services are ordered in writing by the participant’s physician.
b. Services are furnished under the direction of that physician and consistent with the participant’s plan of care.
c. The physician’s order authorizing special circumstances nursing is renewed at least every six (6) months. If the order is not renewed, coverage under this exception ends until a new order is obtained.
2. Relative qualifications (all required)
The relative must:
a. Be a licensed nurse and meet all applicable licensing, training, and reporting requirements.
b. Be employed by a licensed home health agency.
c. Not conduct required assessments or develop the plan of care; an independent nurse or physician must complete these.
d. Implement the authorized plan of care.
e. Pass a criminal background check with no disqualifying convictions or substantiated findings of abuse, neglect, or misappropriation.
3. Relative circumstances (at least one required)
The relative must also meet one of the following:
a. Resigned from employment specifically to provide private duty nursing services to the participant; or
b. Reduced from full-time to part-time employment, resulting in less compensation, to provide private duty nursing services; or
c. Taken an unpaid leave of absence from employment to provide private duty nursing services; or
d. Incurred substantial expenses by providing private duty nursing services; or
e. Is needed to ensure an adequate number of qualified nurses to meet the participant’s plan of care due to labor conditions or intermittent hours of care.

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

PDN is not available except for limited, discrete hours during times when the residential provider or family/natural support cannot supply the needed nursing support.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Employee
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Individual Employee

Provider Qualifications

License *(specify):*

Registered Professional Nurse
A registered professional nurse employed directly or through a contractual relationship with a home health agency or acting as an individual practitioner may provide private duty nursing services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed.

Certificate *(specify):*

n/a

Other Standard *(specify):*

The participant or Authorized Representative must submit minimum qualification documentation to the FMS to generate a background check and for record-keeping purposes.

The participant or Authorized Representative must maintain documentation that the employee received adequate orientation to assure that the employee can meet the needs of the participant and demonstrate competency in all required tasks.

Any employee may be a family member of the participant.

If an Authorized Representative directs services on behalf of the participant, the Authorized Representative may not be paid to deliver this service.

If the guardian is acting as the Authorized Representative on behalf of the participant, the guardian may not be paid to deliver this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual. The participant or Authorized Representative choosing to self-direct submits documentation of the worker meeting the requirements to provide the service and a signed attestation to the FMS who maintains this information as part of the worker's record.

Frequency of Verification:

The participant or Authorized Representative choosing to self-direct is responsible for employee verification procedures. The FMS completes the background checks on behalf of the participant, prior to the participant's decision to hire the individual.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

1. Registered Professional Nurse
A registered professional nurse employed directly or through a contractual relationship with a home health agency or acting as an individual practitioner may provide private duty nursing services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed.

2. Licensed Practical Nurse
A licensed practical nurse employed directly by or through a contractual relationship with a licensed home health agency may provide private duty nursing services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed provided they are supervised by a registered professional nurse.

Certificate *(specify):*

n/a

Other Standard *(specify):*

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must have:
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
2. Received approval from OADS for provision of waiver services as required in MIHMS.

Providers delivering PDN services must comply with Maine DHHS Electronic Visit Verification system standards and requirements for these services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Remote Monitoring and On-Call Response Service

HCBS Taxonomy:

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

Service Definition *(Scope):*

Remote Monitoring and On-Call Response supports a participant to live safely in their own home by using live, two-way technology and staff who monitor from a different location. This service provides 24-hour monitoring only. It is not a telehealth visit or another waiver service delivered remotely or virtually. Remote/telehealth is a way to deliver other waiver services; Remote Monitoring is its own service focused on safety and check-ins.

With Remote Monitoring, awake staff at a remote monitoring base stay connected to the participant in real time through reliable equipment that allows live two-way communication. Staff do not watch recordings and do not have other duties while monitoring. The service is designed to respond to the participant's assessed needs at home while supporting privacy, independence, and choice.
Remote Monitoring may use one or more tools such as motion or door sensors, smoke or bed sensors, personal alert devices, live audio or video, web-based monitoring systems, or other technology that allows live two-way contact.

Every participant using Remote Monitoring has written up-to-date protocols as part of their SIP, described in Appendix D of this waiver, which explains what Remote Monitoring staff should do in different situations. This includes emergency and non-emergency situations. In the event of an emergency the remote monitoring provider must remain on the line with the participant until EMS or on-call response arrives. In the event of a non-emergency when on-call response is indicated, on-call response must arrive within no more than 30 minutes.

Every participant's plan includes an identified On-Call Response person who can go to the participant's home if in-person support is needed. At least one On-Call Response person is always identified, available and responsible for responding to the site of the participant's residence whenever indicated. The On-Call Response person may be a paid provider or an unpaid person(s) chosen by the participant and able to commit to filling the role (e.g., family member, neighbor). When On-Call Response is paid, that local provider is the main in-person contact for the remote monitoring agency.

Remote Monitoring is considered before authorizing more intrusive in-home services. The participant and planning team decide if Remote Monitoring is the right level of support to meet health and safety needs, based on the participant's preferences and the response plan. The response plan also describes what happens if the participant asks to turn off the monitoring equipment, including how health and safety will be protected during that time.

Remote Monitoring and On-Call Response may be used while a participant is temporarily out of state only when it is necessary to maintain health and safety and no other support is available.

If a Reportable Event occurs while a participant is receiving this service, the Remote Monitoring provider shall timely report the event and retain, or ensure the retention of, any video and/ or audio recordings and any sensor and written information pertaining to the incident for at least five years from the date of the incident to align with the requirements for retaining documentation as set forth in MBM, Section 1, Ch I.

Remote Monitoring shall only be provided in waiver participants' places of residence when paid or unpaid sources of support are not present in the residence, except temporarily, if needed, when the Remote Monitoring is being initially introduced. The Remote Monitoring and On-Call Response service is not available in Agency Group Home Per Diem. In Shared Living and Community Supported Living settings this service is only available when the Shared Living or Community Supported Living provider is not present.

When a participant receives Remote Monitoring with paid On-Call Response, the Remote Monitoring vendor shall bill for the Remote Monitoring portion of the service, and the On-Call Response provider shall bill separately for the On-Call Response portion of the service.

For children 21 years and younger, State Plan services available through EPSDT are utilized prior to expending waiver funds.

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

Remote Monitoring is limited to up to 12 hours per day when supported by assessment that indicates in-person staff would otherwise be required.

On call, in-person response is authorized for the same hours as Remote Monitoring when an unpaid person(s) is not available to provide this response if needed.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Monitoring and On-Call Response Service

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:
A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.
B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.
C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.
3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.
D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on state of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Providers delivering Remote Monitoring and On-Call Response services must comply with the Department's EVV system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Self-Employment Start-Up Plan and Outcome

HCBS Taxonomy:

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

Service Definition *(Scope):*

Self-Employment Start-Up Plan and Outcome is a short-term service that helps a participant plan and begin competitive integrated self-employment. It supports the participant to take a business idea they are interested in and turn it into a clear, workable plan, and then to move toward starting the business.

The service begins with at least one planning meeting with the participant and other people the participant chooses who will support them in this process. From these conversations, the provider creates a Self-Employment Profile. This is a simple "starting summary" of the participant's business direction. It explains:

- what kind of business the participant wants to try,
- what the participant is good at and enjoys doing,
- what supports they may need to run the business successfully, and
- what has already been learned from any other employment services they have received.

The Self-Employment Profile is not a formal business plan. It helps the participant and planning team understand the participant's ideas and strengths before building the full launch plan. During this early phase, the provider also supports the participant to access Benefits and Work Incentives Counseling focused on self-employment. The information from that counseling is used to guide the plan, especially around how business income may affect public benefits and what options the participant has.

Next, the provider supports the participant to write a Self-Employment Business Plan using the OADS-approved template. The Launch Plan lays out how the business will start and operate. It includes:

- what the business is and what the participant wants it to achieve,
- what product or service will be offered,
- who the customers are likely to be,
- what other businesses offer something similar and how this business will stand out,
- how the participant will reach customers and make sales,
- expected income and expenses, and
- possible ways to pay for start-up costs since Medicaid cannot pay for business start-up or other capital expenses.

As needed, the provider may support the participant to connect with regular community business resources in Maine—such as small business programs, training, mentors, or online tools—that can help develop or begin the Launch Plan. Once the Launch Plan is completed, the key parts are added to the participant's person-centered service plan. The Launch Plan is then submitted to OADS for approval before the business is launched. This review confirms the plan matches the participant's goals and meets expectations for competitive integrated self-employment.

This service may also be used when a participant wants to use self-employment to advance their career and increase income. In those situations, the service results in a clear career-advancement goal, a realistic plan to reach it through self-employment, and progress toward that outcome.

After the business begins, ongoing support to maintain it is available through Work Support–Participant services and/or

natural supports, as documented in the participant's plan. If Benefits and Work Incentives Counseling is needed later to maintain the business, Work Support–Participant may help the participant access it.

During the hours this service is provided, the provider is responsible for meeting any personal assistance needs the participant has so they can fully take part in planning and start-up activities.

The Self-Employment business must be owned or co-owned by the waiver Participant. The business may not be owned or co-owned by a provider of waiver, VR services or an Ability One or State Use employer.

The Self-Employment business must follow all state and federal requirements for business of the type established including tax, registration/licensing, and wage designations and reporting.

The Self-Employment business will be set up as a Limited Liability Corporation (LLC) or a Sole Proprietor designation, at a minimum.

This service does not include support for making a business plan that involves a goal to volunteer.

This service does not include support for making a business plan that involves a goal to sell products or services for income that is less than competitive wage, excluding the first two years after the business start date. after a reasonable start-up period for the business which can be up to two years not longer than two years after start-up.

This service does not include supporting paid employment in facility-based settings, or in a business social enterprise owned by a provider of waiver or Vocational Rehabilitation services, or an Ability One or State Use employer.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable. The participant may access Community Transportation services only when they need transportation to and from an integrated community location when NET is not allowable and transportation is not the responsibility of the provider.

This waiver will not cover services which are otherwise available to the participant under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). When it is determined that the public Vocational Rehabilitation (VR) program through the Division for the Blind and Visually Impaired (DBVI) and the Department of Vocational Rehabilitation (DVR) are not available to the participant in a timely manner, the participant may access waiver Work Supports-Individual.

The following are situations where OADS would consider VR or DBVI unavailable including unavailable due to being untimely:

1. the participant is determined to be ineligible for VR or DBVI Services and receives written notice from VR or DBVI; or
2. the participant is competitively employed and needs assistance to transfer to a similar job; or
3. the participant is already competitively employed and solely needs extended supports to maintain the current job; or
4. eligibility determination and an Individual Plan for Employment (IPE) has not been developed and implemented within 120 days of the application date to VR or DBVI; or
5. the participant has received an offer of CIE through their personal network before implementation of the IPE, then VR and DBVI services are considered to not be available to the participant.
6. If VR or DBVI implements an order of selection, the participant may receive Employment Specialist services without a referral to VR or DBVI.

If this service is authorized, the agency must maintain documentation that the service is not timely available to the participant including any information regarding access or denial of VR and DBVI.

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

Service to be authorized up to 50 hours for up to two months for the development of the Self-Employment Profile. Then, the service is authorized up to 50 hours for up to 2 months for development of the Self-Employment Launch/Business Plan. Then the service is authorized up to 9 months to achieve the start-up of the Self-Employment business. There may be one extension to the 9-month authorization if progress is being made on start-up, and additional time is needed. The extension may be no longer than 6 months.

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self-Employment Start-Up Plan and Outcome

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Department-approved Employment Specialist Certification
The Department makes available an approved list of certifications on its website.

Other Standard *(specify):*

The Employment Specialist must:
1. Successfully complete a department-approved Employment Specialist Certification program prior to working with a participant.
2. Successfully complete the Work and Benefit Navigator training within the first year of employment.
3. Be at least eighteen (18) years of age and have graduated from high school or hold a GED or equivalent.
4. Have at least one (1) year of experience working with individuals with disabilities.
5. Complete six (6) hours of Department-approved continuing education every twelve (12) months.

Staff must also complete the following Department-approved trainings, within the first six (6) months from date of hire and thereafter every thirty-six (36) months.
1. Reportable Events System (14-197 C.M.R. ch. 12) and Adult Protective Services System (14- 197 C.M.R. ch. 12)
2. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5).
3. Rights and Basic Protection of Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury (14-197 C.M.R. ch. 1).
4. Grievance Process for Persons with Intellectual Disabilities and Autism (14-197, ch. 8).

Staff must be trained upon hire and annually thereafter on the Global HCBS Waiver Person Centered Planning and Settings Rule, MaineCare Benefits Manual, Chapter 1, Section 6.

In order to provide transportation in their own or an agency vehicle, staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver’s License based on State of residence.

C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90) days. At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Vehicle registration and inspection must be current and valid.
F. Automobile liability insurance must be in effect.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Shared Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*

Shared Living is direct support that is individually tailored residential habilitation, personal care (e.g., homemaker, chore, attendant care, companion), protective oversight and supervision, and medication oversight (to the extent permitted under State law). These supports assist the participant with acquiring, retaining, and developing skills necessary for living in the most integrated setting appropriate to their needs including but not limited to adaptive skill development, assistance with ADLs and IADLs, community inclusion, transportation, and social and leisure skill development. The service facilitates the participant's full access to the greater community, including opportunities to seek employment and work in competitive, integrated settings; engage in community life, control personal resources, and receive services in the community like individuals without disabilities. Services are delivered according to the participant's PCSP.

The Shared Living Provider delivers services to the participant with whom they share a home. For the purposes of this waiver Shared Living Home means a single dwelling unit that is the primary and usual residence of both (a) one or two eligible participants receiving services and (b) one Shared Living Provider household, in which the provider has ongoing, round-the-clock responsibility for the adult's health, safety, and daily support. A Shared Living Home does not include an accessory dwelling unit, in-law apartment, or any other self-contained secondary dwelling unit located on the same lot or within the same structure, and only one Shared Living Home and one Shared Living Provider may be authorized in any single dwelling unit or at any single street address

The Shared Living Provider is a contractor of an Administrative Oversight Agency (AOA) who supports the provider in fulfilling the requirements and obligations agreed upon by DHHS, the AOA, and the participant's Planning Team as documented in the participant's PCSP.

The participant may access NET for transportation to and from the locations where this service is delivered. During service delivery the provider is responsible for transporting the participant as the reimbursement rate for this service includes the cost of transportation and is not separately billable.

Services authorized at provider-owned or controlled residential settings or disability-specific settings cannot be delivered out of state.

The State may allow a qualified legal guardian (when the legal guardian is a parent, grandparent stepparent, sibling, stepsibling, other biological family member or adoptive parent when the participant was adopted as a minor child) to deliver only the following provider-directed reimbursable services: Shared Living services and Community Transportation. Additionally, the State may allow qualified family members (including parent, grandparent, stepparent, stepsibling, other biological family member or adoptive parent when the participant was adopted as a minor child) to deliver only the following provider-directed reimbursable services: Shared Living, Community Transportation and Respite Breaks and Opportunities.

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

This service is billed at 350 days per year.

State Plan Services available through EPSDT are accessed prior to expending waiver funds for children 21 years and younger .

When a participant receives Shared Living Services, they may not also receive Agency Per Diem, Personal and Home Assistance or Respite Breaks and Opportunities services.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Shared Living

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

n/a

Certificate *(specify):*

Staff must obtain and retain the following certifications to deliver this service:
1. Cardiopulmonary Resuscitation/First Aide (CPR/FA) Certification
2. Department-Approved De-escalation Certification
3. Certified Residential Medication Aide (CRMA) Certification
4. Direct Support Professional Certification.

Staff may not work alone with a participant if they do not have CPR/FA, De-escalation, and CRMA Certifications. Staff holding the DSW Certification, but who have not yet received the DSP Certification, may work alone with a participant so long as they have received CPR/FA, De-escalation, and CRMA Certifications.

Minimum requirements to obtain and retain DSP Certification:
A. Individuals seeking certification as a Direct Support Professional (DSP) must:
1. Hold a valid Department-issued DSW certification; and
2. Successfully complete the Department-approved DSP certification program including the DSP Pathway within 6 months of hire.
B. Existing DSPs
1. Individuals who hold a valid DSP certification through the College of Direct Support must complete Unit 1 of the Department-approved DSP Pathway curriculum prior to working alone with a participant receiving waiver services.
2. Existing DSPs must complete recertification training as approved by the Department to maintain active certification status.
3. DSPs who fail to complete required recertification within Department-established timeframes will be considered to have a lapsed certification and may not provide reimbursable services until certification is reinstated.
4. DSPs employed prior to implementation of this waiver program must successfully complete the DSW curriculum within three (3) years of the date they first render services under the program.
C. Ongoing Competency and Recertification
1. DSWs and those that have completed the DSP Pathway must complete continuing education and recertification as approved by the Department, including annual and triannual modules.
2. The Department or its contracted training administrator monitors certification status and ensures timely completion of recertification requirements.

3. DSPs with a lapsed or inactive certification may not provide reimbursable services until certification is reinstated in accordance with Department procedures.
D. Ongoing Compliance
1. The provider must verify and retain documentation that DSWs and those that have completed the DSP pathway meet all applicable provider standards and background check requirements on an ongoing basis in accordance with this waiver and state regulation.
2. The provider must verify and retain documentation of certification and recertification status through the Department-approved certification tracking system prior to authorization of service delivery.

The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker (DSW) Training and Certificate Program. The Department does not offer CRP/FA, De-escalation or CRMA trainings.

Other Standard *(specify):*

DSPs must be at least seventeen (17) years of age.

DSPs who are between seventeen (17) and eighteen (18) years of age must be directly supervised by a supervisor or another DSP, both of whom must be over 18 years of age and meet all the qualifications of a DSP.

In order to provide transportation staff must meet the following requirements:
A. Must be at least eighteen (18) years of age.
B. Must have a current and valid Driver's License based on State of residence.
C. Must maintain an acceptable driving history. This means the driver must not:
1. Have more than two (2) chargeable accidents or moving violations in the previous three (3) years.
2. Have had their driver's license suspended or revoked within the last five (5) years. (Excludes participants whose cause for license suspension is for non-payment of child support (once the courts release the participant and such release can be verified, and the participant remains in good standing for a minimum of ninety (90)days). At any point should the participant's status change and they are in in arrears of child support payment(s), said driver's approval would be revoked permanently.)
3. Be convicted of two (2) moving violations and/or accidents during service delivery under this waiver or any MaineCare program where the driver was at fault.
D. Must have a current and valid vehicle registration.
E. Must have current and valid vehicle inspection.
F. Must have in effect automobile liability insurance.

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Office of MaineCare Services (OMS) and receive approval from OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Speech Therapy (Maintenance)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Speech Therapy (Maintenance) service supports the maintenance of the participant's current abilities and level of functioning. This service may include the delivery of direct therapy and/or consultation services in the participant's environment. The service provides ongoing therapeutic activities designed to sustain communication skills and prevent further decline.

Speech therapy (maintenance) under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from Speech Therapy (maintenance) services in the State plan. State plan coverage limits therapies to participants with rehabilitation potential or to those participants who would experience significant physical decline putting them at risk for institutionalization.

Evaluative and rehabilitative Speech Therapy is included in the State plan and is not covered as a component of maintenance therapy. State plan services must be exhausted prior to accessing this service. The service is not available for participants under age 21, as it is covered under EPSDT.

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

This service is limited to 50 hours per calendar year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OADS approved Provider Agency
Individual	Independent Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy (Maintenance)

Provider Category:

Agency

Provider Type:

OADS approved Provider Agency

Provider Qualifications

License *(specify):*

The provider of this service must meet licensure requirements as set forth in 02-643, Ch 1, Board of Speech Audiology and Hearing:
Speech-Language Pathologist
To qualify for licensure as a speech-language pathologist the applicant must satisfy the requirements of Pathway 1, Pathway 2 or Pathway 3 immediately below.
1. Pathway 1 – Transcript Analysis, Completion of Clinical Fellowship, Examination
A. A master's degree, doctoral degree or equivalent degree from an accredited institution:
(1) In a speech-language pathology program that was accredited by the Council on Academic Accreditation (CAA);
(2) In a program that was accepted by ASHA for certification purposes following evaluation by the Council for Clinical Certification at the request of the applicant; or
(3) In a speech-language pathology program which was substantially equivalent to the requirements of combined undergraduate and graduate coursework and supervised clinical experience contained in Standards III and IV of the ASHA 2005 Standards and Implementation Procedures for the Certificate of Clinical Competency in Speech-Language Pathology (CCC-SLP);
B. Completion of a clinical fellowship which was substantially equivalent to the requirements of a 36-week speech-language pathology clinical fellowship contained in Standard VI of the ASHA 2005 Standards and Implementation Procedures; and
C. Evidence of a passing score on the PRAXIS Examination in Speech-Language Pathology that was obtained no more than 5 years prior to the board's receipt of the license application.

2. Pathway 2 – Certificate of Clinical Competency
A. A master's degree, doctoral degree or equivalent from an accredited institution as described in Section 1(1)(A) of this chapter; and
B. A valid Certificate of Clinical Competency in Speech-Language Pathology from ASHA that is current at time of application.

3. Pathway 3 – Licensure in Another Jurisdiction
Proof of current licensure in another jurisdiction that maintains professional standards determined by the board to be substantially equivalent to those set forth in Section 1(1) or 1(2) of this chapter.

Certificate *(specify):*

See licensure requirements

Other Standard *(specify):*

Any staff providing direct care must be trained on the Global Settings rule (10-144 C.M.R. Chapter 10, MaineCare Benefits Manual Chapter 1, Section 6).

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with OMS and receive approval from the OADS. Oversight and responsibility of provider enrollment and verification activities is a shared responsibility. A number of entities within DHHS, including OMS PIU, OMS Provider Enrollment Unit, Division of Licensing and Certification (DLC) and OADS, share and review provider applications and requisite materials. OMS Provider Enrollment completes the final approval and verification.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy (Maintenance)

Provider Category:

Individual

Provider Type:

Independent Practitioner

Provider Qualifications

License *(specify):*

The provider of this service must meet licensure requirements as set forth in 02-643, Ch 1, Board of Speech Audiology and Hearing:
Speech-Language Pathologist
To qualify for licensure as a speech-language pathologist the applicant must satisfy the requirements of Pathway 1, Pathway 2 or Pathway 3 listed below.
1. Pathway 1 – Transcript Analysis, Completion of Clinical Fellowship, Examination
A. A master's degree, doctoral degree or equivalent degree from an accredited institution:
(1) In a speech-language pathology program that was accredited by the Council on Academic Accreditation (CAA);
(2) In a program that was accepted by ASHA for certification purposes following evaluation by the Council for Clinical Certification at the request of the applicant; or
(3) In a speech-language pathology program which was substantially equivalent to the requirements of combined undergraduate and graduate coursework and supervised clinical experience contained in Standards III and IV of the ASHA 2005 Standards and Implementation Procedures for the Certificate of Clinical Competency in Speech-Language Pathology (CCC-SLP);
B. Completion of a clinical fellowship which was substantially equivalent to the requirements of a 36-week speech-language pathology clinical fellowship contained in Standard VI of the ASHA 2005 Standards and Implementation Procedures; and
C. Evidence of a passing score on the PRAXIS Examination in Speech-Language Pathology that was obtained no more than 5 years prior to the board's receipt of the license application.

2. Pathway 2 – Certificate of Clinical Competency
A. A master's degree, doctoral degree or equivalent from an accredited institution as described in Section 1(1)(A) of this chapter; and
B. A valid Certificate of Clinical Competency in Speech-Language Pathology from ASHA that is current at time of

application.

3. Pathway 3 – Licensure in Another Jurisdiction
Proof of current licensure in another jurisdiction that maintains professional standards determined by the board to be substantially equivalent to those set forth in Section 1(1) or 1(2) of this chapter.

Certificate *(specify):*

See licensure requirements

Other Standard *(specify):*

The provider must ensure all personnel are acting within the scope of their position. The provider must ensure that any employee or contracted individual delivering this service to a participant meets all of the requirements of the position and any additional standards in accordance with this waiver. The provider must retain documentation of all training necessary to meet the requirements of this section in each employee's personnel file.

The provider agency must:
1.Complete the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS) including the Provider Agreement.
2. Receive approval from OADS for provision of waiver services as required in MIHMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency or individual must enroll with OMS and receive approval from the OADS. Oversight and responsibility of Enrollment activities is a shared responsibility. The application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment, but this action represents review by staff from some or all of the following areas: PIU, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:

The Provider Enrollment unit within OMS verifies provider qualifications at the time of enrollment and every five (5) years thereafter.

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered

planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Community Resource Coordination (CRC)
Home Support Agency Per Diem
Financial Management Services
Supports Brokerage
Behavioral Support Consultation
Benefits and Work Incentive Counseling
Community Connections Assistance
Community Supported Living
Community Transition Case Management
Employment Exploration
Family Empowerment and Systems Navigation
Home-Based Independent Living Skills Training
Housing Counseling
Housing Start-Up Assistance
Job Coaching
Job/Career Development Plan and Outcome
Peer Specialist Services
Remote Monitoring and On-Call Response Service
Self-Employment Start-Up Plan and Outcome

1. Will any in-person visits be required?

- ◉ **Yes.**
- ○ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

- ☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

At time of enrollment, and prior to the service delivery, providers must attest that the systems of support, including the technology required for remote service delivery or monitoring complies 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.

The state does not set regulations nor have oversight of participants' private residences. The CRC is responsible for monitoring and ensuring health and safety for the participant receiving waiver services in the home in accordance with applicable sections of the MaineCare Benefits Manual, including protecting individual rights and privacy. Cameras will not be placed in places where privacy is assumed including bedrooms and bathrooms.

The CRC must document in the PCSP the participant's selection and agreement to accept any service via remote means including the projected (as appropriate to the service) amount of time the participant will receive remote/telehealth vs. in-person delivery methods.

The CRC must also document in the PCSP agreement with the use of remote monitoring technology (e.g. cameras or other types of monitoring devices) by family members or housemates living in the same residence as the participant.

☒ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

All services delivered via remote means promote and ensure safety and functional skills independence across settings to support and prepare each participant to access, engage and integrate in the participant's community of choice in accordance with their PCSP.

☒ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

All Lifespan providers are required to comply with the safeguards and requirements outlined in MaineCare Benefits Manual, Ch I, Section 4, Telehealth Services. Additionally, as part of the PCSP team's obligation to ensure health and safety for the participant, the team must also ensure specific services delivered via telehealth are rendered in the most appropriate manner.

☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

The participant will meet with the provider agency to assess technology needs specific to their functional assessment in the place(s) where the participant will use the technology. The provider agency is responsible for training the participant regarding the use of all devices and equipment including the activation or deactivation of the equipment.

☒ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

The CRC is responsible for ensuring, monitoring and documenting the delivery and efficacy of the service through monthly contact with the participant, guardian and/or the Remote Support Provider.

The CRC must maintain a safety/risk plan describing the potential risks to the Member's health and welfare while receiving Home Support-Remote Support or other services that allow remote/telehealth service delivery and the reasonable steps to alleviate those risks. The safety/risk plan must be documented in the PCSP and reviewed at least annually or more frequently when the participant's needs change.

Further, the safety/risk plan must identify emergency back-up arrangements. Back-up plans will be specific to the participant and based upon their individual needs and include addressing contingencies for power outages and equipment/technology failure.

Appendix C: Participant Services

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

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

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

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Providers must conduct criminal background checks consistent with DHHS Division of Licensing and Certification Maine Background Check Center (MBCC) Rule (10-144 C.M.R. Ch. 60) as well as Child Protective Services (CPS), and Adult Protective Services (APS) background checks for all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Section.

Background checks on persons professionally licensed by the State of Maine must include confirmation that the licensee is in good standing with the appropriate licensing board or entity.

For participants choosing to self-direct certain services, the Financial Management Services (FMS) agency conducts the criminal background check on behalf of the participant or their Authorized Representative for all prospective employees. For the purposes of this waiver, the Authorized Representative refers to an individual responsible for managing self-directed services on behalf of a participant accessing Self-Direction.

The FMS also conducts background checks on the Authorized Representative who will act as employer of record (EOR), as described in Appendix E-1-a of this waiver, but in advance of performing any employer responsibilities under self-direction.

Employers must conduct background checks at least every five years following the date of hire or the anniversary date of a previous background check.

The agency provider or FMS agency is responsible for fees associated with conducting the background checks.

In accordance with Maine Statute, the MBCC maintains a list of disqualifying offenses that adversely affect an individual's eligibility for employment as a direct access worker. The provider/self-direction EOR shall not hire or retain in any capacity any person who may directly provide services to a participant under this waiver if that person has a record of committing any of the offenses on that list.

Additionally, MBM, Ch I, Section I, General Administrative Policies and Procedures (See § 1.03-3 (B)) establishes the conditions by which OMS shall deny enrollment or subsequent enrollment of any individual or entity seeking to deliver MaineCare covered services. OADS, DHHS Division of Licensing and Certification (DLC), and OMS Program Integrity Unit (OMS PIU) perform oversight and monitoring through ad hoc audits and when they receive a complaint. For those providers who are licensed, DLC routinely looks at personnel records to ensure that the background checks are conducted on all direct care workers. OMS PIU reviews credentials and background checks when conducting investigations or reviews.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) In accordance with state statute, 22 M.R.S. §1812-G, the Department must maintain a registry of Direct Care Workers who have criminal convictions in the last ten years and/or substantiated findings of abuse, neglect, or misappropriation of property.

Additionally, the provider agency or FMS entity will contact the CPS and APS units within DHHS to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a substantiated incident of abuse, neglect or exploitation by a prospective employee, it is the provider agency's or the self-directing participant and their Authorized Representative's (as applicable) responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with regulation.

(b) The Direct Care Worker registry must contain a listing of certified nursing assistants and direct care workers including but not limited to the following positions: direct support professionals; mental health rehabilitation technicians; personal care or support specialists; certified residential medication aides; and mental health rehabilitation technicians.

(c) The provider agency or FMS entity will verify that all staff have a criminal history check as required prior to enrollment and annually thereafter. DLC, OMS PIU and OADS provide oversight through ad hoc audit and when they receive a complaint. DLC routinely audits personnel records to ensure that the background checks are conducted on all direct care workers for all licensed providers. OMS PIU reviews credentials and background checks when conducting investigations or reviews.

(d) The provider agency or FMS entity must have written policies regarding continuity of care for any waiver participant whose service provider was added to the abuse registry. OMS reviews and approves these policies during provider enrollment and re-enrollment procedures.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments

are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

a. Types of legally responsible individuals and services they may provide:

In Maine, the legal responsibility of relatives is set forth in 19-A M.R.S. § 1504: “A person shall support that person’s child and that person’s spouse when in need.” “Child” is defined as “a person who has not attained 18 years of age.” 19-A M.R.S. §101(2). So, for adults (18 and older in Maine), family member legal responsibility for the support of the adult is limited to spouses; parents are not a “legally responsible relative” of their adult children.

Under this waiver, a qualified legally responsible individual may be paid to deliver only the services specified in Appendix C-1/C-3.

For the purposes of this waiver the following definitions apply:
Representative refers to an individual chosen by the participant, including a family member or friend, to assist with making decisions or communicating on behalf of the participant, but who does not necessarily have legal authority under state law. This designation is based on participant preference and does not require legal documentation.

Legal Representative/guardian/legal guardian refers to an individual who has been granted legal authority under Maine law to act on behalf of another person, including but not limited to:
a) a court-appointed guardian or conservator (See 18 C.M.R. § 5-301 and § 5-401),
b) an agent under power of attorney (See 18 C.M.R.§ 5-901 et seq.), or
c) a parent of a minor.

b. Method for determining “extraordinary care”
Payment may be authorized to a legally responsible individual only for the provision of “extraordinary care”. Extraordinary care is defined as care that:
Exceeds the range of activities that a parent of a minor child or a spouse would ordinarily perform in the household on behalf of an individual without a disability or chronic illness of the same age; and
Is necessary to assure the health and welfare of the participant and to avoid institutionalization.
The State determines that the amount of personal care or similar services provided by a legally responsible individual constitutes extraordinary care when all of the following conditions are met:
1. No alternative provider is available. There is no other willing and able provider agency or self-direction worker available to provide the authorized HCBS waiver services to the participant.
2. Care exceeds ordinary parental/spousal responsibilities. The legally responsible individual provides only those services that go beyond age-appropriate care typically expected of a parent or spouse for a person without a disability or chronic illness of the same age.
3. Need and amount of personal care or similar services are documented in the PCSP. The specific extraordinary tasks, amount, frequency, and duration of services are identified through the assessment and person-centered service planning process and documented as necessary to assure the participant’s health and welfare and to prevent institutionalization.
A legally responsible individual who meets these conditions may deliver services when employed by a qualified provider agency or when hired under the self-directed model.

c. State policies to determine that using a legally responsible individual is in the participant’s best interest
The CRC is responsible for determining whether the use of a legally responsible individual as a paid provider is in the best interest of the waiver participant through the comprehensive assessment and PCSP planning processes. The CRC reviews the participant’s assessed needs, goals, preferences, and risks. The CRC also considers the availability, capacity, and suitability of other individuals who are not a legally responsibility individual and evaluates potential conflicts of interest associated with a legally responsible individual serving as a paid provider.

The CRC documents the determination and rationale in the PCSP, including why the legally responsible individual is the provider most able to assure that services are delivered in a manner that supports the participant’s health, welfare, and person-centered outcomes. The PCSP planning team reviews and approves the use of a legally responsible individual as the provider when it is determined to be in the participant’s best interest.

d. State processes to ensure substituted judgment by legally responsible individuals with decision-making authority
When a legally responsible individual has decision-making authority over the selection of waiver service providers (e.g., as a legal guardian or other authorized decision-maker), the State uses the following processes to ensure that the legally responsible individual exercises substituted judgment on behalf of the participant rather than acting in

their own self-interest:
1. Person-centered planning expectations. During the PCSP process, the CRC informs the legally responsible individual with decision-making authority that decisions regarding providers, including any decision to select the legally responsible individual as a paid provider, must be based on the participant's preferences, goals, health and welfare needs, and what the participant would choose if able to express informed preferences.
2. Documentation of rationale. When a legally responsible individual is selected as a paid provider, the CRC documents in the PCSP how the decision reflects the participant's needs and preferences and why the arrangement is appropriate, including consideration of alternatives.
3. Conflict-of-interest review. The CRC and PCSP planning team review for potential conflicts of interest and may require additional safeguards (e.g., increased monitoring, additional unpaid advocates in planning) when a legally responsible individual makes decisions and provides paid services.
4. Ongoing monitoring. Through regular PCSP reviews and monitoring contacts, the State verifies that the services and provider selections continue to align with the participant's goals and preferences, and that the legally responsible individual's decisions remain consistent with substituted judgment on behalf of the participant.

e. Limitations on circumstances and amounts for which payment may be made
Payment to LRIs under this waiver is subject to the following limitations:
1. Extraordinary care only. Payment is authorized only for extraordinary care as described in subsection (b). Routine parental or spousal responsibilities otherwise done for a person without a disability or chronic illness of the same age are not reimbursable.
2. No other available provider. Payment may be authorized only when there is no other willing and able provider agency or self-direction worker available to provide the needed waiver services.
3. Within assessed need and service limits. The amount, frequency, and duration of services provided by an LRI may not exceed the participant's assessed needs, limits established in this waiver, or any applicable service caps and prior authorization limits.
4. No payment to either the legally responsible individual or the Authorized Representative. When the legally responsible individual is acting as the Authorized Representative under the self-directed model, that individual may not be paid to deliver any waiver services to the participant.
5. No duplication of payment. The State does not authorize payment to legally responsible individuals for services that are duplicative of services funded by other payers or programs.

f. Additional safeguards when legally responsible individuals provide personal care or similar services
In addition to the general waiver safeguards, the State employs the following additional safeguards when legally responsible individuals provide personal care or similar services:
1. Heightened review at authorization. Requests for legally responsible individual-provided services receive enhanced review by the CRC and as needed, supervisory staff to confirm that all criteria for extraordinary care, best interest and limitations on payments to legally responsible individuals are met and documented.
2. More frequent monitoring. Participants receiving services from a legally responsible individual may be subject to more frequent PCSP reviews or monitoring contacts to verify that services are appropriate, delivered as authorized, and aligned with participant outcomes.
3. Role separation where possible. The State prohibits a legally responsible individual from being both the paid provider and the Authorized Representative in the self-directed model and encourages the use of additional unpaid advocates or team members in planning when the legally responsible individual is a paid provider.
4. Provider compliance expectations. Any legally responsible individual functioning as a paid provider must deliver services in accordance with the service definition and comply with applicable training and documentation requirements as specified in regulation and this waiver

g. State oversight and procedures to ensure payment only for services rendered
The State employs the following controls and oversight processes to ensure that payments to legally responsible individuals are made only for services actually rendered and in accordance with the approved PCSP:
1. Prior authorization by OADS. OADS authorizes all reimbursable services based on the participant's assessed needs and approved PCSP.
2. Documentation requirements when paying legally responsible individual s. Providers and Authorized Representatives must document that all authorized services are delivered in accordance with the PCSP and must maintain adequate records (e.g., timesheets, encounter notes, staff schedules) to substantiate each claim.
3. Post-payment claims review. OMS performs post-payment claims reviews of authorized services, provider documentation, and employee staff schedules to ensure that claims align with services actually delivered and that

billed services were rendered as authorized.
4. Enforcement and corrective action. When discrepancies are identified, OMS may recoup overpayments, require corrective action plans, provide technical assistance, or apply other remedial actions consistent with state policy and provider agreements.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

A qualified legal guardian (who is also a parent, grandparent stepparent, sibling, stepsibling, other biological family member or adoptive parent when the participant was adopted as a minor child) may deliver self-directed services specified in Appendix C-1/C-3 or only the following provider-directed services: Shared Living services and Community Transportation. Additionally, qualified relatives (including parent, grandparent, stepparent, stepsibling, other biological family member or adoptive parent when the participant was adopted as a minor child) may deliver self-directed services specified in Appendix C-1/C-3 or only the following provider-directed services: Shared Living, Community Transportation, and Respite Breaks and Opportunities.

In either case, these services must be prior authorized and rendered in accordance with state regulations and this waiver. This includes meeting the qualifications and specifications for these services as outlined in C/1-C/3 of this waiver.

Legal guardians and relative(s) should be paid to provide waiver services only to the extent this is necessary to continue their role in the waiver participant's life as a source of natural unpaid support to the greatest extent possible.

Relatives and legal guardians may seek reimbursement from the NET broker for transportation to and from a MaineCare reimbursable services (including waiver services) if the relative or legal guardian is unable to transport at no charge, there is no other viable option, and the PCSP planning team recommends the same.

The CRC is responsible for determining whether the relative or legal guardian is the provider that can assure services are delivered in a way that is in the best interest of the waiver participant through comprehensive assessment and PCSP planning processes. This is documented by the CRC in the PCSP and approved by the PCSP planning team.

The State employs the following controls:
1. OADS authorizes all reimbursable services.
2. Providers must document that all authorized services are delivered in accordance with the PCSP and ensures that payments are made only for services rendered.
3. The State performs post-payment claims reviews of the authorized services, provider documentation, and employee staff schedules to ensure claims align with the services delivered.
4. If a participant requires or has selected an Authorized Representative to direct services on their behalf, the Authorized Representative may not also be paid to deliver waiver services to the participant. When the legal guardian is acting as the Authorized Representative on behalf of the participant, the legal guardian may not be paid to deliver waiver services to the participant.

The State performs post-payment claims reviews of the authorized services, provider documentation, and employee schedules to ensure submitted claims aligned with services delivered.

In Maine, the legal responsibility of relatives is set forth in 19-A M.R.S. § 1504: "A person shall support that person's child and that person's spouse when in need." "Child" is defined as "a person who has not attained 18 years of age." 19-A M.R.S. §101(2). So, for adults (18 and older in Maine), family member legal responsibility for the support of the adult is limited to spouses; parents are not a "legally responsible relative" of their adult children.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Any person or entity showing interest in various MaineCare programs may enroll as a provider so long as all necessary qualifications are met including holding a Medicaid provider agreement to deliver the service, except for transportation 1915(b) brokers and 1915(b)(4) providers who deliver CRC and/or Community Transition Case Management services specified in Appendix A of this waiver. Provider requirements and procedures to qualify to deliver services are on OADS website (https://www.maine.gov/dhhs/oads/providers/provider-application-onboarding-resources).

OADS accepts applications on an ongoing basis for entities seeking to become qualified to deliver home and community-based services. OADS utilizes an online portal for all application submissions which allows the applicant to complete the application and upload all required materials. OADS reviews the application for completeness, using qualification criteria. If all requirements are met during the application review, then a formal interview is conducted with the applicant to determine whether the applicant is willing and qualified to enroll. OADS conducts provider recruitment as necessary to ensure adequate access to services statewide.

In accordance with MBM, Ch I, Section 1 (1.03-1, Enrollment Process) entities or individuals must enroll in MaineCare including an executed Provider Agreement to provide home and community-based waiver services. All MaineCare providers are also required to revalidate their enrollment at least every five (5) years. MaineCare has a structured revalidation process with escalating outreach and consequences to ensure provider compliance with this requirement.

• Advance notification: MaineCare's enrollment vendor, Gainwell Technologies, sends written notices to providers 60 and 30 days before their revalidation window opens. These notices inform providers that their revalidation window will open and that they have 60 days to submit their revalidation without any impact on claims payment.
• Pend status after 60 days: If a provider does not submit the required revalidation information within the 60-day window, new claims are placed in a PEND status in the claims processing system until the provider completes revalidation.
• Disenrollment review at 90 days: If the provider still has not revalidated within 90 days, MaineCare reviews the provider for possible disenrollment. Gainwell's revalidation team, in coordination with MaineCare, conducts additional outreach (letters, email, and/or phone contact) to providers who have surpassed the 90-day mark to facilitate completion. If these efforts are unsuccessful, MaineCare disenrolls the provider from the program.

In addition to the formal 5-year revalidation process, provider oversight occurs throughout the five-year period through multiple state-level activities, as outlined in MaineCare rules and program integrity processes, including but not limited to:
• Ongoing program integrity and claims surveillance: MaineCare conducts pre- and post-payment review activities, including claims system edits, utilization review, and focused audits to identify aberrant billing patterns and potential non-compliance.
• Continuous eligibility and exclusion checks: MaineCare regularly screens providers and owners against state and federal exclusion databases and other required checks to ensure that excluded or otherwise ineligible individuals are not participating in the program.
• Licensure and certification monitoring: Providers must maintain any required state licensure, certification, or accreditation as a condition of participation. MaineCare may verify licensure status and take action if a provider loses or fails to maintain required credentials.
• Complaint- and incident-based review: MaineCare may initiate targeted reviews or investigations based on complaints, critical incidents, or other reports, and can impose corrective actions, sanctions, or termination as appropriate under state rules.

These combined activities operate continuously during the 5-year cycle and, together with the structured revalidation process, ensure that providers remain compliant with MaineCare and waiver requirements.

Additionally providers must maintain current licenses, as applicable, and submit copies of initial and renewal licenses to the OMS Provider Enrollment Unit. All applicants seeking to deliver Lifespan Waiver services and current providers seeking to add Lifespan to their service array must be licensed by DLC in accordance with 10-144 CMR Ch. 108, Home and Community Support Services Agencies Licensing Rule.

In accordance with this waiver, the providers must:
1. Complete the enrollment process for MIHMS including the Provider Agreement.
2. Receive additional approval from OADS for provision of waiver services as required in MIHMS Provider.
3. Maintain and retain copies of contracts or service agreements when the provider manages services delivered by another provider, thereby documenting the cooperative, affiliated service, or the subcontracting agreement. Providers must update

and renew the agreement at least annually.
4. Outline the business structure in an organizational chart, identifying management, staff and other individuals compensated by the provider for assisting in the care of participant(s) and illustrating the supervisory responsibilities; including credentials as required for service delivery.
5. Develop a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns, and volunteers.
6. Develop personnel policies that include a description of the education, experience, and training required for waiver service delivery including but not limited to, Direct Support Professionals, Supervisors, Program Directors, and administrative staff.
7. Develop and maintain policies governing essential elements of service provision including but not limited to, Behavioral Regulations, Rights and Protection, Reports of Abuse, Neglect and Exploitation, Duration of Care, and Medication Management.
8. Develop written policies and procedures governing the identification and oversight of services delivered or monitored by a legal guardian/family member, as well as development and maintenance of an effective quality management program to ensure quality service delivery consistent with federal and state laws and regulations.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- (●) **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ( ) **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - [ ] **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - [ ] **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - [ ] **The HCBS must be identified in the individual's person-centered service plan; and**
  - [ ] **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or***

certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of provider agencies whose staff meet licensure and certification and other waiver requirements prior to providing waiver services. Numerator: Total number of provider agencies whose staff have a license or certification and meet other waiver requirements prior to providing waiver services. Due to character count limit, see Main, Optional.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of agencies whose staff meet licensure and certification and other waiver requirements as measured annually. Numerator: Total # of agencies whose staff have a current license or certification and meet other waiver requirements as measured annually. Denominator: Total # of agencies reviewed whose staff are required to have a license or certification and meet other waiver requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of independent practitioners who meet licensure/certification/waiver standards prior to providing waiver services.
Numerator: Total # of independent practitioners who have a current licensure/certification/waiver standard prior to providing waiver services.
Denominator: Total number of independent practitioners reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of independent practitioners who meet licensure/certification/waiver standards annually. Numerator: Number and percent of independent practitioners who meet licensure/certification/waiver standards annually. Denominator: Total # of independent practitioners reviewed who are required to have a license or certification and meet other requirements as measured annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of provider agencies whose non-licensed and non-certified direct support staff meet all waiver requirements. Numerator: Total number of provider agencies whose non-licensed and non-certified direct support staff meet all waiver requirements. Denominator: Total number of providers agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

	Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of providers who have met all training requirements.
Numerator: Number of providers who have met all training requirements.
Denominator: All providers subject to training requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

Data Aggregation and Analysis:

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

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

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

DSW and DSP Certification is required for DSPs supporting waiver participants. The Department offers no-cost online training, certification, and recertification as described and defined in the Department's Maine Direct Service Worker Training and Certificate Program.

OADS staff work with local/agency administrators to monitor the learning management system and ensure completion of all required units prior to the provision of waiver services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Through formal and informal review, the OADS quality management (QM) unit reviews license/certification for all licensed and non-licensed providers of waiver services on an annual basis through on-site or desk review. In addition, the QM unit works with provider agencies on a quarterly basis to ensure that DSP waiver requirements are initially and continually met. Providers who fail to meet licensing or certification are referred to OADS senior management, DLC, and/or OMS PIU. Additionally, OADS reports any concerns about training to the OMS PIU.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ( ) **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- (●) **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☒ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

a. Waiver services to which the limit applies:
The State employes an annual monetary level limit methodology for each participant grouping.
This limit applies to all waiver services except the following which are paid outside the monetary level limit:

Assistive Technology
Behavioral Support Consultation
Peer Specialist services
Family Empowerment and Systems Navigation
Employment Exploration
Benefits and Work Incentives Counseling
Career Planning
Job/Career Development Plan and Outcome
Self-Employment Start-Up Plan and Outcome
Private Duty Nursing
Occupational Therapy (Maintenance)
Physical Therapy (Maintenance)
Speech Therapy (Maintenance)
Housing Counseling
Housing Start-Up Assistance
Minor Home Modifications
Supports Brokerage
Financial Management Services

b. The basis of the limit:
This waiver sets a prospective annual monetary level limit for each participant grouping. It uses the results of a valid and reliable support needs level assessment combined with age and living arrangement to generate the annual monetary level limit. (Age and living arrangement are two key factors that predict support costs.). A budget exceptions process is available when needed and is described in detail later in this section.

DHHS developed the monetary level limit methodology in collaboration with HSRI, Inc., Burns and Associates (a division of Health Management Associates), Airam Actuarial Consulting and Moving To A Different Drum, LLC. The Department is using the Supports Intensity Scale – Adult Functional Assessment tool, version 2 (SIS-A™) developed by the American Association on Intellectual Disabilities and Developmental Disabilities (AAIDD). The SIS-A is a valid, reliable instrument to assess a participant's support needs level in major domains of daily living, as well as behavioral and medical needs. These assessments identify the level of support necessary but do not identify the sources of support available to the participant. The sources (e.g., State Plan; EPSDT; waiver; IDEA; VR; natural supports; community supports) are identified during the PCSP planning process.

OADS has adopted a series of supplemental questions for the participant and those who know the participant best. These questions are asked during both assessments to identify exceptional behavioral, medical, and communication support needs, to ensure the annual monetary level limit takes account of these exceptional needs. All Lifespan participants receive the age-appropriate support needs level assessment prior to enrollment and every three years thereafter unless the participant experiences a change in condition that the PCSP planning team expects will last at least six months. In this instance the participant or guardian can request a new support needs level assessment. The support needs level and annual monetary level limit may be adjusted based on the new assessment results. The participant and guardian will be notified in writing by OADS of any adjustment to their support needs level and annual monetary level limit. The results of the support needs level assessment inform but do not replace the comprehensive assessment which is completed upon enrollment and updated no less than annually.

Age and living arrangement are used along with the support needs level to set the annual monetary level limit. The methodology for setting annual monetary level limits incorporates the projected service utilization and costs associated with each of these factors based on an analysis of these factors and their relationship to historical waiver utilization and costs. For adults 18+, the Department analyzed data for those enrolled in four of Maine's existing HCBS 1915(c) waivers [ME.1082, ME.0995, ME.0159, and ME.0467] and for children under age 18, the Department analyzed national Residential Information Systems Project (RISP) longitudinal

data on long-term services and supports for children with intellectual and developmental disabilities (www.risp.umn.edu). RISP provides figures from forty States addressing waiver spending on children as compared to adults. Similar to a support needs level change, if there is a documented change in age and/or living arrangement for a participant, the annual monetary level limit will be recalculated, and the participant will be notified in writing by OADS of their new annual monetary level limit.

The annual monetary level limit includes three components.

1. Living Arrangement:
This is the cost associated with the living arrangement chosen by the participant from among options appropriate to the participant's assessed need. This is determined through the comprehensive assessment and person-centered planning process. This is a pre-determined annual cost included in the PCSP, based on the participant's support needs level, the type and size of living arrangement and the established reimbursement rate. The rate methodologies and rates were developed through a 2024 cost study conducted for this waiver.
The range of living arrangements supported in Lifespan include living with unpaid natural support; independent living; community supported living; shared living; and group home. To qualify for one or more of these options, a participant must have assessed needs appropriate for the living arrangement and not otherwise have access to State Plan residential habilitation services.

2. Core Services:
This portion of the annual monetary level limit is for all services in addition to living arrangement, except for those services paid for outside of the annual budget limit since utilization is time-limited per service definition or because utilization is projected to be limited to a small sub-set of the entire waiver population.

The Core Services are:
Community Resource Coordination
Home-Based Independent Living Skills Training
Personal and Home Assistance
Respite Breaks and Opportunities
Remote Monitoring and On Call Response
Integrated Employment Path
Job Coaching
Co-Worker Supports
Community and Relationship Connecting
Community Connections Assistance
Facility-Based Day services
Community Transportation
Individual Goods & Services

3. Employment and Community Integration services Annual Budget Add-On:
This portion of the annual monetary level limit is only available if one or more of the following core services is included in the PCSP:
Integrated Employment Path services
Job Coaching
Co-Worker Supports
Community and Relationship Connecting
Community Connections Assistance
When, as a result of the comprehensive assessment and PCSP planning process, one or more of these services is included in the PCSP, the budget covers the differential per-unit cost associated with using one or more of these services rather than Facility-Based Day services. If none of the employment and community integration services are included in the PCSP, this add-on budget is not available.
The budgets for the "core" and "employment and community integration" components of the annual monetary level limit use historical service utilization levels including costs associated with the State's existing waivers and align these with Lifespan Waiver services and costs, based on support need level, age range and type of living arrangements being utilized.
Lifespan services are paid for outside of the annual monetary level limit as listed in this section when needed and based on comprehensive assessment and PCSP planning process.

The annual monetary level limits do not vary by geographic location. The methodology for determining annual monetary level limits is available for public review and inspection upon written request to OADS.
Through the comprehensive assessment and PCSP planning process, all waiver services a participant requires to meet their needs, address their goals, safeguard their health and welfare, and which are not available to the participant through another source, are included in the PCSP. Consistent with the purpose of HCBS waivers, the PCSP planning team initially makes every effort to meet the participant's identified needs and goals through the use of supports and services covered by private insurance, natural supports, generic community resources, services available through other public programs and systems, including the Medicaid State Plan, must be included in the PCSP. By doing this, the PCSP planning team will include Lifespan Waiver services in the PCSP, the cost for which will be within the annual monetary level limit.

c. How the limit will be adjusted over the course of the waiver period:
The limit will be adjusted when required due to any adjustment to reimbursement rates for services. The Department ensures participants experience no reduction in services as a result of reimbursement rate increases. The methodology will be re-evaluated in light of utilization patterns in the first five-year waiver period as part of the first renewal of this waiver.

d. Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; and (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs indicated below.

DHHS recognizes that exceptions may be required. Participants may have unplanned service needs and changes in their personal circumstances that require reexamination of their monetary level limit. A change may be temporary or permanent. It may require a one-time or short-term expenditure or a permanent adjustment to the annual monetary level limit. Participants may have needs that are extraordinary or fluctuate often as to require a permanent exception to the annual monetary level limit methodology. Accordingly, this waiver makes provision for these needs by reserving a portion of the overall waiver budget to meet these adjustments. Thus, if through the comprehensive assessment and PCSP planning process, it appears there may be a change in assessed service needs for a participant, causing the total cost of waiver services in the PCSP to exceed the annual monetary level limit, the participant/representative has the option to apply to OADS for a Request for Exception (increase) to the annual monetary level limit which, if approved, enables the participant to access these additional funds based on the following process:

As part of the PCSP planning process, waiver services are identified in the PCSP, including the amount, duration, and frequency of each service. The total cost of the PCSP is calculated by the CRC. If the total cost of the PCSP exceeds a participant's assigned annual monetary level limit, the CRC will inform the participant/Representative of the annual monetary level limit and the difference between the total cost of the PCSP and the annual monetary level limit. The CRC will inform the participant/Representative and the PCSP planning team the options to bring the PCSP total cost in line with the annual monetary level limit. Among other things, this may include where possible: the substitution of a less expensive waiver service for a more expensive waiver service if both services can effectively address the same need and/or goal., The CRC will make any required changes to bring the PCSP cost to within the annual monetary level limit. If the participant/ does not agree with any of the options available the CRC will assist the participant to seek approval to exceed the monetary limit, through a Request for Exception process ("exception process"). If the participant is receiving or will be receiving services under the State Plan, in conjunction with Lifespan Waiver services, any limits on those State Plan services remain applicable to the participant.

The Department complies with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134 and, as such, has policy and procedures in place to receive and process Title II modification requests, including requests to modify financial limitations pursuant to the ADA. Additionally, the following Request for Exception procedures for authorizing services that exceed an annual monetary level limit are applicable as part of the person-centered planning process:

A participant/Representative may submit a Request for Exception to exceed the annual monetary level limit for their participant grouping. DHHS recognizes that some Lifespan Waiver participants may need to submit a Request for Exception to seek services, consistent with their assessed needs, which are in excess of the otherwise-applicable annual monetary level limit for their participant grouping. Services sought may include

services that exceed the service-specific monetary and/or unit caps, if applicable.

Participants or their Representatives may seek an exception to the annual monetary level limit for their participant grouping by submitting a written request on a Department-approved Request for Exception form, which may be completed by the participant, the participant's Representative, and/or the CRC.

The Department, or its Authorized Entity, may approve a Request for Exception to an annual monetary level limit so long as the exception is submitted on the Request for Exception form, the details of the exception request are fully documented within the participant's PCSP, and the written request meets all of the below criteria:
1. The service(s) in the exception request is a Covered Service(s) that the participant is otherwise eligible to receive given the service limitations specified in the approved waiver and MBM.
2. The assessed need(s) for which the exception is requested cannot be met with a service, or combination of services, available to the participant through the State Plan.
3. The participant lacks access to natural supports, community supports/services, workplace supports/services, and other public/private services which can meet the assessed need(s) that the requested exception is intended to address. If available, all of these types of supports must be utilized to meet the applicant's needs first, and outlined in the PCSP, before waiver services will be authorized.
4. The participant reasonably requires the exception to achieve or maintain community living, and failure to grant the exception will place the applicant at serious risk of institutionalization or segregation.
5. The exception will ensure the participants' needs will be met in the most integrated setting where the needs, related to their goals, health and welfare, can be appropriately and effectively me.

Procedures and requirements for the Department's review and decision regarding a participant's Request for The Department shall issue a written decision ("Decision") on the Request for Exception within sixty (60) days of receipt of all materials submitted by or on behalf of the participant or requested by the Department.

The CRC shall note any approved exception to an annual monetary level limit, including the duration, in the participant's PCSP. An exception granted to a participant under this provision shall expire as set forth in the Decision.

The Department may deny a participant's Request for Exception to the annual monetary level limit if the Department has previously denied a substantially similar Request for Exception from the participant, or if the participant has previously been denied a reasonable modification under the Americans with Disabilities Act for a substantially similar request, unless new information is available regarding the participant's need for the requested exception.

Additionally, the Department may deny a Request for Exception to the annual monetary level limit (even if the participant demonstrates the exception is required to live in the most integrated setting and if the Department determines that any or all of the below applies:
1. The participant's health and safety cannot be assured in the community even if the exception is granted.
2. The exception, if granted, would fundamentally alter these waiver services.

A participant may appeal the Department's Decision on a Request for Exception to the annual monetary level limit, or a request to renew this type of exception, within sixty (60) calendar days through the Department's MaineCare appeals process as detailed in Chapter I, Section 1 of the MBM.

Request for adjustment to annual monetary level limit based on the participant identifying technical error in completion of the support needs level assessment:
A technical error is defined as one or more of the procedural requirements for administering the support needs level assessment not being met. If a participant/representative believes a technical error has been made in the determination of the support needs level, and they have not previously requested a reassessment of the determination for this reason, the participant/representative may request a support needs level reassessment. If through this process and use of the annual monetary level limit methodology, OADS determines that no adjustment to the annual monetary level limit is warranted, OADS will inform the participant or their legal guardian in writing that the request for reassessment has been closed and explain the procedures for receiving services within the annual monetary limit and for pursuing the "exceptions process". If the

participant/representative believes a technical error in the support needs level reassessment has been made, or that OADS has made an error in applying the support needs reassessment result to the annual monetary level limit methodology, the participant/representative may request a Medicaid Fair Hearing on this limited issue. They may not, at this juncture, request a Medicaid Fair Hearing on any other issues, including the sufficiency of the annual monetary level limit in meeting the participant's needs. During any Medicaid Fair Hearing process or exceptions process, the participant will continue to receive services as documented in their PCSP. Filing a Request for Exceptions is neither a waiver of nor a substitute for the Participant’s right to an administrative hearing on an appeal under Chapter I, Section 1; to file a grievance under 14-197 C.M.R. ch. 8; or to file a complaint pursuant to 34-B M.R.S. § 5611.

f. How participants are notified of the amount of the limit:
The participant is informed of the annual monetary level limit when, through comprehensive assessment of needs and PCSP planning process, it is initially determined that the participant’s needs for services exceed the annual monetary level limit. At that time, the CRC will follow the process as described above in (d) and (e).

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

Participants receive services in their own homes, in provider-controlled residential settings, in provider-controlled day habilitation settings, and in communities of their own choosing.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

In accordance with PL 2023 Ch. 89, Maine has developed regulations for licensing HCBS settings – CMR Chapter 108, 10-144, Home and Community Support Service Agencies Licensing Rule. This licensing rule in conjunction with the HCBS Global Rule will meet this requirement.

At the time of application for any new location, OADS reviews the applicant's policies and procedures to ensure compliance with the HCBS Global Rule. When the disability-specific/provider owned or controlled settings service location is identified the provider completes an HCBS Compliance Attestation form and is subject to ongoing monitoring through on-site reviews, desk level reviews or Participant Experience Assessments (IEA).

The State will use three types of ongoing monitoring activities to ensure previously enrolled providers maintain compliance with the HCBS Global Rule in provider owned and controlled settings and in settings the State could presume compliant. The three types of ongoing monitoring activities include Participant Experience Assessments completed with participants, on-site compliance visits, and desk level reviews.

Provider Owned and Controlled Settings (provider owned or controlled residential settings, Shared Living-Related Caregiver settings, and disability-specific non-residential settings):
The State expects to conduct on-site visits for every Provider Owned and Controlled Setting at least once every three to five years that includes a site survey and Participant Experience Assessment interview with a select number of waiver participants in that setting. For providers found to be out of compliance with the HCBS Global Rule, the State will issue a letter (including a notice of the provider's right to appeal) requiring that the provider submits a plan of corrective action. Failure to complete the plan may jeopardize the agency's ability to participate as a provider of HCBS services.

Participant Experience Assessments (IEAs):
OADS will ensure a selected number of participants per provider setting completes an IEA. OADS will review the completed IEAs and ensure the particular setting remains fully compliant with the HCBS Global Rule.

Onsite Compliance Visits:
OADS and/or the contracted entity will conduct onsite compliance visits for provider owned or controlled settings selecting a particular setting for review that has not received an on-site compliance visit in the previous three-to-five-year cycle.

Desk Level Reviews:
OADS will conduct annual desk level reviews for selected provider owned or controlled settings. OADS will ensure a provider selected for desk level review also engaged in a full onsite review in the previous three- to-five-year cycle.

Settings the State could Presume Compliant:
Individual Experience Assessments (IEAs)

For settings the State presumes compliant with the HCBS Global Rule (people's privately-owned/leased home or other individualized integrated community settings that are not provider owned or controlled and not disability-specific), the State will select a provider agency once every five years and in the selected year, all participants served by the provider agency will receive an IEA to complete. OADS will review and assess all IEAs to ensure that the participant's experience in that setting is consistent with the HCBS Global Rule.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices,**

including but not limited to, daily activities, physical environment, and with whom to interact.

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

○ **No, the waiver does not include provider-owned or controlled settings.**

◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☒ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☒ **Each individual has privacy in their sleeping or living unit:**

☒ **Units have entrance doors lockable by the individual.**

☒ **Only appropriate staff have keys to unit entrance doors.**

☒ **Individuals sharing units have a choice of roommates in that setting.**

☒ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☒ **Individuals have the freedom and support to control their own schedules and activities.**

☒ **Individuals have access to food at any time.**

☒ **Individuals are able to have visitors of their choosing at any time.**

☒ **The setting is physically accessible to the individual.**

☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Service Plan (PCSP)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☒ **Social Worker**

Specify qualifications:

State Employee- Human Services Caseworker
a. must have a bachelor's degree from an accredited educational institution in Social Work/Social Welfare; OR
b. must have a bachelor's degree in a related social service/social welfare/social work area which includes at least 12 courses in behavioral science, social science, or social work; AND
c. must have or be eligible for conditional or full licensure as a Licensed Social Worker (LSW) as determined by the Maine State Board of Social Worker Licensure.
d. Licensing requirements include full or conditional licensure as a Licensed Social Worker (LSW) as issued by the Maine State Board of Social Worker Licensure.

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

CRCs must meet with the participant prior to each planning meeting to provide the information that the participant needs, and also identify supports the participant needs, to lead the planning process as much as possible, make informed choices and decisions and ensure conflict-free planning. The planning process must reflect the participant's cultural preferences and provide information in plain language that is accessible to the participant and, when applicable, their legal guardian.

Additionally, in accordance with Maine law (Title 34-B §5466), participants are entitled to have access to an advocate. The CRC must ensure participants are aware of this entitlement prior to the planning meeting to allow for inclusion of an advocate when the participant so chooses. An advocate may assist and support the participant with leading the planning process, if the participant needs and wants this support, and is otherwise participating fully in the planning process.

The participant determines the composition of their Planning Team. The CRC will give adequate notice to participants if the participant wishes to attend and participate in developing the PCSP. Additionally, the participant's parent(s)/family member(s), if applicable, should have a participatory role, as defined by the participant, unless State law confers decision-making authority as a legal guardian. If such authority is conferred, the legal guardian(s), like all members of the Planning Team, must identify and try to mitigate any conflicts of interest, as well as make decisions based on what the participant would likely decide for themselves, if otherwise legally competent to make their own decisions.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

In all aspects, the PCSP, and the planning for the PCSP, must comply with the requirements of the Global HCBS Waiver Person-Centered Planning and Settings Rule ("Global HCBS Rule"), MBM, Chapter 1, Section 6.

a. Who develops the plan, who participates and timing of the plan.

Initial PCSP Prior to Enrollment:
The CRC develops and completes the initial PCSP in collaboration with the participant and their planning team prior to enrollment. Planning team members include the participant, legal guardian (if applicable), CRC and other individuals chosen by the participant. The CRC also informs the participant of their right to set the date, time, and location most convenient to the participant. The initial PCSP is developed after an eligible individual, offered enrollment, has completed a Supports Intensity Scale (SIS-A) Assessment. The PCSP is documented in OADS data management system .

For participants with a SIS-A resulting in a support needs level of 1-3, the initial PCSP addresses the need for the CRC service and any other services that are needed to address immediate health and safety. These needs are identified through informal and formal assessments completed during the application and initial PCSP process to include documentation from intake and referral sources, Department-approved standardized assessment tools, SIS-A assessment, and face to face meetings with the participant. The initial PCSP for participants with a SIS-A level of 1-3 may not exceed 60 days.

For participants with a SIS-A resulting in support needs level of 4, M or B, an initial comprehensive person-centered planning process [as described in (d) below] occurs and the PCSP is developed after a comprehensive assessment, exploration and discovery is completed by the CRC. This allows OADS to determine whether the participant's PCSP will exceed the cost limit for enrollment, and if so, to follow the process outlined in Appendix B-2-a. The initial comprehensive PCSP for participants with a SIS-A level of 4, M or B is not limited to 60 days.

Upon Enrollment:
Immediately upon enrollment, a CRC is assigned by the CRC agency that the participant selected from among available options presented by the OADS SW during the development of the Initial PCSP.

For participants with a SIS-A level of 1-3 who have an initial PCSP not exceeding 60 days, the CRC meets face-to-face with the participant (and legal guardian, if applicable) to complete the comprehensive assessment, exploration and discovery. The CRC then collaborates with the participant and their person-centered planning team to conduct a full person-centered planning process [as described in (d) below] to develop the first comprehensive PCSP within sixty (60) days of enrollment.

For participants with a SIS-A level of 4, M and B, who had an initial comprehensive PCSP developed prior to enrollment, at 90 days post-enrollment, the CRC is required to review the PCSP with participant, and legal guardian if applicable, and make any needed updates or changes to the PCSP.

PCSP Reviews and Revisions Over Time, Including Annual PCSP Update:

The CRC must revise the PCSP periodically including when a participant's needs change or the participant requests updating/revising the PCSP.

At least every 90 days, the CRC will monitor service delivery and make notes within the client database system of service delivery and record changes and reviewed with the participant/guardian. Any change or revision in the type, amount and frequency of services requires OADS approval and sign off from the participant/guardian and all providers responsible for implementing the service plan.

At least annually, the CRC must update the comprehensive assessment and facilitate the PCSP planning process, with the participant and their team, to update the PCSP. The PCSP process is the same process as described in (d) below for development of the initial comprehensive PCSP. Planning team members include the participant, legal guardian (if applicable), CRC and other individuals chosen by the participant. The CRC is responsible for ensuring participation is limited to providers and others necessary to support informed decision-making and the person's goals This annual PCSP planning process and PCSP update is preceded by eligibility redetermination in accordance with this waiver.

b. The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status:

The CRC completes a department-approved comprehensive assessment annually to support the PCSP planning process. The SIS-A support needs assessment is conducted prior to enrollment and then every three years, or more frequently as needed. In interim years, the Department will use the SIS-A Annual Review Protocol (ARP) to determine if significant changes of conditions occurred that warrant a full SIS-A be conducted.

The department-approved comprehensive assessment addresses the participant's strengths, desired goals, and desired outcomes of the service(s) that are authorized. The CRC will assist with identifying goals, related needs, health and safety needs, expressed preferences, areas of independence to be maintained, and areas where independence can be increased with the right services and supports. These supports can include technological supports.

The CRC also utilizes the "Charting the Life Course" tools focused on employment to identify employment goals and related needs to be addressed in the PCSP. Needs related the participant's defined goals are identified and carried over from the comprehensive assessment to the PCSP process and incorporated in the PCSP.

The assessment process also addresses the strengths of the participant's local community and natural support network, as well as what is necessary to effectively maintain and, where needed, expand the natural and community support networks. To augment and thus preserve these natural and community supports, the CRC identifies all other programs and services the participant is eligible for, in addition to this waiver. The assessments and tools, taken together, synthesize all of the information necessary to inform a robust PCSP planning process by the participant's planning team.

c. How the participant is informed of services under the waiver:

Prior to waiver enrollment, OADS provides information in accessible formats that describe the services available under this waiver. Once enrolled, the PCSP planning team identifies the necessary waiver services to meet the participant's assessed needs and identified goals including health and safety needs.

d. How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:

The PCSP planning process includes the following:
1. Defining the participant's vision for living their best life, including staying safe and healthy, and building on the participant's strengths, abilities and untapped potential for greater independence, community inclusion, and employment.
2. Identifying the participant's goals that are necessary for the participant to achieve or sustain their vision for a living their best life.
3. Identifying needs that must be met to ensure the participant can achieve or sustain their vision for living their best life, including health and safety needs.
4. Identifying supports and services available through sustainable natural/family relationships, local community resources, and/or other private or public programs and systems, including the MaineCare State Plan, which can meet one or more of the participant's goals and/or needs.
5. Identifying and choosing specific Lifespan Waiver services from among those services appropriate to the goals/needs, including healthcare needs, not otherwise addressed by non-waiver sources. Choice of setting(s) for each of the services is also facilitated, including the option of non-disability specific settings.
6. Determining, based on assessed need, the amount, duration and frequency for each Lifespan Waiver service identified.
7. Considering the options for self-direction or use of agency providers for identified Lifespan Waiver services.
8. Selecting a Financial Management Service (FMS) if the participant will be self-directing some or all of the services in the PCSP.
9. Selecting an agency provider when the participant will be using agency-managed service(s). As part of the person-centered service planning process, the Service Implementation Plan (SIP) is the provider's plan for how they will carry out the services in the PCSP. The SIP turns the participant's goals and needs into practical service strategies and explains what the provider will do to support progress. It includes clear, individualized steps for service delivery,

along with expected timeframes and any related needs or risk factors the provider should address. The SIP is attached to the PCSP record and reviewed with the participant (and guardian, if applicable) to make sure it matches the participant's goals and needs identified through the person-centered planning process. Together, the PCSP and SIP help ensure services are delivered as planned, coordinated across team members, and monitored over time. The selected agency providers are required to sign a SIP as a formal willingness to perform the service(s).
10. The CRC then reviews the plan to assure that all goals, needs and preferences have been addressed for the participant. The CRC then sends the PCSP to the participant and legal guardian (if applicable) for review and signature for approval.

e. How waiver and other services are coordinated:

The CRC is the lead in assisting the participant and/or guardian (if applicable) in coordinating waiver services with all of the other services and supports identified during the PCSP planning process and documented in the PCSP. The CRC monitors the implementation of the PCSP, including waiver service quality and effectiveness, while also collaborating with any other professionals and service providers responsible for non-waiver services.

The planning process identifies natural supports, waiver support, MaineCare State Plan and other generic community supports regardless of funding source. The PCSP documents all identified services and the CRC provides continuous and ongoing coordination and monitoring of service implementation.

Following the planning meeting, the CRC enters the PCSP in a web-based application as it was discussed and agreed upon during the planning team meeting including the scope, amount, type, frequency, name of service provider, service funding source, and start/end dates of the service.

As indicated in D-1-d above, each provider selected by the participant must complete a SIP describing the waiver service(s) the provider will deliver consistent with the PCSP. For each relevant goal, the provider must detail service delivery strategies that are specific, measurable, achievable, and include clear timeframes (i.e. start and projected completion dates) and related needs and risk factors for the requested waiver service.

The provider enters (or "attaches") the SIP into the PCSP within the web-based application noted above. The CRC verifies and documents the participant's agreement that the SIP is consistent with their needs and goals identified during the PCSP planning process.

The SIP is an optional tool for participants accessing Self-Direction, and OADS recommends and encourages its use in the PCSP planning process for self-directing participants.

f. How the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The PCSP lists the waiver services for the participant including the amount, frequency, name of service provider (or FMS/Support Broker if service is being self-directed), and start/end dates (duration) of the service. It also lists natural/family and other no-cost supports the participant will receive and from whom or what source. Finally, it lists the paid services the participant will receive from sources other than the waiver, including service provider name and source of funding. One activity of the PCSP planning meeting includes making an assignment of responsibility to a person to implement the PCSP. The service/support provider identified in the PCSP is assigned responsibility for the implementation of each specific service/support, based on the participant's goal(s), and/or assessed need(s) for which each service/support is authorized. Where there is a natural or other no-cost source, or a source other than waiver, the CRC is responsible for notifying the source of their role in implementing the PCSP if the source is not part of the PCSP planning team.

When a provider is selected by the participant, from among available and willing providers, the CRC assists the participant (and guardian if applicable) to request a Service Implementation Plan (SIP), to be integrated into the PCSP. The SIP details how the provider will implement the service with the participant in order to effectively address the identified goal(s)/outcome(s) and related needs for which the service is being authorized.

The CRC then reviews each SIP with the participant (and guardian if applicable) to ensure the SIP(s) is consistent with the goals/outcomes and needs of the participant, and the SIP(s) also reflects the preferences of the participant. If

any changes or additions are needed, the CRC communicates this to the provider. Once the SIP(s) is finalized and accepted by the participant (and guardian, if applicable), the CRC ensures the provider(s) is listed in the PCSP and the provider(s) signs the PCSP. The PCSP is then signed by the participant (and guardian if applicable) and the CRC which indicates the PCSP is agreed upon by all signers. The participant (and guardian if applicable) shall receive a copy of the PCSP and others as determined by the participant (and guardian if applicable). Waiver service providers (and FMS & Support Broker if applicable) who are responsible for some aspect(s) of implementation of the PCSP must also receive a copy of the signed PCSP within two (2) business days of the PCSP being signed by all required parties.

Once the PCSP is in place, the CRC begins monitoring and coordinating the selected services and supports in the PCSP, including waiver-funded agency-provided and self-directed services as well as other services and supports that have no cost and/or are funded through sources other than the waiver. The day-to-day monitoring of the implementation of the PCSP is the responsibility of the CRC in conjunction with the participant and guardian (if applicable). Unless otherwise specified in the PCSP, the CRC has no less than monthly contact and quarterly face-to-face contact with the participant (and guardian if applicable) to conduct thorough monitoring of the entire PCSP in order to identify any issues or needs that must be addressed by the CRC.

As previously noted, the PCSP lists the waiver services that are authorized for the participant including the amount, type, frequency, name of service provider, service funding source, and start/end dates of the service as well the natural/generic supports. During the PCSP planning meeting, the team discusses and documents the responsibilities for service delivery and support for each member of the participant’s team.

The CRC, participant and guardian (if applicable) are responsible for the day-to-day oversight, monitoring, and implementation of the PCSP. Minimally, and unless otherwise specified in the PCSP, the CRC meets no less than monthly with the participant to review the PCSP implementation. The CRC also conducts more in-depth monitoring through home and program visits quarterly.

g. How and when the plan is updated/changes to the plan:

The participant (and guardian, if applicable) reviews and updates the PCSP as necessary at 90-day intervals. The full planning team then redevelops the PCSP annually, after a full update of the annual assessment. Additionally, re-evaluation, and updating of the assessment and the PCSP must occur whenever a change in the participant’s needs occurs. Changes in the participant’s needs may include but are not limited to a change in medical/behavioral status; hospitalization; nursing facility stay; prior to a service change; prior to a change in service location, major life changes, or a change in outcomes/goals. The CRC is responsible for ensuring milestones related to the comprehensive assessment and the PCSP are met each year.

If changes are to be made, a revised PCSP must be created by the team and signed by the participant, guardian (if applicable), CRC, and any providers responsible for implementing the change.

The CRC reviews the PCSP every 90 days as part of monitoring of the services and plan. The participant/guardian, if applicable, can request a review or an update of the plan at any time.

h. How the participant engages in and/or directs the planning process:

The planning process must reflect the participant’s cultural preferences and provide information in plain language that is accessible to the participant and, when applicable, their legal guardian.
Additionally, in accordance with Maine law (Title 34-B §5466), participants are entitled to have access to an advocate. The CRC must ensure participants are aware of this entitlement prior to the planning meeting to allow for inclusion of an advocate when the participant so chooses. An advocate may assist and support the participant with leading the planning process, if the participant needs and wants this support, and is otherwise participating fully in the planning process.
The participant determines the composition of their Planning Team. The CRC will give adequate notice to participants the participant wishes to attend and participate in developing the PCSP. Additionally, the participant’s parent(s)/family member(s), if applicable, should have a participatory role, as defined by the participant, unless State law confers decision-making authority as a legal guardian. If such authority is conferred, the legal guardian(s), like all members of the Planning Team, must identify and try to mitigate any conflicts of interest, as well as make decisions

based on what the participant would likely decide for themselves, if otherwise legally competent to make their own decisions.

i. How the State documents consent of the PCSP from the waiver participant or their legal representative:

Following the planning meeting, the CRC enters the PCSP in a web-based application which was discussed and agreed upon during the planning team meeting including the scope, amount, type, frequency, name of service provider, service funding source, and start/end dates of the service.

If changes are to be made, a revised PCSP must be created by the team and signed by the participant, guardian (if applicable), CRC, and any providers responsible for implementing the change.

At least annually, the CRC must update the comprehensive assessment and facilitate a person-centered planning process, with the participant and their person-centered planning team, to update the PCSP.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**
- ☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The CRC identifies current and potential risks for the participant. In addition, the comprehensive assessment process identifies and documents past effective risk mitigation strategies. Risks may include such things as decision making, self-determination, mental health or behavioral health needs, self-harm, harm to others, risk of victimization, criminal behavior or legal issues, access to health and dental care, sleep and nutrition, family issues, housing safety and environmental safety. The risks and risk mitigation strategies identified are carried over to the PCSP planning process for discussion. When a participant's PCSP is being updated, the PCSP planning team also reviews all Reportable Events over the past 12 months including any remediation action steps implemented.

Through the PCSP planning process, risks are assessed by the CRC and the planning team in relation to the participant's current and desired vision for their life. Risks that are assessed and require current mitigation or as the result of the PCSP being implemented, are discussed along with past and current risk mitigation strategies that have proven effective for each of the assessed risks. The PCSP planning team identifies the most effective and least restrictive risk mitigation strategies that are consistent with the needs and preferences of the participant (and the guardian if applicable). This includes clarifying who will use these risk mitigation strategies in supporting the participant. The CRC must document the same in the PCSP.

The PCSP must also address rights modifications pursuant to the HCBS Global Rule and any rights restrictions and behavioral support interventions pursuant to 14-197 CMR Chapter 5. Documentation of less intrusive methods and any other approaches that have been tried unsuccessfully to mitigate risks must be included in the PCSP. Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications must be attached to the PCSP and approved by the Review Committee consisting of participants from DHHS, the Maine Developmental Services Oversight and Advisory Board (OAB), and Disability Rights Maine (DRM).

The PCSP planning team will develop back-up plans to address gaps in provider availability for either self-directed or agency-managed services. The CRC will document the same in the PCSP.

The planning team may develop a preventative back-up plan if crisis services are involved. DHHS has district crisis teams able to respond to emergency situations on a 24/7 basis. If a district crisis team intervenes three or more times within a two-week period, it will trigger a PCSP planning team meeting, focusing on the crisis situation and developing an interim plan or altering the current plan to reduce the risk to the participant and prevent continued crisis involvement.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The CRC ensures choice of providers during PCSP planning, when the participant expresses a desire to change providers, and when a participant stops self-directing services. The CRC meets with the participant and guardian (if applicable) to review the options available for qualified providers of the service(s) in the participant's PCSP for which a provider is necessary. OADS maintains a Lifespan Waiver provider directory on its website that includes a link to the providers' websites and the counties they serve. OADS staff reviews the Lifespan provider directory semi-annually and removes non-qualified providers from the list to ensure an accurate directory. The directory is located at: http://www.maine.gov/dhhs/oads/provider/developmental-services/directory/index.html.

When a service need is identified for a participant:

1. The CRC will use the provider directory on the OADS website to identify providers in the participants area. A provider directory is posted on the OADS website and is updated at least annually. https://www.maine.gov/dhhs/oads/providers/provider-directory/case-management.

2. As part of the service planning process, the CRC provides the participant with sufficient information and supports to ensure freedom of an informed choice of approved waiver providers.

The CRC may contact the waivers services unit to verify the enrollment of any provider. If the participant is interested in the services of a provider that is not approved to deliver waiver services, the waiver services unit may assist the provider with the MaineCare provider application process. Once a provider (or several) is selected for referral, the CRC will use request a proposed SIP from the provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

As described in appendix A of this waiver, OMS delegates authority to approve participant service plans to the OADS.

OADS PCSP Planning Process Instruction Guide ensures compliance with 42 CFR § 441.301(c). The HCBS Global Rule implements the federal requirements for Maine's Section 1915(c) home and community-based waiver programs set forth in 42 C.F.R §441.301(c) and also includes requirements for PCSP planning.

Please see OADS PCSP Planning Process Instruction Guide at the following link: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine-Person-Centered-Planning-Process-Instruction-Guide-Sections-13-21-29.pdf.

Further, the participant's PCSP documents the waiver services based on an assessment of functional need as well as the generic services and natural supports the participant receives. OADS reviews and authorizes necessary waiver services, up to prescribed service caps. The CRC review services and limits within the PCSP and approve the limits both annually and when there is any change in service.

OADS staff conduct a retrospective quality review of the PCSP as part of the certification requirements under 14-197 C.M.R ch. 10. The quality review evaluates whether PCSPs are conducted consistently with the Department's standards outlined in OADS PCSP planning Process-Instruction Manual.

OADS staff review a representative sample of all PCSPs from each individual provider agency during the agency's re-certification process. The State reviews a minimum of 10% of all PCSPs for each Case Management agency upon initial certification date and every three years thereafter. The review tool for the PCSP reflects requirements in 42 CFR §441.725 and Maine Revised Statues, Title 34-B §5470-B.

Annually, OADS provides Department-approved reports (that include appeals outcomes to assess trends in the fair hearings process and proper service planning) to OMS. OADS and OMS meet quarterly specifically to review Department-approved reports and identify trends that may require action. Additionally, OADS and OMS meet bi-weekly to review and discuss operational aspects of the waiver to identify and address individual problems that may arise.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

Specify:

Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

A. CRCs are responsible for monitoring the implementation of the PCSP. This includes monitoring the health, welfare and safety of the participant, as well as the effectiveness of services and supports being provided. The CRC completes regular reviews of the PCSP with the participant (and legal guardian if applicable) both virtually (minimum monthly unless otherwise specified in the PCSP) and in-person (minimum quarterly). The focus of the reviews is on the effectiveness of services and supports being provided to meet the needs of the participant in a way that assists the participant to achieve their goals and outcomes. The CRC supports the participant in obtaining and maintaining all waiver services and supports, as well as other non-waiver services and supports identified in the PCSP.

B. The CRC will check monthly and as needed with the participant and/or their guardian to discuss how implementation of the PCSP is addressing service delivery and if there are any issues or concerns. If a participant is seeking a provider(s), either through self-direction or provider agencies, the CRC will make frequent contact (minimum bi-weekly) with the participant to secure the needed provider(s) and to determine if the back-up plan is working in the absence of the provider(s). If a problem is identified in relation to the participant, the CRC will assess the severity of the problem and respond accordingly. CRCs use multiple sources of information and documentation to ensure the health, safety, and welfare of the participant. This is included in a monthly CRC activity tool, the Reportable Events system and documentation/contacts from others involved in the implementation of a participant’s PCSP. All Reportable Events are in the participant’s record.

C. The CRC can review Reportable Events in real time and every 90 days, as required. In the 90-day review, the CRC reviews all Reportable Events for the quarter to ensures any necessary changes to goals, outcomes, assessed needs, service types, back-up plans, identified risks and risk mitigation plans in the PCSP are made.

D. If a Reportable Event is filed for a participant, the CRC will review the Reportable Event and assess the severity of the incident. If immediate intervention by the CRC and/or changes to the PCSP are needed, the CRC will make contact with the participant and their PCSP planning team within three (3) business days to address the participant's emergent needs resulting from the Reportable Event.

E. The OADS data and compliance team collects and reviews data from PCSPs. Quarterly, the data and compliance team selects a random sample of participants for whom they review the current PCSP. This review ensures that all personal goals/outcomes and assessed needs (including health and safety risks) have been addressed through waiver services or other means and interim plans are in place for any unmet, assessed need(s). Results of the analysis are shared with the Waiver Manager and the OMS.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the**

participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
 # and % of PCSPs that address participants' assessed needs (including health and safety risk factors) and personal goals with waiver services or through other means.
Numerator: Total number of PCSPs that address assessed needs (including health

and safety risk factors) and personal goals with waiver services or through other means. Denominator: Total number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

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

Performance Measure:
Number and Percent of participant service plans that were updated on or before the participant's annual review date. Numerator: Total number of participant service plans that were updated on or before the participant's annual review date. Denominator: Total number of participant service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of participant service plans that were revised due to change in participant needs. Numerator: Number of participant service plans that were revised due to change in participant needs. Denominator: Total number of participant service plans reviewed that required a revision due to change in participant needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

	Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
 # and % of participants who received services in accordance with the specified type, scope, amount, frequency, and duration described in their authorized care plan.
Numerator: # of participants who received services in accordance with the specified type, scope, amount, frequency, and duration described in their authorized care plan.
Denominator: The total number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MaineCare claims data

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants with signed evidence of choice of services and providers. Numerator: Total number of participants with signed evidence of choice of services and providers. Denominator: Total number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

		Confidence Interval = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

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

When individual problems are discovered, they are reported to the appropriate staff at OADS and OMS, including senior management, as necessary. OADS may conduct audits as a result of any problems that arise. Additionally, the Compliance Team selects a random sample of current PCSPs for review each quarter. This review ensures that all assessed needs (including health and safety risks) and personal goals have been addressed through waiver services or other means and that interim plans are in place for all unmet needs. Results of the analysis are shared with the Waiver Manager and with OMS.

Transportation is provided through a brokerage system in Maine, via a 1915(b) waiver (Me.19). The transportation broker collects extensive data on performance measures for reporting on the 1915(b) waiver. The data will be provided to the 1915(c) waiver administrators for inclusion in the quality review process on an annual basis. Office of MaineCare Services and the program offices responsible for 1915(c) waiver administration (i.e., PIU and Financial Accountability) will work together to discover, identify and remediate any problems as they arise.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Annually, the quality management unit pulls a representative sample of participant records to ensure there is evidence to support that all participants have a signed Freedom of Choice; that each plan addresses the participant's identified needs for waiver services, health care and other ancillary services in accordance with their expressed preferences and goals; that services are delivered in the type, scope, amount, duration and frequency as specified in the service plan; and that significant changes in the needs of the participant have triggered a modification of the service plan. This information is tracked; any deficiencies are noted and reported to OADS for corrective action. Information is also shared with the OMS.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Direction under this waiver promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered. The participant makes decisions regarding certain waiver services and accepts the responsibility for taking a direct role in managing them in accordance with their needs and personal preferences.

For the purposes of this waiver the following definitions apply:

Whenever this waiver application refers to the election of self-direction or the exercise of decision-making authority, references to the participant mean: 1. the participant acting independently on their own; 2. a legal guardian when the guardian has the authority to make decisions on behalf of the participant; or 3. a (non-legal) Authorized Representative who has been freely chosen by the participant to make decisions on their behalf.

Representative refers to an individual chosen by the participant, including a family member or friend, to assist with making decisions or communicating on behalf of the participant, but who does not necessarily have legal authority under state law. This designation is based on participant preference and does not require legal documentation.

Authorized Representative refers to an individual responsible for managing self-directed services on behalf of a participant accessing Self-Direction.

Legal Representative/guardian/legal guardian refers to an individual who has been granted legal authority under Maine law to act on behalf of another person, including but not limited to:
a. a court-appointed guardian or conservator (See 18 C.M.R. § 5-301 and § 5-401),
b. an agent under power of attorney (See 18 C.M.R.§ 5-901 et seq.), or
c. a parent of a minor.

The term Employer of Record (EOR) refers to the self-directing participant or the Authorized Representative acting on behalf of the participant for self-directed services.

a. the nature of the opportunities afforded to participants:

This waiver offers participants the opportunity to self-direct certain services using employer authority or budget authority. Under employer authority, the participant is supported to recruit, hire, supervise, direct, and discharge the workers who furnish supports. The participant functions as the employer of their employees. Under budget authority, the participant accepts the responsibility to manage their self-directed budget. This authority permits the participant to make decisions about acquiring approved individual goods and services authorized in the PCSP and manage the dollars included in a participant-directed budget.

Additionally, under budget authority, participants manage and allocate funds accordingly as set forth in a “fixed budget” or in a “flexible budget” arrangement and specified in the PCSP. A fixed budget includes state-specified, direct vendor-purchased services for which the participant has only employer authority. The chosen Fiscal Intermediary (FI) to provide Financial Management Services (FMS) pays the vendor who procures or delivers the service up to the monetary value of the authorized service. There is no flexibility in how the fixed budget is spent outside of the prior authorized amount. A flexible budget includes state-specified services in which the participant has both employer authority and budget authority. The flexible budget arrangement allows the participant to exercise control over how their budget is spent on these services as necessary to live in the community. The participant may determine the wages of their staff as well as the types of allowable and necessary goods and services under this flexible budget arrangement.

Services that can be self-directed under fixed budget authority include:
Assistive Technology
Career Planning
Community Connections Assistance
Employment Exploration
Financial Management Service (FMS)
Home-Based Independent Living Skills Training
Job/Career Development Plan and Outcome
Job Coaching
Minor Home Modifications

Private Duty Nursing

Services that can be self-directed under flexible budget authority include:
Home-Based Personal Assistance
Respite Breaks and Opportunities
Community Transportation
Individual Goods and Services

b. how participants may take advantage of these opportunities:

Participants may take advantage of the self-directed opportunities through the PCSP process. The process for developing the PCSP will not be different from that of traditional waiver services as set forth in the HCBS Global Rule.

The participant's planning team will meet and develop the PCSP based on the participant's needs as identified in the Department-approved assessment and choices from among covered services appropriate to their needs. The CRC will discuss the option of self-directed services and provide information on services eligible under self-direction. Initially and annually thereafter, the CRC informs the participant and guardian (as applicable) about self-direction and available self-directed services using standardized written or electronic media materials.

The PCSP process will also determine if the participant, not subject to full guardianship, can self-direct independently or if they require an Authorized Representative. CRCs must use a department-approved questionnaire and assessment tool to support the determination.

The CRC submits the PCSP and a service authorization request to the Department for approval based on the participant's documented goals and needs and specifies the units of service assigned to each identified waiver service. The authorization request may include both traditional and self-directed waiver services.

c. the entities that support participants who direct their services and the supports that they provide:

The participant chooses an FI for both Budget Authority and Employer Authority. The participant must also choose a Support Broker to assist with the responsibilities of self-directing services. Participants must receive FMS and Supports Brokerage, at a minimum in order to access self-direction.

Support Brokers provide information and assistance to participants regarding self-directed services, including assistance developing the PCSP for self-directed services, and skills training for participants to exercise their Employer Authority.

FI performs financial transactions on behalf of the participant, ensuring the participant effectively carries out their responsibilities under the Employer Authority with Budget Authority.

At a minimum, the FI must deliver the following supports to the Self-Directing participant and/or Authorized Representative (when involved):
Employer authority: (minimum supports)
1. Assist the participants in verifying employee's citizenship status and completing the necessary background checks
2. Collect and process timesheets of the employees approved by the participant or Authorized Representative
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment- related taxes and insurance

Budget Authority: (minimum supports)
1. Maintain a separate account for each participant's budget
2. Track and report payments made and balances of participants self-directed funds
3. Provide participant with reports of expenditures and their self-directed budget.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Shared Living arrangements; Community Supported Living arrangements

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

A. Participants under full guardianship must have an Authorized Representative acting on their behalf and fulfilling the employer responsibilities associated with self-direction.

B. Participants must accept Supports Brokerage and FMS to access self-direction.

C. As a part of the PCSP process, the CRC will inform the participant about the self-direction opportunities available under this waiver, as well as the services allowed under the self-directed option.

D. Participants who are unable, as determined by the PCSP planning process, or unwilling to function as the employing authority, may select an Authorized Representative to do so. The Authorized Representative assumes all responsibilities as the employer on behalf of the participant but may not be employed as a direct worker.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The CRC is responsible for informing the participant about the opportunities for self-direction under this waiver, including the services that may be self-directed. Furthermore, the CRC must discuss the benefits and potential risks associated with self-direction along with information about the participant's responsibilities related to self-directing services. The CRC must ensure that the participant is supported to weigh the pros and cons of self-direction as well as to seek any additional information the participant requires to make an informed decision before electing this option.

In addition, the CRC must provide this information in writing or electronic media materials are in plain language, standardized and approved by the Department during the initial PCSP planning process and at least annually thereafter.

At a minimum the CRC must discuss the following with the participant:
A. Support Broker and FMS roles;
B. Benefits and potential risks associated with self-direction;
C. EOR's responsibilities including hiring, managing, scheduling, and discharging employees;
D. Options and requirements for appointing an EOR;
E. Services that can be self-directed; and
F. Opportunities for exercising Employer Authority and Budget Authority as well as the differences between fixed and flexible budgets.

Services that can be self-directed under fixed budget authority include:

Assistive Technology
Career Planning
Community Connections Assistance
Employment Exploration
Financial Management Service (FMS)
Home-Based Independent Living Skills Training
Job/Career Development Plan and Outcome
Job Coaching
Minor Home Modifications
Private Duty Nursing

Services that can be self-directed under flexible budget authority include:

Personal and Home Assistance
Respite Breaks and Opportunities
Community Transportation
Individual Goods and Services

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

If a participant requires or has selected an Authorized Representative to direct services on their behalf, the Authorized Representative may not be paid to deliver services to the participant. When the guardian is acting as the Authorized Representative on behalf of the participant, the guardian may not be paid to deliver direct support to the participant.

A participant under guardianship may have an Authorized Representative complete the employer duties on their behalf (including signing timesheets and managing employer responsibilities).

In addition to their obligation to report suspected abuse, neglect, or exploitation of the participant under Maine's Adult Protective Services Act, providers must report any allegation, assertion, suspicion, or indication that the participant has suffered a rights violation or unexpected death as a result of any act or omission by a current or former employee, contractor, consultant, or volunteer using OADS' Reportable Events reporting system. Further, providers must report incidents that may negatively affect the health or safety of a participant, such as a hospital admission or assessment at an Emergency Department or clinic through the Reportable Events reporting system.

During the initial PCSP planning meeting, and annually thereafter, the CRC must discuss and provide information in writing to the participant, guardian, and Support Broker regarding the procedures and contact information for filing a complaint or a grievance.

The CRC, Support Broker, and FI must report any complaints involving financial abuse, waste and fraud involving the participant, guardian, Authorized Representative, or any entity funded through a self-directed budget to OMS' PIU. The FI notifies the CRC and OADS resulting in a review and plan (as needed) for the participant's immediate health and safety as a result of the allegations. At a minimum, the FI is required to provide information and education on financial abuse, waste and fraud to the participant, Authorized Representative (as applicable) and Support Broker on an annual basis for reporting to PIU.

The FI and Support Broker, as the monitors of the participant-directed budget, provide support to prevent depletion of funds associated with overutilization and address potential service delivery problems associated with underutilization. The CRC, as the monitor of health and safety and participant rights, ensures the Authorized Representative functions in the best interest of the participant to meet their goals and outcomes outlined in the PCSP.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Career Planning	☒	☒
Community Connections Assistance	☒	☒
Community Transportation	☒	☒
Assistive Technology	☒	☒
Job Coaching	☒	☒
Employment Exploration	☒	☒

Waiver Service	Employer Authority	Budget Authority
Job/Career Development Plan and Outcome	☒	☒
Supports Brokerage	☒	☒
Respite Breaks and Opportunities	☒	☒
Financial Management Services	☒	☒
Personal and Home Assistance	☒	☒
Private Duty Nursing	☒	☒
Minor Home Modifications	☒	☒
Individual Goods and Services	☒	☒
Home-Based Independent Living Skills Training	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services (FMS)

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Any willing and qualified provider may enroll as an FMS agency providing FI services. DHHS or its Authorized Entity requires providers to deliver high quality services that, at a minimum, meet the expectations of the participants who utilize those services. Entities must be approved by OADS and enrolled in MaineCare as specified in this waiver and in accordance with regulations and this waiver.

Prospective FMS providers must meet expectations in the areas of organization and operation of individual programs or services, personnel administration, environment and safety, quality management, and compliance with all HCBS Settings requirements. OADS may authorize agencies to deliver FMS following submission of a completed application with supporting documentation.

As part of the provider application process, in addition to the above, prospective FMS entities must demonstrate through a readiness review the ability to provide customer service to participants that minimally includes ensuring electronic systems and communication regarding health information and other program and/or participant-specific information necessary for the participant to engage in and access Self-Directed services meets state and federal privacy standards.

Finally, the FMS provider must comply with Federal Internal Revenue Service regulations related to the employment of support workers.

Financial Management Service (FMS) delivered as a waiver service by a qualified FI includes performing financial transactions on behalf of the participant to ensure the participant and Authorized Representative effectively carry out their responsibilities under the Employer Authority with Budget Authority state-selected model for Self-Direction.

At a minimum, the FMS must deliver the following supports to the Self-Directing participant and Authorized Representative:

Employer authority: (minimum supports)
1. Assist the participants in verifying employee's citizenship status and completing the necessary background checks
2. Collect and process timesheets of the employees approved by the participant or Authorized Representative
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment- related taxes and insurance

Budget Authority: (minimum supports)
1. Maintain a separate account for each participant's budget
2. Track and report payments made and balances of participants' self-directed funds
3. Provide participant with reports of expenditures and their self-directed budget.

In accordance with this waiver, FMS is a minimum service. The participant may not be able to access self-direction unless they select an FMS provider for support and assistance with the employer and budget authority responsibilities listed above. The Case Manager ensures the participant receives information about available FMS providers during the PCSP planning process. The Case Manager must provide this information in writing if the participant requests.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment for the FMS is through MMIS. The FMS is paid a set per person/per month rate for delivery of fiscal management services so long as the FMS meets the requirements set forth in this waiver.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

FMS agencies must conduct criminal background checks of all direct support workers in accordance with 10-144 C.M.R. ch. 60, MBCC rule. This includes an Office of Inspector General (OIG) check. The FMS must maintain evidence of employee qualifications and training including annual abuse, neglect and exploitation and critical incident report training and requisite service delivery documentation, as applicable.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other services and supports**

Specify:

The FI must ensure the EOR is aware that they may negotiate a stipend or wage adjustment to assist the employee with costs of procuring their own benefits, such as healthcare coverage. The Department does not require employers to offer health insurance coverage.

Payments for services must not be made directly to a participant, either to reimburse for expenses incurred or enable the participant to directly pay a service provider or employee.

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other**

Specify:

The FMS must demonstrate evidence of satisfactory customer service to participants, meet all contractual requirements and offer electronic communication options.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS agency is subject to the current processes for oversight, monitoring, and financial integrity assurances enumerated in Appendix I-1 of this waiver, including integrity at the individual and MaineCare level.

As noted, agency billing for delivered services requires medical eligibility, financial eligibility, PCSP and the service authorization. Claims are rejected for any date where both medical and financial eligibility are not in place or when the Prior Authorization (PA) does not match the classification code assigned.

OMS is subject to an annual Single State Audit by the Office of the State Auditor on all programs. The Program Integrity Unit (PIU), a separate agency from the Office of the State Auditor, also conducts continuous and ongoing audits triggered by anomalies related to claims as well as complaints/inquiries made directly to the PIU.

The Operating Agency also oversees and monitors FMS entities through review of quarterly complaint logs, reports, annual surveys, as well as ad hoc reviews and inquiries based on a complaint(s). An annual survey is sent to participants who have elected the self-direction service model to garner feedback related to their experience(s) with the FMS entity.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

During the planning phase of PCSP development and annually thereafter, the CRC, at a minimum, will provide information about the benefits and potential liabilities associated with self-direction along with information about the participant's responsibilities when they elect to direct their services.

Information on self-direction must be provided on a timely basis to permit informed decision making by the participant, allowing sufficient time for the participant to weigh the pros and cons of self-direction and obtain additional information as necessary before electing this option.

Supports Brokers deliver support and information to ensure that the participant understands the responsibilities involved with Self-Direction. Duties of the Supports Broker include coaching and advising the participant about the responsibilities of being an employer, managing their personal budget, or implementation of their PCSP.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech Therapy (Maintenance)	☐
Career Planning	☐
Community Connections Assistance	☐
Community	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Resource Coordination (CRC)	
Community Transition Case Management	☐
Community Supported Living	☐
Benefits and Work Incentive Counseling	☐
Community Transportation	☐
Assistive Technology	☐
Behavioral Support Consultation	☐
Job Coaching	☐
Self-Employment Start-Up Plan and Outcome	☐
Employment Exploration	☐
Job/Career Development Plan and Outcome	☐
Supports Brokerage	☒
Co-Worker Supports	☐
Home Support Agency Per Diem	☐
Respite Breaks and Opportunities	☐
Community and Relationship Connecting	☐
Financial Management Services	☒
Personal and Home Assistance	☐
Private Duty Nursing	☐
Shared Living	☐
Physical Therapy (Maintenance)	☐
Remote Monitoring and On-Call Response Service	☐
Occupational Therapy (Maintenance)	☐
Peer Specialist Services	☐
Integrated Employment Path Services	☐
Minor Home Modifications	☐
Housing Start-Up Assistance	☐
Individual Goods and Services	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home-Based Independent Living Skills Training	☐
Housing Counseling	☐
Facility-Based Day Program Services	☐
Family Empowerment and Systems Navigation	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

In accordance with 34-B M.R.S. §5466, participants are entitled to have access to an advocate. CRCs must inform all participants of this entitlement prior to the PCSP planning meeting to allow for inclusion of an advocate if the participant so chooses.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant or Authorized Representative chooses to stop self-direction, the CRC or FI will assist the participant in accessing self-direction through the appointment of another Authorized Representative or accessing services through the traditional agency model, whichever is appropriate. All efforts will be made to transition the person without any gap in service. Failure to adhere to budget; ongoing failure to hire staff to provide service; failure to follow program rules are generally the reasons why a change of Authorized Representative/employer may be required to continue with self-direction.

Additionally, when the participant wishes to voluntarily terminate Self-Directed services, they will inform the CRC. The CRC and the participant will discuss all available options including whether changing service delivery (schedule, hours, etc.) or changing members of the team delivering supports (i.e., locating new providers or locating a different Authorized Representative) would prevent the voluntary termination. The CRC, through the PCSP planning process, will support the participant to select agency-directed service delivery options to meet the identified needs. The CRC is responsible for updating the PCSP.

If the participant decides to move forward with terminating Self-Directed services, the CRC is responsible for arranging agency-directed services and supports in the short-term while a long-term plan is developed.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The Department may deny or involuntarily terminate a participant's ability to utilize Self-Direction, if it determines that the participant, or the participant's Authorized Representative:
A) Engaged in fraud, waste, or abuse, including submitting time sheets inconsistent with authorized services or that do not accurately reflect services delivered to the participant;
B) Provides fraudulent or repeatedly inaccurate information to the Department, Community Resource Coordinator, Support Broker, or Fiscal Intermediary in connection with obtaining or receiving services;
C) Refuses to comply with the requirements for Self-Direction;
D) Engages in course of conduct or performs an act deemed improper, abuse of the MaineCare Program, or continues such conduct following notification that said conduct should cease;
E) Demonstrates any other action that may have a direct bearing on the participant's ability to adhere to the requirements for self-direction or to be fiscally responsible to the program for care, services or supplies to be furnished under the program, including actions by persons affiliated with the participant; or
F) Demonstrates any other action which may affect the effective and efficient administration of the program.

Additionally, a participant who overutilizes and schedules employees more hours than the authorized budget can cover, may receive a written warning from the Department. The written warning may include a requirement that the participant receive increased assistance from the Support Broker to remedy the contributing factors leading to overutilization. Upon the third occurrence within a twelve-month period, the Department may issue a notice of suspension or termination of the option to self-direct.

Prior to, and as part of denying or terminating the participant's ability to elect Self-Direction, the Community Resource Coordinator will support the participant to transition to another Authorized Representative or to Provider-Managed services, as appropriate.

Pursuant to Ch I of the MBM, the Department will provide written notice of the denial or termination including the participant's right to appeal the denial or termination.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect

for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		400
Year 2		500
Year 3		600
Year 4		700
Year 5		800

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☒ **Other**

Specify:

In order to fulfill their employer responsibilities of recruiting, hiring, orienting, and training, supervising, or discharging employees, the participant and Authorized Representative must receive an orientation on the mechanics of their chosen FMS system including the systems for processing payroll, requirements for accessing Individual Goods and Services and how to access customer support when needed. The FMS must ensure this is completed in advance of the participant or representative conducting their employer functions.

The FI also provides an online link outlining the employer responsibilities and requirements for self-directing. The Support Broker is responsible for reviewing this information with the participant and/or Authorized Representative. The Support Broker will also ensure the participant and/or Authorized Representative sign an attestation confirming they have received and reviewed the information. The participant and/or Authorized Representative may voluntarily decline reviewing the information with the Support Broker and attest to the same.

In collaboration with the FI, the participant or Authorized Representative recruits and hires prospective employees once the FI has verified that the employee is eligible for hire. The Support Broker assists and coaches the participant and/or Authorized Representative to establish the employee's rate of pay, to use budgeted dollars to pay for additional hours of service, if necessary, and to appropriately use Individual Goods and Services as outlined in this waiver. The employee's rate-of-pay must be within the at least minimum wage and no more than two hundred (200) percent of the minimum wage set by the state or local authority.

The participant and/or Authorized Representative must also set the standards for orienting and training newly hired employees to assure that the employee meets the participant's individualized needs and demonstrates competency in all required tasks. The participant and/or Authorized Representative must maintain employee orientation and training documentation such as: CPR and First Aid certification cards, as well as a record of disability-related training for each employee.

Employees may be friends or family of the participant, including their spouse or the legal guardian. If a participant requires or has selected a Authorized Representative to direct services on their behalf, the Authorized Representative may not be paid to deliver Direct Support to the participant. When the guardian is acting as the Authorized Representative on behalf of the participant, the guardian may not be paid to deliver Direct Support to the participant. In either case, the Financial Management Services provider is responsible for ensuring that payment made for the delivery of services under the Self-Directed services option complies with applicable restrictions recited in this waiver.

The Support Broker must provide to the participant and/or Authorized Representative training and information on how to report abuse, neglect and exploitation. The training and information shall include use of the Self-Directed Incident Reporting Form and shall occur within 30 days of initiating Self-Direction. The Support Broker must provide training and information to the participant and/or Authorized Representative each year by the same date.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in**

Appendix C-1/C-3

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☒ **Other**

Specify:

The participant may determine the amount paid for specified services over which they have flexible budget authority so long as the employee's rate-of-pay is at least minimum wage and no more than two hundred (200) percent of the minimum wage set by the State or Local Authority.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

To calculate the participant's annual budget for Self-Direction:
A. Convert the units of service for each service to a total dollar amount.
B. Combine the dollar amounts and units of service for services that fall into the "flexible" budget category, into a single budget and total number of units. (See Appendix E-1. a. for the list of services allowable under the flexible budget option.)
C. Establish a dollar amount as described in A. above for each service that falls into the "fixed" budget category and attach a total number of units of service, per the PCSP, to the dollar amount. (See Appendix E-1. a. for the list of services allowable under the fixed budget option)
D. Combine the total dollar amounts in the flexible and fixed budget categories to the sum of a total self-directed budget.

The Support Broker and FMS must support the participant and Authorized Representative in developing a spending plan following the policies outlined in this waiver applicable to Self-Direction.

Any budget dollars not used in providing authorized units in accordance with the rules for the flexible and fixed budgets (See Appendix E-1. a.) or budget dollars saved through wage negotiations or tax changes, may be applied to Individual Goods and Services described in C-1/C-3. The FMS provides information on the minimum and maximum hourly wage.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The CRC must submit the self-directed budget to the Department for final approval and communicate final approval to the participant and Authorized Representative, the FMS and the Support Broker. A participant or their legal guardian may request an adjustment to the budget amount by contacting their CRC. The CRC will convene the PCSP planning team to consider whether a change in the PCSP is needed and supports a change in the self-directed budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

With full budget authority, the participant is allowed to modify the frequency and amount of currently approved services within the authorized annual budget amount without prior approval or updates to the SIP or the PCSP. The FI ensures the changes are allowable and fall within the participant's authorized annual budget and reflect the changes in the established budget on record.

Examples of changes that do not require prior approval:
1. Adjusting hours of direct support services on any given day/week to meet individual needs; or
2. Accessing a different vendor (i.e. a transportation company such as Uber or Lyft).

The CRC must update and sign the PCSP and involved providers must update and sign the applicable SIP and PCSP when the participant and/or representative wishes to modify the budget by adding new waiver services or increasing hours of service that would require a new or updated authorization for services. The CRC, Support Broker, and FI support the participant to reflect these changes within the PCSP and secure necessary authorizations.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Supports Broker, CRC and FI ensure the PCSP identifies the mix of services (employment, State Plan, Provider-Managed services and Self-Directed services) and natural supports to maximize the participant's self-directed budget.

A participant must use personal funds or access another funding source (through this benefit or the State Plan) to purchase services, equipment, or supplies when available. When the participant does not have personal funds or funding through another source, the participant may access accrued funds available in the self-directed budget.

A participant may only purchase approved Individual Goods and Services (IGS) with accumulated reserved ("accrued") funds; a participant may not purchase IGS with projected but not yet accumulated reserved funds.

The participant and/or representative, and FI must attest that the selected IGS fall within the federal requirements.

A participant may not "cash out" their services for the sole purpose of generating or increasing the available funds for Individual Goods and Services.

A participant may not roll over unspent IGS funds across fiscal years.

A participant may not exceed authorized budget limits unless the participant has received an approved Request for Exceptions or Americans with Disabilities Act Accommodation.

A participant who overutilizes and schedules employees more hours than the authorized budget allows may receive a written warning from the Department. The written warning may include a requirement to receive increased assistance from the Support Broker to remedy contributing factors leading to overutilization. Upon the third occurrence within a twelve-month period, the Department may issue a notice of suspension or termination of the option to self-direct.

The FI or Supports Broker will review monthly expenditures and provide reports and information to the participant as needed regarding the participant's real-time account balance of available funds, or use of funds over time, etc.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

OADS Intake and Eligibility Specialists provide written information on applicable grievance processes and how to request a Fair Hearing, during their initial meeting(s) with waiver applicants. CRCs must provide the same written information to participants and guardians (as applicable) during annual service planning. CRCs must document provision of this information in the PCSP.

OMS mails or delivers in person written notice when there has been a denial, termination, suspension or reduction of eligibility for MaineCare or covered services.
Specific information that must be in this notice includes:
1. A statement of the intended action;
2. An explanation of the reasons for the action, as well as a specific citation to the underlying state or federal regulations that support the action;
3. A statement that the participant has a right to a hearing;
4. An explanation of exactly how to obtain a hearing;
5. A statement that a participant may be represented by legal counsel, relatives, friends or a spokesperson and a list of selected legal service providers available to assist the participant in arranging for legal counsel;
6. The name and telephone number of the person who should be contacted, should the participant have questions regarding the notice; and
7. An explanation of the circumstances under which medical eligibility for MaineCare or covered services are continued if a hearing is requested.

All written notices from OMS regarding denial, reduction, suspension, or termination of services or eligibility include information about the applicable grievance and appeals processes, including how to request a Fair Hearing. The Division of Administrative Hearings conducts administrative hearings and retains Notices of Hearings and any fair hearing reports completed by OADS, as applicable.

Additionally, a participant may request an administrative hearing as specified in MBM, Ch I, Section 1, General Administrative Policies and Procedures (See §1.24-3, Procedure to Request an Administrative Hearing, copied below).

" A member may request an administrative hearing if they are aggrieved by any Departmental action that may deny, terminate, reduce, or suspend services provided by MaineCare. The Department may respond to a series of individual requests for a hearing by conducting a single group hearing. Members must follow the procedures
described in this section when requesting an administrative hearing.
A. A member or their Authorized Representative may request an administrative hearing.
B. Unless otherwise specified in this Chapter, a request for an administrative hearing must be received within sixty (60) calendar days of the date of written notification to the member of the action the member wishes to appeal.
C. Unless otherwise specified in this Manual, the request must be made by the member or their representative, in writing or verbally, to: MaineCare Member Services, P. O. Box 709, Augusta, ME 04332, or an address otherwise specified by the Department in a written notice, for a hearing with the DAH, Department of Health and Human Services. For the purposes of determining when a hearing was requested, the date of the hearing request shall be the date on which the request for a hearing is received by MaineCare Member Services. The date a verbal request for an administrative hearing is made is considered the date of request for the hearing. MaineCare Member Services may also request that a verbal request for an administrative hearing be followed up in writing but may not delay or deny a request on the basis that a written follow-up has not been received. MaineCare Member Services shall send a fax or copy of all hearing requests to a Hearings Representative and to the DAH no later than five (5) business days after receiving the request. MaineCare Member Services shall send all expedited hearing requests within twenty-four (24) hours of identifying the request.
D. The hearing will be held in conformity with the Maine Administrative Procedure Act, 5 M.R.S. §8001 et seq. and the Department's Administrative Hearings Regulations.
E. The hearing will be conducted at a time, date and place convenient to the parties and at the discretion of the DAH, and a preliminary notice will be given at least ten (10) calendar days, from the mailing date. Shorter notice may be given in order to comply with provisions of Section 1.14-1 governing denials of mental health services. In scheduling a hearing, there may be instances where the hearing officer shall schedule the hearing at a location near the member or by telephone or interactive television system.
F. The Department and the member may be represented by others, including legal counsel and may have witnesses appear on their behalf.
G. An impartial official will conduct the hearing.
H. The hearing officer on their own motion or at the request of either Department representatives or the member may request or subpoena persons to appear where that person can be expected to present testimony or documents relating to the issues at the hearing. The cost of the subpoena shall be borne by the Department.
I. When a medical assessment as defined in 42 C.F.R. §431.240(3)(b) by a medical authority other than the one involved in the decision under question is requested by the hearing officer or the member, and considered necessary by the hearing officer, it

will be obtained at the Department's expense, and forwarded to the member or the member's representative and hearing officer allowing both parties to comment.
J. When the member, the Department, or an Authorized Entity of the Department requests a delay, the hearing officer may reschedule the hearing, after notice to both parties.
K. The decisions, rendered by the hearing authority, in the name of the Maine Department of Health and Human Services will be binding upon the Department, unless the Commissioner directs the hearing officer to make a proposed decision reserving final decision-making authorization to him or herself.
L. Any person who is dissatisfied with the hearing authority's decision has the right to judicial review under Maine Rules of Civil Procedure, Rule 80C."

Participants or their guardians may obtain additional information by writing or calling the Office of Administrative Hearings directly at the following address/telephone number: DHHHS, Office of Administrative Hearings, 35 Anthony Ave 11 State House Station Augusta, ME 04333-0011/TEL: (207)624-5350, FAX: (207)287-8448,
TTY: 211(Hearing Impaired).

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

In accordance with 34-B M.R.S. §5604, OADS is responsible for the operation of the grievance system for participants with intellectual disabilities, autism or acquired brain injuries who are 18 years of age and older served by the Department. OADS has drafted, and is in the process of proposing, a revised grievance rule (10-149 Grievances). The revised grievance rule outlines grievance system requirements specific to grievance types, processes, timelines, and mechanisms used for grievance resolution.

In accordance with 34-B M.R.S. §5604, Children's Behavioral Health Services (CBHS) is responsible for the operation of the grievance system for participants with intellectual disabilities, autism or acquired brain injuries who are younger than 18 years of age. CBHS rule, 14-472, Chapter 1, Rights of Mental Health Services Who are Children in Need of Treatment describes the process which children with intellectual disabilities and autism, who are receiving services or supports from the Department, can seek to enforce their rights or process their grievances.

The link to 14-472, Chapter 1 is: https://www.maine.gov/sos/sites/maine.gov.sos/files/content/assets/472c001.doc

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

OBH System:
As indicated in F-3-b, the State operates a grievance system for children (under the age of 18) overseen by CBHS and a grievance system for adults (18 years of age and older) overseen by OADS. The nature of grievances/complaints addressed by these two systems fall into three general categories and are related to the action or inaction of (1) the Department, or (2) a participant or agency providing services or supports to a participant; or (3) a complaint which alleges a violation of the participant's rights or the participant's dissatisfaction with present services or supports.

OADS System:
For participants aged 18 years of age and older receiving services under this waiver, OADS has established three levels of grievance resolution.

Level I allows the participant and their CRC up to sixteen (16) calendar days to attempt to resolve the issue. If the grievance cannot be resolved within that time frame, the CRC shall refer for a Level II grievance review and resolution with the OADS designee.

Level II allows the OADS designee up to thirty (30) calendar days to review the grievance, attempt to resolve, and issue a Level II decision. The participant and OADS may agree in writing to extend the deadline if necessary during this phase in the process. OADS' written decision must include language that the participant has a right to appeal the decision by requesting a
Level III administrative hearing.

Level III allows the participant twelve (12) calendar days from receipt of the Level II decision to request a Level III Administrative Hearing. The OADS designee will forward the appeal within five (5) calendar days to OADS Central Office. OADS Central Office will forward the appeal to the Administrative Hearings Unit within ten (10) calendar days of receipt of a completed appeal.

Additionally, as specified in Appendix F-1 of this waiver, participants receive notice of their right to request a Fair Hearing when there has been a denial, termination, suspension or reduction of eligibility for MaineCare or covered services.

OADS maintains information regarding the grievance and fair hearings processes, including plain language documents regarding the grievance process and hyperlinks to the Fair Hearing process, on their public-facing website at the following link: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Grievance-Process_0.pdf.

To align with Maine's five other HCBS 1915(c) waivers, all providers must provide each participant information on the grievance process outlined in 14-197 C.M.R. ch. 8, Grievance Process for Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury. Providing notice includes, at a minimum, ensuring that written notice of the grievance process is provided to the participant and their guardian at any planning meeting; posting notice of the grievance process in an appropriate common area of all facilities operated by the provider; and posting notice of the grievance process on any website maintained by the provider. The participant is informed that filing a grievance is not a pre-requisite or substitute for a Fair Hearing.

For youth aged 16 to 17 years of age receiving services under this waiver, CBHS provides service recipients with an annual notice of grievance rights which includes information about the process and how to seek additional assistance with submitting grievance. There are two grievance processes, one for mediation and one for administrative hearings. Each process follows a five (5) calendar day timeline unless the recipient waives this requirement. Administrative hearings comply with the Maine Administrative Procedure Act, 5 M.R.S. §§ 9051 et seq. The link to 14-472, Chapter 1, Rights of Mental Health Services Who are Children in Need of Treatment is https://www.maine.gov/sos/rulemaking/agency-rules/department-health-and-human-services-rules.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Providers must report instances of abuse, neglect, and exploitation through the CPS and APS hotlines. Additionally, the State requires providers electronically report the following critical incidents ("reportable events")": abuse, neglect, exploitation, deaths, medication errors, emergency situations, events requiring medical treatment, unauthorized restraint use, and events involving law enforcement personnel.

Depending upon the population (adults or children), providers must comply with the following state statutes and regulations that define reporting requirements:

- Children Abuse, Neglect, Exploitation (ANE) - 22 M.R.S. § 4011-A
- Adults ANE – 22 M.R.S. § 3477
- Individuals with I/DD and Autism Critical Incidents - 34-B M.R.S. §5604-A
- ANE Regulation – 10-149 CMR Ch. 2
- Reportable Event Regulation – 14-197 CMR Ch. 12

People across the service delivery system are required to report critical incidents. Specifically, some individuals are required to act as mandatory reporters. Additionally, others are required to report dangerous situations and/or harm as a part of their work as a Medicaid-funded provider.

Mandatory reporters for ANE of a child include: people working in a professional capacity as a health care worker, a mental health expert, a law enforcement official, a member of the clergy, educational staff, and domestic violence advocates, people with responsibility for care of the child, or any person affiliated with a religious institution that has assumed a position of trust to members of that organization.

Mandatory reporters for ANE of an adult include: people working in a professional capacity as a healthcare worker, a mental health expert, a law enforcement official, a member of the clergy, court appointed guardians, or advocates, any person with responsibility for care of the dependent adult, any person providing transportation services, and any person affiliated with a religious institution that has a position of trust to members of that organization. Additional people who must report critical incidents include any individual involved in the support of a participant and anyone who learns of an incident related to client care or lack thereof. This includes providers of direct services, case managers, guardians, etc.

Mandated reports may report critical incidents electronically or via a phone hotline. The electronic forms include information about the situation that is being reported, information about the reporter, information about when the event was discovered, and information about alleged witnesses, victims, other related people, and perpetrators. The two ANE hotlines, one for children and one for adults, operate 24 hours a day, 7 days a week, including on holidays.

Reporting timelines vary based on severity of the critical incident and population (adults or children).

Children:
In accordance with 22 M.R.S. §4012, reports regarding abuse or neglect must be made immediately by telephone to the department unless otherwise specified in this subsection and must be followed by a written report within 48 hours if requested by the Department.

Adults:
In accordance with 22 M.R.S. §3477, reports regarding abuse, neglect or exploitation must be made immediately by telephone to the department and must be followed by a written report within 48 hours if requested by the department. The reports must contain the name and address of the involved adult; information regarding the nature and extent of the abuse, neglect or exploitation; the source of the report; the person making the report; that person's occupation; and where that person can be contacted. The report may contain any other information that the reporter believes may be helpful.

In accordance with 14-197 CMR Ch. 12 providers must report reportable events to the Department, including reports of other types of critical incidents, within one business day of the incident. Waiver service providers or the OADS Incident Data Specialists (IDS) enter reportable events directly into an electronic database system. OADS expects all providers to conduct follow-up reviews on reportable events to determine and record the cause of critical incidents and develop strategies to reduce or mitigate the risk of future occurrences.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities

when the participant may have experienced abuse, neglect or exploitation.

OADS Intake and Eligibility Specialists provide information that is understandable and accessible to participants, family members, and guardians (when applicable) regarding rights and protections from abuse, neglect, and exploitation. This staff effort also provides contact information in writing to the Department's APS hotline and online reporting information. CRCs provide the same information during initial and annual service planning or more frequently if needed. Additionally, CRCs must inform participants about how they can notify appropriate authorities when they may have experienced abuse, neglect, and exploitation.

Participants can access training opportunities through the case management system, DRM, and local Self-Advocacy Groups. DRM's training regarding rights, protections and supported decision making is specifically geared toward families and guardians. However, DRM also offers training through the State Education and Training Unit available to the general public. Additionally, APS offers in-person, state-wide trainings multiple times each year about identifying and reporting abuse, neglect, and exploitation. Finally, OADS offers an online APS mandated reporter training. The trainee receives a certificate of completion after successfully completing the course.

This training can be found at the following link: https://www.maine.gov/dhhs/oads/get-support/aps/mandated-reporters . The website also includes information and resources concerning violence prevention and protection from abuse, neglect and exploitation.
MINORS (aged 14 to 17 years of age)
Like the process for adults, PCSP planning for youth includes ensuring the CRC informs and seeks acknowledgement from the minor of the CPS Act.

Additionally, the CPS Act requires that service providers develop a mandated reporting policy, and that the policy must be made available to staff, participants and the public (§4010-A). The agency policy must include:
1. a description of how the agency offers positive supports to prevent abuse or neglect;
2. expectations for the reporting of suspected abuse or neglect or other violations to the appropriate authorities;
3. the agency's course of action if allegations of abuse or neglect are made against the agency or its staff; and
4. the agency's grievance procedures for staff and for youth and their parents or guardians regarding alleged abuse or neglect.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Different groups receive and follow up on different types of critical incidents. The OADS Quality Team oversees providers as they investigate and follow up on reportable events related to their agency. The OADS, APS and CPS teams are responsible for receiving, evaluating, and investigating allegations of abuse, neglect, and exploitation (ANE). OADS responsibilities related to the receipt of reports include managing the IT systems through which reporting occurs, encouraging high-quality reporting with limited missing information, and managing internal responses. DRM, the protection and advocacy agency in Maine, receives and reviews reports of rights violations (a type of reportable event) and completes investigations in addition to the review work completed by the State.

Both providers and the OADS QA team share reportable event report evaluation and incident investigation responsibilities. Providers are responsible for completing follow-up on an incident within 30 calendar days of the event. The review/ follow-up may include, but is not limited to, communication with the participant receiving services, communication with any witnesses to the critical incident, survey of the area where the critical incident occurred, and communication with the participant's CRC to determine the cause of the critical incident and to identify remediation steps to prevent or reduce future incidences. They must share documentation of their follow-up investigation with OADS.

At a minimum, the report must include the following:

1. The date and time of the reportable critical incident
2. A summary of the circumstance that resulted in the reportable critical incident.
3. An outline of any remediation steps that were taken following the event incident to prevent or decrease recurrence.
4. The date of implementation of remediation steps including the party responsible for implementing remediation steps.
5. The explanation as to why no remediation action steps are necessary, if appropriate.

Critical incident reports are evaluated by the OADS Quality Team. This evaluation includes review of information submitted by the provider, case manager notes, and (if applicable at the time of review) provider notes about follow-up activities. This report evaluation is completed as a desk-level review and does not include interaction with the provider unless substantial information from the report is missing. This evaluation results in the identification of missing information, and in a determination of whether additional attention is needed. Critical incident reports are transferred electronically from the submission system to the Quality Team's work queue on at least a weekly basis. The Quality Team does not routinely share results of reportable event investigations with participants and their family members.

Events requiring additional attention, often events that have been identified as a part of a cluster and/ or trend within an agency, are investigated by the Quality Team or the Division of Licensing and Certification (DLC). For example, DLC follows up on medication administration error related issues. These investigations include a review of the participant's record and may include contact with the participant's CRC, the participant, provider, and others involved. The goal of an investigation is to identify systemic challenges within a provider agency's operations that contribute to critical incident frequency.

APS is responsible for screening (evaluating) reports and for all investigations of ANE involving adult waiver participants. To evaluate a report, an APS intake worker determines whether APS has the jurisdiction to investigate the allegation, or if the report meets established criteria for closure. An intake worker may close a report if one or more of the following criteria are met: the report lacks information outlining allegations that could reasonably meet the definition of ANE, the report lacks information indicating the client involved meets the definition of a dependent/ incapacitated adult in Maine, or no action can be taken by APS under the circumstances.

Based on prioritization, an APS Investigation may begin on the date the allegation is received through APS Central Intake and will begin no later than five (5) business days from the date the allegation is received. Final written findings shall be entered into the electronic APS system by the assigned APS Caseworker no later than thirty (30) days from the date of assignment to the APS Caseworker. In the event an APS Investigation cannot be completed within thirty (30) days of assignment, the APS Caseworker shall document the reasons and estimate the number of days needed to complete the investigation in writing. An APS Supervisor shall review and approve the APS Investigation extension and document this approval in the electronic APS system. Any necessary subsequent extensions shall be reviewed and documented through the same process. APS documents the actions taken to reach a finding such as dates of phone calls, interviews, site visits, and document reviews.

Subject to the confidentiality provisions of 22 M.R.S. §3474(2)(A), APS must immediately report instances of suspected abuse, neglect or exploitation of an incapacitated or dependent adult to the appropriate district attorney's office, whether

or not APS investigates the report.

When APS issues a Substantiation finding against an individual, the individual shall be notified in writing and APS will include the potential consequences of the Substantiation. A Substantiation notice shall be accompanied by a written notice to the individual of the right to appeal the Substantiation finding to the Department's Administrative Hearings Unit. When an individual who is found Substantiated by APS exercises the right of appeal, the participant who was abused, neglected, or exploited, their guardian, if applicable, and Disability Rights Maine shall receive notice of the hearing and may request the status of an intervenor at the hearing.

In all APS investigations, information related to the investigation and the outcome may be shared with participants, family or guardians and other relevant parties in accordance with the confidentiality requirements outlined in 22 M.R.S. § 3474 and processes specified in 10-149 C.M.R. ch. 2.

Child Protective Services (CPS) has responsibility for evaluating reports and completing investigations of allegations of ANE against children. To evaluate a report, CPS intake determines whether a report is an emergency or a non-emergency. Emergency reports must receive a CPS response within 24 hours and non-emergency reports receive a CPS response within 3 days from receipt of the report. Depending on the nature of the incident, CPS may make a referral to the Children's Advocacy Center or coordinate with law enforcement. If CPS initiates an investigation, then casework activities must be completed within 40 days of the investigation period. If the incident reported to CPS is identified as involving a licensed facility or program, CPS also refers the incident to the Division of Licensing. The Division of Licensing determines if the incident results in any fines, sanctions or corrective action involving licensed facilities or programs.

Furthermore, if an allegation involves agency staff, while working with children in a professional capacity and licensed or funded by the Department, then Child Protective Intake refers the report to Children's Licensing and Investigation Services for review/disposition by an Out of Home Investigator. Out of Home Investigation is part of the Child Protection Act, Subchapter 18, statutory authority to conduct these investigations is pursuant to section 4099-N (J.) An unlicensed provider for children with cognitive impairment and functional limitations that is funded by the Department. In addition, CPS incidents involving HCBS services providers are sent to OADS for additional review and possible technical assistance or corrective action.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OADS is responsible for overseeing the operation of the incident management system, including management of reportable events and allegations of abuse, neglect, and exploitation. Critical incident screening and provider meetings occur on a routine basis to review data compliance, quality, and agency quality improvement efforts. A Critical Incident Dashboard affords OADS the capability to review critical incidents by provider agency on a quarterly basis.

A data tool is updated at least weekly and accessible by the Quality Team for use in identifying trends in event occurrence, underreporting, reporting timeliness, and health and safety risk for participants. This tool is populated with critical incident data, claims data, and includes logic to flag various events (reported or not) as being high risk for participants (illustrative example: events related to the fatal five).

The data tool is used in day-to-day work as a way to inform investigation activities completed by the Quality Team, and it is also used as the basis for data that is reviewed quarterly with providers about their performance. These quarterly meetings are structured as an opportunity for a provider to direct their own internal QA process and report out on risk mitigation activities to OADS. However, OADS uses information from the dashboard and related oversight activities (licensing reviews, complaint management, etc.) to inform the topics addressed in these meetings and the feedback offered to providers.

OADS also completes oversight activities related to critical incidents as a component of licensing. The OADS licensing application/ reapplication process may include a review of critical incident frequency and reporting timeliness for the agency. If there are deficiencies in risk mitigation practices (such as staff training) that are in violation of licensing requirements and contributing to observed issues related to reportable events, OADS may issue a statement of deficiency and require the provider comply with a plan of corrective action. Providers are required to reapply for a license every two years.
OADS issues a Critical Incident Trend Report annually that highlights, in aggregate, reportable event trends. The purpose is to communicate information about trends and use the data to plan, prioritize, and implement proactive initiatives to reduce or prevent incidents from recurring. The Critical Incident Trend Report is reviewed by the waiver management team who makes recommendations to OMS and OADS Executive Management Teams Senior Leadership teams for provider and/or systemic follow up.

APS and CPS provide a report to OADS that describes the total number of investigations of reports of ANE that resulted in substantiated incidents of the following categories/types of ANE: self-neglect, exploitation, physical abuse, safety issues/at risk, caretaker neglect, sexual abuse, emotional abuse, inability to give informed consent, and financial abuse. The report also includes the remediation of substantiated incidents of abuse, neglect, and exploitation.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Participants are entitled to be free from restraint. State statute prohibits the use of restraints, including planned restraints. Pending amendments underway to 14-197 CMR Ch. 5, if a restraint is used for any reason (e.g., emergency), the service provider must report the restraint incident in accordance with Maine's Revised Statutes and Reportable Event System Rule (14-197 C.M.R. Ch. 12) . Each use of restraint must be documented in accordance with the Department's Reportable Event requirements. For the purposes of this subsection, "restraint" does not include blocking or physical redirection. Blocking is a momentary deflection of a participant's movement without holding when that movement would be destructive or harmful. Physical redirection is steering a participant without holding or coercion.

For reports involving adults, the Department shall convene a support and safety committee, at least quarterly, to review data on the number and types of plans implemented for adults under this subsection. The committee must include, at a minimum, a self-advocate, a family member of the participant receiving services, a representative of the advocacy agency designated pursuant to 5 M.R.S. §19502, a member of the Maine Developmental Services Oversight and Advisory Board established pursuant to 5 M.R.S. § 12004-J(15) and the licensed clinical social worker or psychologist employed by or under contract with the Department under paragraph C.

The Department shall provide to the committee deidentified plans and data to support their review work.

Critical incidents reported to OADS involving youth are shared with the Office of Behavioral Health (OBH) for further review by the protection and advocacy agency pursuant to 5 M.R.S. §19502.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete

Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Per 34-B M.R.S. §5605, restrictive interventions for youth are prohibited. Restrictive interventions include seclusion, corporal punishment, actions or language intended to humble, dehumanize or degrade the participant, totally enclosed cribs or beds, and painful stimuli. If a youth requires a behavioral health support plan, the plan must comply with 34-B M.R.S. §5605 and may only be used to correct behavior more harmful to the participant than the plan itself and must be recommended by the participant's personal planning team after an assessment by a physician. While restrictive interventions are prohibited for youth, the CRC is responsible for monitoring behavioral health support programming and convening a team meeting should the participant's behavioral support needs change.

For adults, the State has several safeguards regarding allowable restrictions upon participant movement and restrictions upon participant access to other participants, locations, or activities.

In-Home Stabilization means a limited period of time for which a participant, whose challenging behavior has placed that participant or the community at imminent risk of harm, may be denied access to the community for safety and assessment. When In-Home Stabilization is utilized, the Planning Team must develop an In-Home Stabilization Plan. In-Home Stabilization must be used only to ensure the safety of the participant or the community and upon assessment that the participant's Challenging Behavior may continue to pose imminent risk to the participant or the community. In-Home Stabilization must be tied directly to safety and not used as a teaching or behavior modification technique.

The participant's functional assessment must address the challenging behavior and the justification for the use of In-Home Stabilization. The justification must include the history of the challenging behavior and the types of problems it poses and how the In-Home Stabilization addresses those problems.

The proposed use of In-Home Stabilization for a period greater than one hour, but not to exceed 24 hours, is a Level 3 intervention. The use of a Level 2 In-Home Stabilizations three times or more during any two-week period of time requires review and approval as a Level 3 Plan. A Level 3 In-Home Stabilization Plan must be incorporated into the Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications, and is subject to all requirements for Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications, review and approval prior to implementation.

In-Home Stabilization at Level 2 or Level 3 must not be applied cumulatively. Once the criteria for safety have been met, or the identified time period has expired, In-Home Stabilization must end, and the participant must be supported to transition to regular activities or be supported to seek emergency medical attention.

When the Planning Team identifies a need for In-Home Stabilization beyond 24 hours, the planning team must submit an In-Home Stabilization Plan for a Level 4 intervention. The Level 4 In-Home Stabilization Plan must be justified by the functional assessment and documentation of prior interventions.

The Level 4 In-Home Stabilization Plan must be incorporated into a Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications proposed for review. at Level 4. A Level 4 In-Home Stabilization Plan must include but is not limited to: all information required in the In-Home Stabilization Plan; Aa safety assessment describing the criteria to be used at the end of the 24-hour period to determine if there is a need for continued In-Home Stabilization; and a plan for an in-participant safety assessment of the participant by the qualified professional overseeing the plan.

Use of unauthorized restrictive interventions is a prohibited practice. Safeguards against the unauthorized use of restrictive interventions are accomplished via by several monitoring strategies, including event management activities (including detection of unreported events, complaints monitoring, and assessment of suspected deficiencies). In these three quality activity areas, OADS staff flag use of prohibited practices, when detected.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

For youth, restrictive interventions are prohibited. If a youth requires a behavioral health support program, then this program must be approved by a review team. The review team is composed of a representative from the advocacy agency designated pursuant to 5 M.R.S. §19502, a team leader of the Department's children's services division and the children's services medical director or the director's designee. The review team must approve new plans on an as needed basis.

The OADS is responsible for monitoring and tracking the Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications for adults. Monitoring the Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications includes the following: the Statewide Review Panel is responsible for monitoring the quality and consistency of the Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications. This includes reviewing all new Level 4 Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications for quality assurance purposes, including concerns regarding the review process, inconsistencies and/or the quality of Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications. The Statewide Review Panel may request a random sample of Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications for a quality review. The Statewide Review Panel reports and advises the Department regarding interventions that may put consumers at risk and assure the applicable policies, regulations and laws are being followed.

The planning team and the qualified, responsible professional must monitor the implementation of an approved Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications and make modifications as necessary.

Responsibilities include but are not limited to the following:
The qualified professional must oversee implementation of the plan, monitor and document progress at least monthly. Documentation must include a description of the current and baseline measurements of the frequency, duration, intensity, and/or severity of each challenging behavior, including the type of interventions used and the result(s). Documentation must also include recommendations about continuation or modification of plan elements. The qualified professional must meet and observe the participant at least twice annually.

At a minimum, one representative from each agency responsible for the implementation of the approved plan must be present during these monthly clinical reviews with qualified professionals. Their role is to provide documentation and discussion regarding the effectiveness of the approved plan and to provide other pertinent input regarding less restrictive alternatives.

The participant’s guardian, if applicable, and CRC must also be provided the option to participate in the monthly clinical reviews with the qualified professional.

The planning team, in consultation with the qualified professional, must review, monitor and document the effectiveness of the plan at least quarterly.

Any increase in restrictive measures must be approved by the planning team and the review team prior to implementation.
All modifications of the Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications which include a reduction of restrictive measures must be approved by the Planning Team prior to implementation, and the revised Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications must be sent to the Review Team within thirty (30) days.

When a participant has a Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications, the CRC must conduct an in-person review of the implementation plan at least quarterly. When the participant does not have a CRC, the Q.I.D.P. must monitor the Positive Behavioral Health Support Plans, safety device plans, and HCBS modifications.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is defined as the solitary, involuntary confinement of a participant for any period of time in a room or a specific area from which egress is denied by a locking mechanism, barrier or other imposed physical limitation.

The OADS has the responsibility to detect the unauthorized use of seclusion. This is not permitted at any time (a Prohibited Practice), and it must be reported through the reportable events system and may also be detected through reports to Maine's APS and CPS system or licensing system. Additionally, OADS staff are alert for signs of the use of seclusion during on-site monitoring activities.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

As of late 2025, all agencies that provide case management, home support agency per diem, home support quarter hour, shared living, day, and employment services are required to be licensed by the DLC in accordance with the HCBS Licensing rule. As part of this licensing process, DLC will review agency practices for compliance with rule requirements, including those regarding medication administration, at least every two years. This includes verifying staff credentials and training (registered nurse and medication administration certifications), reviewing medication records for participants, and conducting on-site verification that medication storage procedures are being followed. The licensing rule requires that if an agency is responsible for medication administration, then the agency must retain either contracted, or on staff, a registered nurse (RN) to assure compliance with medication administration standards. These nurses are responsible for observing individual symptoms, reviewing medication/ health records, reviewing written orders, reviewing medication administration practices and procedures, reviewing therapeutic diets, and reviewing and recommending staff training related to these topics.

Additionally, all providers must monitor the health and safety of participants related to administration of medications, including those that self-administer medications. The Department requires provider agencies to have policies requiring that the participant and/or the Guardian (as applicable) and/ or family members (when authorized) are notified and authorize/agree to medication changes. The department also requires that the staff working in an agency have the required expertise (clinical) to provide appropriate oversight of medication administration practices.

Beyond the licensing process, both OADS and DLC routinely monitor medication errors. A medication error is an event involving the incorrect or inappropriate prescribing, packaging, dispensing, administering, monitoring, or a participant's refusal to comply with medications orders that may result in serious health or safety implications for the participant. Specified medication errors (including those resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death) are entered into the state database as a critical incident by the provider or CRC. DLC and the OADS Quality Team work together to monitor and review critical incidents related to medication errors.

When a serious or continuing harmful practice is identified through the licensing review process or review of reported medication errors, the Department may order an agency to use the services of a pharmacist through the licensing rule. DLC and OADS may also engage the agency in other progressive corrective actions in response to identified harmful practices. DLC staff routinely communicate with OADS staff and have organizational structures in place to facilitate collaboration – including meetings to discuss recent findings and follow-up actions regarding specific providers.

When Psychiatric Medications are prescribed the planning team mut comply with 14-197 CMR Ch. 5. Use of behavior-modifying medication outside of this approved process is considered a critical incident, and the OADS Quality Team monitors incidents and follows up through critical incident reporting processes.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

To promote responsible practices around medication management, the OADS Quality Team conducts continuous review of medication errors submitted through the State's critical incident reporting system. Additionally, DLC monitors staff training completion, certification of Registered Nurse instructors, and other staff credentials to pass medications as well as medication management practices during licensing surveys (approximately every two years). If OADS or DLC identifies instances of harmful practices through these regular review activities, they may initiate progressive corrective actions. At its discretion the Department may require an agency use the services of a pharmacist consultant as a result of serious or multiple deficiencies in medication administration in accordance with 10-144 C.M.R. Ch 108, Home and Community Support Services Agency Licensing Rule. OADS and DLC work in collaboration to manage providers, including sharing information electronically and routinely conducting meetings between OADS quality staff and DLC to discuss recent findings and follow up actions.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As of late 2025, case managers, day providers, employment providers, group home providers, and shared living providers are licensed in accordance with 10-144 CMR Ch. 108, Home and Community Support Services Agency Licensing Rule (“the HCBS Licensing rule”). The licensing rule requires that if an agency is responsible for medication administration, then the agency must retain either contracted, or on staff, a registered nurse (RN) to assure compliance with medication administration standards. These nurses are responsible for observing individual symptoms, reviewing Medication Administration Records (MARS), health records, written orders, medication administration practices and procedures, therapeutic diets, and recommending staff training as needed related to these topics. The HCBS Licensing rule also requires that an agency use the services of a pharmacist consultant as a result of serious or multiple deficiencies in medication administration when the Department directs the agency to do so.

Further, the HCBS Licensing rule requires anyone assisting in the administration of medication in a licensed setting must successfully complete a Certified Residential Medication Assistant (CRMA) training and be re-certified every two years. The trainee must successfully pass a standardized test and successfully administer medications in the presence of a qualified observer to receive CRMA Certification. This training is monitored by DLC and includes training and certification by Registered Nurse instructors.

The HCBS Licensing rule specifies the following regarding self-administered medications:
Self-administration of medication is assumed unless the Person-Centered Plan notes otherwise. The agency must, to the extent possible, allow each individual the opportunity to personally take medications according to their prescription.
1. Upon intake, the agency must review the individual’s Person-Centered Plan for information regarding the individual’s ability to self-administer medication.
2. Provider agency and staff must notify the individual’s case manager whenever there is a relevant change in the individual’s capacity to self-administer medications or other factors that may affect the individual’s ability to safely self-administer medications become known to the provider.
3. The individual or the individual’s legal representative must consent in writing in the Person-Centered Plan to have the agency administer the individual’s medications.
4. The agency must maintain evidence that the licensed practitioner who prescribed the medications has acknowledged that the individual self-administers their medication(s).

• **Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Errors are reported to OADS.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record and report any medication error, in the critical incidents reporting system, which leads to a health or safety concern of a serious and immediate nature (i.e. a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death) due to any of the following:
1. Refusal to take a prescribed medication;
2. Taking medication in an incorrect dosage, form, or route of administration;
3. Taking medication on an incorrect schedule;
4. Taking medication which was not prescribed;
5. An allergic reaction to a medication; or
6. Incorrect procedure followed for assisting an individual receiving services with self-medication.

(c) Specify the types of medication errors that providers must *report* to the state:

Same as above

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

OADS is responsible for monitoring the performance of providers through routine event review and the Reportable Events Dashboard. The dashboard displays data by event category type and medication events allowing OADS to review the data within the categories. OADS discusses the findings at quarterly intervals in routine provider quality meetings with the goal of ensuring the health, safety and welfare of all participants. OADS conducts a major review and consideration for progressive corrective action on any events of high concern while also ensuring the health and welfare of the affected participant.

DLC oversees enforcement of licensing standards completing reviews on a 2-year schedule. Licensing reviews include verifying staff credentials and training (registered nurse and medication administration certifications), reviewing participant medication records, and verifying that agencies comply with required medication storage procedures. DLC collaborates with the OADS Quality team to follow up on reported instances of harm related to medication administration. This follow up may include an investigation and corrective action. DLC and OADS share information at a staff and organizational level. Staff communicate about specific cases, and systems (e.g. automatic, electronic information transfers and routine meetings between managers to discuss provider performance) are in place to promote routine information sharing.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

Performance Measure:
Number and percent of members with quarterly visit Safety Assessment forms completed. Numerator: Number of members with quarterly visit Safety Assessment forms completed. Denominator: Number of members required to have quarterly visit Safety Assessment form completed by Community Resource Coordinator.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of deaths reviewed by APS for abuse, neglect, or exploitation. Numerator: Total number of deaths reviewed by APS for abuse, neglect, or exploitation. Denominator: Total number of deaths reported to APS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of reports of abuse, neglect and exploitation that are investigated by APS. Numerator: Total number of abuse, neglect and exploitation reports that are investigated by APS. Denominator: Total number of reports of abuse, neglect and exploitation that were screened in (i.e., met APS jurisdiction criteria) for investigation by APS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # and % PCSPs documenting the participant/legal guardian received information on how to identify and report instances of abuse neglect exploitation and unexplained death. Total number of PCSPs documenting the Participant/legal guardian received information on how to identify and report instances of abuse neglect exploitation and unexplained death. Denominator Total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of abuse, neglect, and exploitation incidents that are reviewed/investigated within the required timeframes. Numerator: Total number of abuse, neglect, and exploitation incidents that are reviewed/investigated within the required timeframes. Denominator: Total number of abuse, neglect, and exploitation incidents that are reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of QA referrals by APS to Disability Quality Assurance (DS QA), where DS QA determines corrective action is required and for which corrective action has been completed within State-determined timeframes. Due to character count limit please see Main Optional.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic database system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of all Reportable Events that are reported according to the time frames outlined in 14-197 C.M.R. Ch. 12. Numerator: Total number of all Reportable Events that are reported according to the time frames as outline in 14-197 C.M.R. Ch. 12. Denominator: Total number of Reportable Events reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of provider follow-up reports required to be and submitted within 30 days from the date of the reported incident. Numerator: Total Number of follow-up reports required to be and submitted within 30 days from the date of the reported incident. Denominator: Number of follow-up reports reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of critical incident with an identified cause where systemic intervention was implemented. Numerator: Total number of critical incidents with an identified cause where systemic intervention was implemented. Denominator: Total number of critical incidents with an identified cause.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incident-related corrective action plans resolved consistent with Department requirements. Numerator: Number of critical incident-related corrective action plans resolved consistent with Department requirements. Denominator: Number of critical incident-related corrective action plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and Percent of providers that implement the use of restrictive interventions according to State policy and this waiver. Numerator: Total number of providers that implement the use of restrictive interventions according to State policy and this waiver. Denominator: Total number of provider records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of providers with policies and procedures governing the use of restrictive interventions that comply with State policy and this waiver. Numerator: Total # of new applicants approved to deliver waiver services with policies and procedures governing the use of restrictive interventions that comply with State policy and this waiver. Denominator: Total # of provider agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and Percent of participants who received an annual physical health exam as evidenced by a paid claim. Numerator: Total number of participants who received an annual physical health exam as evidenced by a paid claim. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
electronic database system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of participants on a medication regimen with evidence in their record that appropriate monitoring has taken place no less than every 6-months. Numerator: Total # of participants on a medication regimen with evidence in their record that appropriate monitoring has taken place no less than every 6-months. Denominator: Total # of participants records on a medication regimen reviewed.

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

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

Data Aggregation and Analysis:

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

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

Responsibility for monitoring the health, safety and welfare of the waiver participant is a shared responsibility between the OADS Developmental Disability & Brain Injury Services Quality Team, CRCs and Providers. OADS developed a Critical Incident Dashboard that includes critical incident data as reported by community-based providers. The information from the Critical Incident Dashboard is used at provider quality meetings to address any issues that have arisen with the goal of ensuring the health, safety and welfare of the individual. OADS compares Medicaid claims for emergency department visits to ensure compliance that all emergency department incidents are reported to the State. OADS compares all deaths reported against the States Vital Statistic Death Registry to ensure that all deaths have been reported. Finally, OADS requests a data pull of all waiver participants from APS to monitor and review instances of abuse, neglect and exploitation of waiver participants.

14-197 C.M.R. Ch. 12, Reportable Events System requires that the provider conduct an internal review into the circumstance surrounding each critical incident to determine the cause of the critical incident and identify potential remediation action steps or other actions to decrease the likelihood that the incident will reoccur. Additionally, the regulation requires that the provider submit this information to the department, and, if no remediation steps are taken provide an explanation as to why no steps were taken.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The OADS Data and Quality Unit monitors and reviews data gathered quarterly for each of the performance measures. Issues and concerns that are discovered are sent to the OADS Quality Team for remediation. Systemic concerns, such as timeliness of reporting or failure to report that involve provider agencies are addressed during the quarterly quality provider meetings via technical assistance, or through the Progressive Corrective Actions Process. Concerns and issues involving individuals are addressed with the CRC who assists the individual with resolving immediate issues and/or addressing those issues in the PCSP.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

OMS and the OADS work together to ensure the health, safety and welfare of the participants receiving services and supports through this waiver. Trending, prioritizing, and implementing systems improvement or design changes are accomplished using multiple methods of data collection.

OADS collects experience of care data using the Consumer Assessment of Healthcare Provider and Systems (CAHPS), Home and Community-Based Services survey. OADS shares survey results with both internal and external stakeholder groups and uses this information to inform plans for additional data collection and /or quality improvement projects.

The OADS Waiver Management Team and the OADS Data and Quality unit develop a waiver performance measures workplan. The waiver performance measures workplan includes measures described in the QIS Sections of Appendices A, B, C, D, G, and I. The performance measure workplan guides additional monitoring and prioritization of improvement targets for each respective appendix. This workplan identifies lead staff, assigned staff start and end dates, data sources and status ensuring that each sub-assurance and performance measure are completed on a quarterly or annual basis. Workplan values are compared against minimum expectations on a quarterly or annual basis and any measures with a score below the minimum performance threshold are sent to the OADS unit responsible for provider oversight.

In addition to the performance measure workplan, the OADS Quality Team conducts routine critical incident reviews, which includes reviewing any use of restrictive interventions that may be in violation of state policy, and monitors complaints. When potential systemic issues are identified through data, event, or complaint, a summary is prepared and forwarded to the respective management team and other involved internal staff for consideration and development of an improvement strategy. Performance measures identified in need of improvement are then addressed using a variety of strategies including provider education, technical assistance, and corrective actions. To ensure timeframes are met and remediation objectives are achieved, the OADS Quality Team captures remediation activities, Notices of Deficiency and corrective actions on a provider agency and settings list.

At the end of waiver reporting year, OADS Data and Quality coordinates the development of a final performance measure summary. The final summary describes any performance measure deficiencies identified and related remediation or quality improvement activities that OADS completed. OADS sends the final performance measure summary to OMS for review and the annual performance measure results are included in the waiver’s 372 report.

As part of the discovery process, OADS has two primary dashboards that collect and synthesize data: the Waiver Dashboard and the Critical Incidents Dashboard. The Waiver Dashboard allows the waiver program manager to review expenditures by waiver, procedure code, participant, provider and service location. This data can be trended on a quarterly or annual basis. The data comes from Medicaid’s Data Analytics Platform (DAP).

The Critical Incidents Dashboard includes all critical incidents as reported by community providers and includes date of incident, critical incidents by provider, location of incident, number of incidents by participant, incidents by type, timeliness of reporting, completeness of 30-day follow-up reports and trends over time. On a quarterly basis the information housed in the Critical Incident’s Dashboard is reviewed with community providers to discuss the reduction or prevention of incidents and opportunities for improvement. In addition, each quarter deaths of participants are matched against the State’s Death registry to ensure that all deaths are reported by community providers and critical incidents are matched against emergency Department Medicaid Claims data to ensure that all critical incidents are reported to OADS.

Furthermore, mandated reporters must report any incidents alleging abuse, neglect and exploitation to CPS or APS for possible investigation, which may result in substantiation. APS shares information about reports with the District Attorney’s Office and the OADS Quality Team. All APS reports are forwarded to the appropriate District Attorney’s Office in the county where the participant resides. If Adult Protective Services identifies service provider quality related concerns, then those quality related concerns are sent electronically to the OADS Quality Team Offices for routine system and provider monitoring. Adult Protective Services also reviews all participant deaths for indications of abuse, neglect or exploitation.

A panel also reviews participant deaths and serious injuries. The Aging and Disability Mortality Review Panel is a multidisciplinary panel established by Public Law 2021, chapter 398, for the purpose of reviewing the patterns of death of and serious injury to all Maine adults receiving home and community-based services (HCBS) under 42

Code of Federal Regulations, Part 441. The panel issues an annual trend report which is shared with OADS. OADS considers the annual mortality trend report when determining additional incident analysis and planning for technical assistance to HCBS providers.

Finally, all providers must comply with all applicable federal and state laws, including applicable Maine licensing laws and regulations. OADS follows a Plan of Corrective Action (POCA) process to expand upon the quality assurance activities and provide increased protections for participants by ensuring providers comply with service requirements, have sufficient clinical and administrative capability to carry out the intent of the service, and have taken steps to assure the safety, quality, and accessibility of the service for participants. The process includes noticing providers of specific deficiencies as well as the timeframes for correcting and remediating identified problems, and which may require the provider to submit a Plan of Corrective Action.

OADS continues to refine several Desk-Level Procedures (DLPs)to guide remediation work, including a DLP for handling corrective actions. The DLP describes the actions and criteria for evaluation of suspected deficiencies as well as criteria for request of a POCA and the procedure for working through a POCA to resolution. A tracking system assures all procedural steps and articulated timeframes are met.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

OADS and OMS have the primary responsibility for monitoring the effectiveness of the system design changes.

OADS is comprised of several divisions responsible for monitoring system design changes. These divisions include a waiver management team, CRCs, HCBS Monitoring Team, Quality Team, and Data Analytics and Compliance Team.

The Waiver Manager(s) monitor trends related to participant access, experience, and needs. They also coordinate with OADS Data Analytics and Compliance unit to evaluate data related to participant experience, waiver service provision, and provider capacity. OMS and OADS are partnering to come into compliance with the federal Access Rule requirements, which will require changes to systems, rules, policies, and practices. Additionally, both offices are partnering with stakeholders to implement a regulation that would eliminate the planned use of restraints. We plan to include updates on changes to the quality management system as it relates to this waiver as part of planned amendments and at renewals

The State is seeking 1915(b)(4) authority to waive participant's freedom of choice of providers for CRC (comprehensive case management as a waiver service). This will allow the State to improve service quality, ensure consistency, and facilitate oversight by limiting service delivery to providers who are part of a contractor arrangement. Network participation will be based on contract award, and providers must meet specific criteria such as service capabilities, geographic coverage, and quality standards.

The HCBS Ongoing Monitoring team monitors service provider compliance with settings requirements, which includes both desk-level and on-site provider reviews of quality assurance standards. This team also assists with implementation and training for any related identified system changes.

The OADS Quality Team triages and reviews critical incidents, conduct quarterly provider quality meetings, assess service quality complaints, and initiates and tracks progressive corrective actions to completion.

The OADS Data Analytics and Compliance unit collects and analyzes data from multiple sources, this includes collecting the CAHPS survey. This unit also assists with provider quality and compliance audits, while working closely with both the Waiver and the Quality Managers to identify opportunities and improvement strategies.

OADS and OMS have adopted the HCBS Quality Framework as a guide to ensure desired outcomes in seven focus areas. The HCBS Quality Framework sets the stage for quality through the perspective of the provider, participant and the system. The seven focus areas also correspond to the State's discovery, remediation and quality improvement activities for this waiver application described in the QIS sections of Appendices A, B, C, D, G, and I.

To assess the impact of system design changes, OADS and OMS regularly review data reports on each of the following focus areas:

Focus Area 1- Participant Access:
Qualified OADS staff review and approve Level of Care assessments. CRCs complete institutional care or HCBS service choice forms, conduct 90-day reviews, document participant unmet needs and ensure participants receive annual preventive health care visits.

Focus Area 2 – Participant-Centered Service Planning and Delivery:
CRCs complete at least an annual review of PCSP plans to ensure that the plan addresses health and safety risks, and goals. PCSPs are based on assessed needs. Critical incidents and reports of abuse, neglect and exploitation are addressed in the plan, if appropriate. Behavioral health plans are is reviewed quarterly to assure health, safety and welfare.

Focus Area 3 – Provider Capacity and Capabilities
All providers are enrolled as MaineCare (Medicaid) providers. Providers are approved based on meeting all HCBS skills, competencies, and qualifications. All providers maintain licensure and certification. Settings where waiver services are provided are reviewed for compliance for with HCBS standards. Agency providers meet quarterly with district staff to review data and trends.

Focus Area 4 – Participant Safeguards:
The OADS Quality Team monitors the Critical Incident Dashboard to protect participants. Service providers complete critical incident 30-day follow-up plans to address incident causes and impacts and document provider actions to reduce or prevent future occurrence. CRCs conduct psychotropic medication reviews, as necessary, every 6 months.

Critical incidents are reviewed to assess for proper reporting of abuse, and neglect or exploitation, provider compliance with rules and regulations, and to assess the need for corrective actions. Quality Team staff meet quarterly with providers to review data and identified challenges,, looking for trends and changing conditions.

Focus Area 5 – Participant Rights and Responsibilities:
Participants are notified of rights, appeals and grievance processes. Grievance and appeals are resolved timely, according to rule .

Focus Area 6 – Participant Outcomes and Satisfaction:
Participants are satisfied with the services and supports they receive.
Participants are integrated into the community.
Participants are employed or working toward career goals.

Focus Area 7 – System Performance:
Data is collected, reviewed, and shared quarterly with the respective management team. Continuous quality improvement through enforcement of quality standards, HCBS provider technical assistance and implementation of quality improvement projects to ensure quality outcomes. Financial accountability is reviewed quarterly and shared with responsible parties.

Focus areas for the OADS staff dedicated to quality oversight include CRC services, provider agency quality, data trending, and event management. They work closely with both the Data Analytics team and Waiver Team to assure OADS meets quality goals.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

OMS and OADS review, assess and make recommendations for continuous quality improvements to the OADS system. The two agencies meet periodically to review CMS updates related to the HCBS Quality Measure Set.

Quality assurance staff and waiver program managers regularly monitor the performance measure workplan, CAHPS survey, Critical Incident and Waiver Dashboards to review data on participants, providers and the system. Results of these reviews may prompt enhancements and changes in performance measures/indicators, data sources, rules, procedures, and policies, and roles and responsibilities of personnel to continuously improve system responsiveness for the participant.

The Quality Improvement Strategy is revisited annually and updated as needed based on related CMS HCBS updates, OADS discovery and remediation activities, and the results of planned quality improvement projects.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ◉ **HCBS CAHPS Survey :**

- **NCI Survey :**
- **NCI AD Survey :**
- **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Integrity of payments at the individual level:
Maine has developed a subsystem to its MMIS system that provides checks and balances to assure that medical eligibility determination and prior authorization have occurred and are valid for the dates of services billed. The classification dates entered 1) match the time period of medical eligibility determined as part of the assessment for waiver services and 2) provide system authorization to assure the participant has been determined eligible for a specific MaineCare program to allow claims to be paid for specific procedure codes. Medical eligibility classification codes are not entered into the subsystem without verification that financial eligibility has been determined. Claims are rejected for any date where both medical and financial eligibility are not in place. The subsystem also tracks persons under appeal to assure continued payment of services if a timely appeal was filed. Each program requiring medical eligibility determination and/or prior authorization of the service has an individual classification code.

Overall Medicaid program integrity:
Chapter I of the MBM, (https://www.maine.gov/sos/cec/rules/10/ch101.htm) §1.16 for Audits states that the Division of Audit or duly Authorized Agents appointed by the Department of Health and Human Services (DHHS) have the authority to monitor payments to any MaineCare provider by an audit or post-payment review. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements. Additionally, on an annual basis, the MaineCare (Medicaid) Program is wholly subjected to a Single State Audit conducted by the Office of the State Auditor. The state does not require providers to secure an independent audit of their financial statements.

The Division of Audit conducts audits and issues final cost settlements on all MaineCare cost reimbursed programs. The OMS PIU, as a duly authorized agent, is tasked with identifying fraud, waste and abuse within the MaineCare program and reviews MaineCare providers to ensure compliance with the MBM including documentation, medical necessity, coding, and billing compliance.

For this waiver, rates are published by the Department and the services are subject to compliance reviews. The Department may recover any amounts due the State based on MBM, Chapter I. Unless the services are of an institutional nature, a yearly independent financial audit is not required. Under Chapter III (Allowances for Services) of the MBM, providers are responsible for maintaining adequate financial and statistical records and making them available when requested for inspection by representatives of DHHS, Maine Attorney General's Office, or the Federal Government. Providers shall maintain accurate financial records for the services provided separate from other financial records.

The OMS PIU conducts continuous and on-going audits on providers through post-payment reviews of MaineCare providers based on complaints, referrals, and/or data analytics. The methods that are used to audit include the use of statistically valid random samples, complaint-focused reviews, and full reviews. Data-driven reviews may not require a review of records or may require the provider to do a self-audit. The scope can vary from a short timeframe to a full 5-year review. An annual work plan determines the services to be reviewed, in addition to complaints and other referrals received. PIU uses a confidence interval 90% and +/- 5% for SVRS.

When the OMS PIU does a review based on a statistically valid random sample (SVRS), it starts with a well- defined universe of claims and uses the RAT-Stats v. 2010 program to obtain the SVRS by claim line. A statistician developed an extrapolation tool for use by the OMS PIU (implemented in 2016) which determines the overpayment amount using a 5% margin of error. All reviews in which the OMS PIU uses an SVRS are done following this process.

The OMS PIU does not currently have the ability to run a report that captures the number of cases done based on a SVRS, but an estimate of the frequency would be approximately 20-35% of the time. For certain services, MaineCare needs to look at all Participants in a specific location in order to determine staff to client ratios, therefore a SVRS would not be appropriate.

In the event that the Department of Health and Human Services (DHHS) is aware that a new provider will be providing a service that has a high capacity for fraud and abuse (such as personal care services), PIU will prioritize that agency. This may range from a desk-level review of claims data to a full review of provider records. Additionally, the Department (DHHS) conducts routine statistical analysis of provider claims data in order to identify billing outliers. The Department then further investigates these outliers. Finally, the Department has engaged in targeted reviews of certain Medicaid services, in response to concerns about potential widespread deficiencies across providers.

Outliers are determined based on a variety of factors, such as the number of services, amount paid, units per Participant, or services per Participant. Factors are reviewed across the same service type or provider type to compare providers against their peers, using a specified standard deviation above the mean. Some services may require a different factor to be considered an outlier, such as an absence of care (e.g. DME prescribed with no prior relationship, or non-emergency

transportation without a corresponding medical claim); where another service may require looking at factors to determine overutilization or upcoding, such as a percentage of what was billed (e.g. percentage of high-level office visits to total office visits). The frequency at which these analyses typically occur is annually, based on an annual work plan.

Provider types with high capacities for fraud and abuse are prioritized in PIU's annual work plan. PIU uses a data-driven approach, and the outcome helps determine the type of review. If the provider has also been the subject of complaints or other concerns, that may warrant a full review. If the provider's claims are homogenous, PIU would tend to use a SVRS. Otherwise, PIU would do a desk-level or full review. In some instances, PIU does not need to review records, such as for coding or limits issues, and that information can be used to strengthen claims edits processing. PIU strives to make the most of PIU resources, including utilizing the Unified Program Integrity Contractor (for the State of Maine, this contractor is Safeguard Services LLC.) for reviews of high-risk provider types.

The State has not engaged in targeted reviews because of widespread deficiencies, but rather, has engaged in targeted reviews to look for such deficiencies. Some services that have been reviewed using this type of approach are Home and Community Based Services and Personal Care Services. Deficiencies noted (though not necessarily widespread) included lack of or untimely background checks on employees, staffing ratios not being met (HCBS services), overbilling units (PCS), and general documentation deficiencies. The actions taken to resolve these issues include recouping overpayments from providers, referrals to Licensing, and recommendations brought forth for policy and system enhancements.

On-site reviews are conducted. Typical reasons for conducting an on-site review include whether there are concerns of fraud, whether the provider is not cooperating with record requests by mail, or there is a need to see where records are secured or to review a provider's electronic health record system.

The OMS PIU leverages EVV data during post-payment review/audits when available. PIU staff compares the information in the EVV to the records submitted by the provider and the claims paid by MaineCare.

PIU utilizes EVV reports to inform decision-making regarding providers and services that should be selected for post-payment review. For example, providers with a high number of exceptions per employee, per consumer, or agency-wide could be prioritized. The PIU sampling approach will include using statistically valid random samples (confidence interval 90% and +/- 5%) of claims for some providers but may also include looking at specific claims based on exceptions for other providers.

Maine has specific reporting requirements outlined in our policies. Regardless of the source, all complaints received in PIU are logged and triaged within 48 hours. The triage process identifies whether there are any Participant safety concerns, and if so, an immediate referral is made to Adult Protective Services or Child Protective Services. The complaint then may be passed on to an auditor for further review. Outliers are identified based on payment amounts and amount paid per recipient being one standard deviation above the mean. Identifying growth over time entails looking at all claims for a specific service over a 2–5-year period to determine if the units increased by 100% or more from one year to the next. The OMS PIU may choose to review providers that are relatively new to the program to check for compliance, or providers that have never been reviewed, even if their claims appear appropriate.

Providers delivering Personal and Home Assistance, Community Supported Living, Respite Breaks and Opportunities, Home-Based Independent Living Skills, Private Dute Nursing and Remote Monitoring and On-Call Response services must comply with Maine DHHS EVV system standards and requirements for these services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:
Number and Percent of claims with appropriate documentation that services were rendered, coded/paid in accordance with the reimbursement methodology in the approved waiver. Numerator: Total number of claims with appropriate documentation of services rendered, coded/paid in accordance with the reimbursement methodology in the approved waiver. Denominator: Total number of paid claims reviewed.

Data Source *(Select one):*
Financial audits
If 'Other' is selected, specify:

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

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and Percent of rates that remain consistent with the approved rate methodology throughout the five-year waiver cycle. Numerator: Total number of rates remaining

consistent with the approved rate methodology throughout the five-year waiver cycle. Denominator: Total number of rates reviewed in the approved waiver.

Data Source *(Select one):*
Financial audits
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

The current MMIS system limits all services provided under the waiver to what is permitted by the policy for each classification group. Claims are denied if improper rates are billed or units of service are billed in excess of the limits outlined in policy.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

If concerns are raised by a provider regarding claims, the provider contacts the provider relations specialist through MaineCare. If additional policy issues are identified, OADS requests data from OMS to verify the information. OADS and OMS work together to develop a plan for making changes in policy, provider's billing process and/or the MMIS system.

If OMS were to identify a problem with claims, they would be evaluated further by having a discussion with the agency submitting the claim. The provider would then need to correct the claim. If there was any indication that the provider knowingly submitted inaccurate claims, or appeared fraudulent in any way, the State's program integrity unit would be contacted. Program Integrity would pull provider records, claims information, member records etc...to determine if there are errors between the service delivered, what's authorized, and how it is billed. Depending on the errors or discrepancies detected, program integrity could seek recoupment, terminate the provider agreement, or even refer the provider to the Health Care Crimes unit of the State's Attorney General's Office.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Office of MaineCare Services of the DHHS in collaboration with the OADS, is responsible for establishing provider payment rates for waiver services. Historically, DHHS has established payment rates through a variety of mechanisms, including consideration of historic cost and budget data, comparisons to rates paid for similar services in other programs, and targeted rate studies. Rates for this waiver are subject to review and amendment by the State legislature. Waiver services are generally reimbursed on a fee-for-service basis, with the exceptions noted below, primarily for items and services that are manually priced. Rates do not vary based on the provider. The waiver rate schedule is available on DHHS' website (https://www.maine.gov/dhhs/oms/providers/code-rates).

Recent legislation will systematize rate setting on an ongoing basis. This will enhance the Department's ability to ensure that rates are regularly reviewed for economy, efficiency, and quality of care, and that rates are sufficient to enlist enough providers. PL 2021, ch. 639 was enacted in 2022 and took effect August 8, 2022. As passed, PL 2021, ch. 639 creates a new stand-alone section of Maine law (22 M.R.S.A. §3173-J) that codifies the processes and principles for the OMS Rate System. These processes and principles include setting a schedule for regular rate review and adjustment, to be reviewed annually in consultation with a Technical Advisory Panel (TAP); reviewing relevant state and national data to inform rate amounts and payment models, with an emphasis on models that promote high value services by connecting reimbursement to performance; and formalizing a clear and transparent process for rate determination that includes public notice and comment.

Rates for shared services – Home Support-Agency Per Diem and Facility-Based Day Program – as well as Shared Living, Community Supported Living, and outcome-based employment services are tiered with higher rates paid for services provided to individuals with more significant needs to account for more intensive staffing expectations. The State uses the Supports Intensity Scale (SIS) as part of the required functional and comprehensive assessment completed by a single services assessment agency which is used by case managers in the development of the person centered plan to assign individuals to one of six levels, which are grouped into four rate categories.

The rate schedule was developed based on a rate study conducted in 2024 and 2025 by the Burns & Associates division of Health Management Associates (HMA-Burns), a national consultant experienced in developing provider reimbursement rates for HCBS waivers. The rate study covered services delivered through the State's existing 1915(c) waivers for individuals with individuals with intellectual and developmental disabilities, autism spectrum disorders, related conditions, and traumatic brain injuries. Given the similarity in service expectations and the likely overlap of service providers, the results of this rate study were used to inform the development of payment rates for this waiver.

The rate study included:

A series of meetings with a Provider Advisory Group. The group was comprised of a diverse cross-section of providers in terms of services delivered, size, and location. The group was convened at key milestones in the study, including development of a draft provider survey and presentation of initial recommendations.

Development and administration of a provider survey related to service design and costs. All current providers were sent the survey and given an opportunity to participate. HMA-Burns provided technical assistance throughout the survey period, including drafting detailed instructions for completing the survey, recording and posting online a webinar to walk-through the survey, responding to questions via phone calls and emails, reviewing each submitted survey and working with providers to resolve potential errors.

Identification of benchmark data, such as cross-industry wage data from the Bureau of Labor Statistics.

Development of rate models for each service that include specific assumptions related to the various costs associated with delivering each service, including direct care worker wages, benefits, and 'productivity' (i.e., billable time); staffing ratios; mileage; facility expenses; and agency program support and administration.

A public comment process through which proposed rate models were emailed to providers and other interested parties and posted online. Interested parties were given several weeks to submit written comments. OADS prepared written responses to all comments received and revised the rates as appropriate.

Rate models were developed for all waiver services with a few exceptions.
Employment Exploration and Self-Employment Start-Up Plan and Outcome are outcome-based payments based on the completion of the task. The development of these rates followed the same process described above for fee-for-service supports with additional assumptions related to the amount of time required to complete the outcome. The Self-Employment Start-Up Plan and Outcome payments are tiered.

The rates for Private Duty Nursing and Therapy services are tied to the rates for the same services delivered through other OMS State Plan services.

AT, Minor Home Modifications, and Housing Start-Up Assistance services are reimbursed based on the cost of the items purchased, up to the limits specified in the service description.

Non-Medical Transportation is reimbursed on a per-member per-month basis, according to a full risk capitation model. The rates were calculated by Deloitte Consulting LLP and are consistent with CMS requirements that the capitation rates be actuarially sound and appropriate. The database variables (by region) included paid amount, number of rides, rides per thousand, average cost per ride, miles, miles per ride, cost per ride, and base per-member-per-month.

Additionally, rate changes for 1915(c)HCBSs waiver have resulted from specific legislation, for example, retroactive rate and service cap increases for ME.0159 that were effective January 1, 2021 resulted from the Maine Legislature's passage of P.L. 2019 ch. 616, An Act Making Supplemental Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2020 and June 30, 2021. The Act provided funding for rate adjustments for specific services, to reflect the rate models prepared for the Department by HMA-Burns.

On an ongoing basis, the Department's rate-setting unit will regularly review and adjust rates in compliance with PL 2021, ch. 398, AAAA. The law required that, effective January 1, 2022, the labor components of OMS reimbursement rates for specified services delivered by essential support workers must equal at least 125% of the minimum wage established in Title 26, section 664, subsection 1. Essential support workers are individuals who by virtue of employment generally provide to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or have direct access to provide care and services to clients, patients or residents regardless of the setting. 22 M.R.S. 7401. In addition, Part AAAA states that the reimbursement rate must include an amount necessary to reimburse the provider for taxes and benefits related to the wages. 22 M.R.S. §7402(2).

PL 2021, ch. 398, OOO authorizes the Department to implement cost of living increases (COLAs) for these services. Each January 1, services will receive an annual COLA, contingent on available funding and legislative approval, equal to the percentage increase in the state minimum wage as set by the Department of Labor consistent with 26 M.R.S. §664. Services that received an increase to their rate within the previous 12-month period will not receive the annual COLA increase effective the following January 1. The Maine Department of Labor determines the percentage increase, if any, as of August of the previous year over the level as of August of the year preceding that year in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) for the Northeast Region, or its successor index, as published by the United States Department of Labor, Bureau of Labor Statistics, or its successor agency, with the amount of the minimum wage increase rounded to the nearest multiple of 5¢.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers bill the Department directly through the MMIS system. Claims are processed and paid directly to each provider.
For NET, the Broker shall receive a monthly capitated per-member-per-month (PMPM) payment for each participant whose eligibility for the current month has been confirmed by the Department regardless of the participant's NET service use. This is a full risk contract outside of the MMIS system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

A participant is not eligible for waiver services until both financial and medical eligibility have been established. Claims would not be processed without establishing eligibility as well as classification for services.

Upon assessment of the participant, the medical eligibility data is entered into the electronic database system. Start and end dates for services are entered also. These dates correspond to the dates in which a provider can submit claims. If an end date has been reached and the participant has not been reassessed for continued medical eligibility and classified with a new set of start and end dates, claims for services provided to that participant will not be paid. When service is recommended in the participant's plan, authorization is given to the provider in advance of provision of services and authorization is electronically transferred to the claims system.

Additionally, effective January 1, 2021, Maine implemented EVV for 1915(c) Authority waiver programs delivering personal care services within the home. Maine contracted with its Fiscal Agent, Gainwell, for an EVV solution. Gainwell has subcontracted with Sandata for the following EVV solution components: mobile and telephony applications that allow providers to create EVV records, a "3rd party aggregator" that allows providers with other EVV systems to submit data into Sandata, a portal to allow provider staff to manage accounts and records, and claims editing within the MMIS to match claims for PCS services with EVV records. The system requires that all visit records include participant ID, caretaker ID, date of service, start and end times of the service, location, and CPT or HCPCS code.

The Maine EVV system includes a pre-payment validation process as well as post-payment review process. Pre-payment validation includes a 30-day pend process such that claims for services subject to EVV pend for up to 30 days while the system searches for a matching EVV record and deny when no verified EVV record is found. The post-payment process includes ongoing monitoring and surveillance of claims data as described below.

Ongoing monitoring is conducted by the operating agency and includes on-site visits to monitor compliance with the waiver document, regulations and contract performance. If, at any time, the services provided do not conform, OADS will notify OMS which will then audit claims for wrongful payment.

Payment for services provided is a multistep process. This is specifically outlined in the MBM, Chapter I- Section 1 General Administrative Policies and Procedures, Chapter II-Specific Policies by Service, and Chapter III- Allowances for Services describes in detail the reimbursement, payment process, and audit oversight including utilization review. Chapter I of the MBM, Section 1.17, Utilization Review, states the following:

The Department or its Authorized Agent is responsible for carrying out a series of safeguarding measures. These measures safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assessing the quality of such services available under MaineCare. The Department may use consultants and peer reviewers with expertise appropriate to the medical care or services to be reviewed.

The Department has the authority to request medical records and other records as necessary to support utilization review, utilization management, concurrent review, or other service review activities. Providers must respond to requests in a timely manner and at no charge to the Department.

Chapter I of the MBM, §1.18, Program Integrity, states the following:
The OMS PIU, Division of Audit and /or the Department's Authorized Agent are responsible for surveillance and referral activities that may include, but are not limited to:
A. A continuous sampling review of the utilization of care and services for which payment is claimed;
B. An on-going sample evaluation of the necessity, quality, quantity and timeliness of the services provided to participants;
C. An extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare;
D. A post-payment review that may consist of participant utilization profiles, provider services profiles, claims, all pertinent professional and financial records, and information received from other sources;
E. The implementation of the Restriction Plans;
F. Referral to appropriate licensing boards or registries; and
G. Referral to the Maine Attorney General's Office, Healthcare Crimes Unit, for those cases in which fraudulent activity is suspected.

DUE TO CHARACT4ER COUNT LIMIT - SEE MAIN OPTIONAL FOR REMAINING INFORMATION TO Appendix 1-2-D

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Transportation is reimbursed through a 1915b Me.19 NET Waiver capitated system with contracted brokers outside the MMIS system.

The process for making the payments is through contracted services, the entity that processes these payments is the Department of Administration and Finance.

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

The Broker submits encounter claims data. A review of the encounter data for each transportation broker is completed regularly. Transportation Service reimbursement is capitated and paid to the broker through the monthly invoice submitted to the Department by the Broker. The monthly invoice is paid through the State's accounting system and subject to the internal controls established by the Office of the State Controller.

An audit trail of payments is based on the Maine Medicaid chart of accounts. A detailed explanation of transportation services is described in greater detail in the transportation waiver.

The appropriation and unit / Object codes for entry onto line 19A of the CMS64 report are as follows:
Appropriation: 0147-
Unit for waivered services: 3618 Object codes: 6772; 6778; and 6786.

Cash draws for the federal portion of the Payment Management System are completed regularly through the Batch Interface claims processing system; and accounted for through the accounting appropriation 0147 for Medicaid. The unit for waivered services is 3618 using object codes 6772; 6778; and 6786.

The basis of the draw is through the Maine Medicaid chart of accounts. The appropriation and unit / Object codes for entry onto line 19A of the CMS64 report are as follows (and previously noted):
Appropriation: 0147-
Unit for waivered services: 3618 Object codes: 6772; 6778; and 6786.
Cash draws for the federal portion of the Payment Management System are completed regularly through the Batch Interface claims processing system; and accounted for through the accounting appropriation 0147 for Medicaid. The unit for waivered services is 3618 using object codes 6772; 6778; and 6786.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on

the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For Transportation services- The limited fiscal agent is selected through an RFP process. The waiver services that the fiscal agent will make payment for are Transportation services. The fiscal agent pays through a capitated system. Chapter I of the MBM authorizes audits for services. The 1915b NET Waiver (Me.19) is covered by these same audit requirements. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data. The broker for transportation is one of 3 contracted entities for the 8 regions depending upon the region in the state. Regions 3 and 4 are served by Penquis Community Action Program, Regions 1, 2, 6, 7 & 8 are served by LogistiCare Solutions, LLC, and Region 5 is served by Mid Coast Connector.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for*

expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess***

and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services

under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

Check each that applies:

- ☐ ***Health care-related taxes or fees***
- ☐ ***Provider-related donations***
- ☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The rate structure for services delivered in residential settings is based solely on the cost of delivering the service and does not include room and board costs. Cost of room and board is paid for separately by a combination of participant funds (e.g., SSI) and other state contracted funds. Any payments made to room and board do not process through the MMIS claim system and are therefore not included with the cost.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	31931.00	16652.00	48583.00	309100.00	14346.00	323446.00	274863.00
2	52192.34	24190.00	76382.34	309100.00	14346.00	323446.00	247063.66
3	56886.45	24068.00	80954.45	309100.00	14346.00	323446.00	242491.55
4	60002.95	23997.00	83999.95	309100.00	14346.00	323446.00	239446.05
5	62425.30	23951.00	86376.30	309100.00	14346.00	323446.00	237069.70

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	680	680
Year 2	1073	1073
Year 3	1466	1466
Year 4	1859	1859
Year 5	2252	2252

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay is 355 days for the estimate of Lifespan enrollees. It is based on Section 21 (age 18 and above) & 28 (age 14 and above) members' utilization information including days of eligibility from MaineCare database (DSS). The time period of the data is 7/1/2024 - 6/30/2025.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The estimates of Factor D were derived from Burns & Associates' "Independent Rate Model Approach". It uses detailed cost assumptions for services from multi data sources. The cost components are based on Sections 21 (age 18 and above) & 28 (age 14 and above) service utilization data (7/1/2024 – 6/30/2025) and factors like staff wages, benefits, staffing ratios, and other operational costs.

The increased cost estimates from WY1 to WY5 are due to the increasing/changing of the enrollees and the units per user. The rate for each service remains the same from WY1-5.

Based on the past actual utilization data, the state believes the cost of the providing services will trend upwards year-to-year for the duration of the five-year waiver. The state decided to add the annual COLA's and trend factor percentages through subsequent amendments and 372 reporting, rather than the prospective waiver application process, allows the state to more accurately project rates and assure cost neutrality within this waiver application.

Transportation PMPM was created as described in I-2-a and added to waiver Years 1-5 for the Concurrent 1915 (b) Non-Emergency Transportation Waiver.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates of Factor D' were derived from Burns & Associates' "Independent Rate Model Approach". It uses detailed cost assumptions for services from multi data sources. The cost components are based on Sections 21 (age 18 and above) & 28 (age 14 and above) service utilization data (7/1/2024 – 6/30/2025) and factors like staff wages, benefits, staffing ratios, and other operational costs.

The increased cost estimates from WY1 to WY5 are due to the increasing/changing of the enrollees and the units per user. The rate for each service remains the same from WY1-5.

Based on the past actual utilization data, the state believes the cost of the providing services will trend upwards year-to-year for the duration of the five-year waiver. The state decided to add the annual COLA's and trend factor percentages through subsequent amendments and 372 reporting, rather than the prospective waiver application process, allows the state to more accurately project rates and assure cost neutrality within this waiver application.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G Derivation was based on the actual payments from SFY2025 (7/1/2024 -6/30/2025) 372 Report. The source for actual utilization including numbers of users, average usage per user and the services paid amounts are from MaineCare database (DSS). The state determined no COLA is added for WY2-5 in this application. Therefore, the numbers for WY1-5 are the same.

Based on the past actual utilization data, the state believes the cost of the providing services will trend upwards year-to-year for the duration of the five-year waiver. The state decided to add the annual COLA's and trend factor percentages through subsequent amendments and 372 reporting, rather than the prospective waiver application process, allows the state to more accurately project rates and assure cost neutrality within this waiver application.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' Derivation was based on the actual payments from SFY2025 (7/1/2024 -6/30/2025) 372 Report. The source for actual utilization including numbers of users, average usage per user and the services paid amounts are from MaineCare database (DSS). The state determined no COLA is added for WY2-5 in this application. Therefore, the numbers for WY1-5 are the same.

Based on the past actual utilization data, the state believes the cost of the providing services will trend upwards year-to-year for the duration of the five-year waiver. The state decided to add the annual COLA's and trend factor percentages through subsequent amendments and 372 reporting, rather than the prospective waiver application process, allows the state to more accurately project rates and assure cost neutrality within this waiver application.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Co-Worker Supports	
Community and Relationship Connecting	
Community Resource Coordination (CRC)	
Facility-Based Day Program Services	
Home Support Agency Per Diem	
Personal and Home Assistance	

Waiver Services	
Respite Breaks and Opportunities	
Financial Management Services	
Supports Brokerage	
Assistive Technology	
Behavioral Support Consultation	
Benefits and Work Incentive Counseling	
Career Planning	
Community Connections Assistance	
Community Supported Living	
Community Transition Case Management	
Community Transportation	
Employment Exploration	
Family Empowerment and Systems Navigation	
Home-Based Independent Living Skills Training	
Housing Counseling	
Housing Start-Up Assistance	
Individual Goods and Services	
Integrated Employment Path Services	
Job Coaching	
Job/Career Development Plan and Outcome	
Minor Home Modifications	
Occupational Therapy (Maintenance)	
Peer Specialist Services	
Physical Therapy (Maintenance)	
Private Duty Nursing	
Remote Monitoring and On-Call Response Service	
Self-Employment Start-Up Plan and Outcome	
Shared Living	
Speech Therapy (Maintenance)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Co-Worker Supports Total:							**9922.82**
Co-Worker Supports	☐	607	7	86.70	16.35	**9922.82**	
Community and Relationship Connecting Total:							**532359.22**
Community and Relationship Connecting	☐	30386	102	297.90	17.52	**532359.22**	
Community Resource Coordination (CRC) Total:							**1797525.60**
Community Resource Coordination (CRC)	☐	4420	680	6.50	406.68	**1797525.60**	
Facility-Based Day Program Services Total:							**501957.30**
Facility-Based Day Program Services	☐	88842	340	261.30	5.65	**501957.30**	
Home Support Agency Per Diem Total:							**11637322.88**
Home Support Agency Per Diem	☐	17094	92	185.80	680.80	**11637322.88**	
Personal and Home Assistance Total:							**114645.96**
Personal and Home Assistance	☐	8752	33	265.20	13.10	**114645.96**	
Respite Breaks and Opportunities Total:							**933473.06**
Respite Breaks and Opportunities	☐	80611	548	147.10	11.58	**933473.06**	
Financial Management Services Total:							**173281.68**
Financial Management Services	☐	1326	204	6.50	130.68	**173281.68**	
Supports Brokerage Total:							**20145.00**
Supports Brokerage	☐	1020	204	5.00	19.75	**20145.00**	

GRAND TOTAL: 21713083.13

Total: Services included in capitation:

Total: Services not included in capitation: 21713083.13

Total Estimated Unduplicated Participants: 680

Factor D (Divide total by number of participants): 31931.00

Services included in capitation:

Services not included in capitation: 31931.00

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Total:							**28000.00**
Assistive Technology	☐	28	28	1.00	1000.00	**28000.00**	
Behavioral Support Consultation Total:							**12448.80**
Behavioral Support Consultation	☐	532	28	19.00	23.40	**12448.80**	
Benefits and Work Incentive Counseling Total:							**9650.55**
Benefits and Work Incentive Counseling	☐	683	21	32.50	14.14	**9650.55**	
Career Planning Total:							**48060.77**
Career Planning	☐	705	13	54.20	68.21	**48060.77**	
Community Connections Assistance Total:							**924666.43**
Community Connections Assistance	☐	132474	381	347.70	6.98	**924666.43**	
Community Supported Living Total:							**605359.80**
Community Supported Living	☐	90	15	6.00	6726.22	**605359.80**	
Community Transition Case Management Total:							**6442.50**
Community Transition Case Management	☐	250	50	5.00	25.77	**6442.50**	
Community Transportation Total:							**820063.68**
Community Transportation	☐	250784	680	368.80	3.27	**820063.68**	
Employment Exploration Total:							**28200.90**
Employment Exploration	☐	13	13	1.00	2169.30	**28200.90**	

GRAND TOTAL: 21713083.13

Total: Services included in capitation:

Total: Services not included in capitation: 21713083.13

Total Estimated Unduplicated Participants: 680

Factor D (Divide total by number of participants): 31931.00

Services included in capitation:

Services not included in capitation: 31931.00

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Empowerment and Systems Navigation Total:							**29393.99**
Family Empowerment and Systems Navigation	☐	2302	17	135.40	12.77	**29393.99**	
Home-Based Independent Living Skills Training Total:							**40281.15**
Home-Based Independent Living Skills Training	☐	2535	26	97.50	15.89	**40281.15**	
Housing Counseling Total:							**4283.58**
Housing Counseling	☐	304	14	21.70	14.10	**4283.58**	
Housing Start-Up Assistance Total:							**5000.00**
Housing Start-Up Assistance	☐	5	5	1.00	1000.00	**5000.00**	
Individual Goods and Services Total:							**346800.00**
Individual Goods and Services	☐	204	204	1.00	1700.00	**346800.00**	
Integrated Employment Path Services Total:							**1701128.80**
Integrated Employment Path Services	☐	113560	136	835.00	14.98	**1701128.80**	
Job Coaching Total:							**80469.74**
Job Coaching	☐	5375	62	86.70	14.97	**80469.74**	
Job/Career Development Plan and Outcome Total:							**45010.57**
Job/Career Development Plan and Outcome	☐	11	11	1.00	4091.87	**45010.57**	
Minor Home Modifications Total:							**35000.00**
Minor Home Modifications	☐	7	7	1.00	5000.00	**35000.00**	

GRAND TOTAL: 21713083.13

Total: Services included in capitation:

Total: Services not included in capitation: 21713083.13

Total Estimated Unduplicated Participants: 680

Factor D (Divide total by number of participants): 31931.00

Services included in capitation:

Services not included in capitation: 31931.00

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy (Maintenance) Total:							**215.27**
Occupational Therapy (Maintenance)	☐	19	1	19.00	11.33	**215.27**	
Peer Specialist Services Total:							**7571.44**
Peer Specialist Services	☐	606	14	43.30	12.49	**7571.44**	
Physical Therapy (Maintenance) Total:							**31.16**
Physical Therapy (Maintenance)	☐	3	1	2.70	11.54	**31.16**	
Private Duty Nursing Total:							**59697.46**
Private Duty Nursing	☐	2654	14	189.60	22.49	**59697.46**	
Remote Monitoring and On-Call Response Service Total:							**221437.12**
Remote Monitoring and On-Call Response Service	☐	71663	21	3412.50	3.09	**221437.12**	
Self-Employment Start-Up Plan and Outcome Total:							**22737.58**
Self-Employment Start-Up Plan and Outcome	☐	1408	13	108.30	16.15	**22737.58**	
Shared Living Total:							**904831.14**
Shared Living	☐	4088	22	185.80	221.36	**904831.14**	
Speech Therapy (Maintenance) Total:							**5667.20**
Speech Therapy (Maintenance)	☐	493	7	70.40	11.50	**5667.20**	

GRAND TOTAL: 21713083.13

Total: Services included in capitation:

Total: Services not included in capitation: 21713083.13

Total Estimated Unduplicated Participants: 680

Factor D (Divide total by number of participants): 31931.00

Services included in capitation:

Services not included in capitation: 31931.00

Average Length of Stay on the Waiver: 355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Co-Worker Supports Total:							**25388.28**
Co-Worker Supports	☐	1553	12	129.40	16.35	**25388.28**	
Community and Relationship Connecting Total:							**1290761.47**
Community and Relationship Connecting	☐	73677	161	457.60	17.52	**1290761.47**	
Community Resource Coordination (CRC) Total:							**4363676.40**
Community Resource Coordination (CRC)	☐	10715	1073	10.00	406.68	**4363676.40**	
Facility-Based Day Program Services Total:							**1217260.86**
Facility-Based Day Program Services	☐	215470	537	401.20	5.65	**1217260.86**	
Home Support Agency Per Diem Total:							**26665914.80**
Home Support Agency Per Diem	☐	39174	133	294.50	680.80	**26665914.80**	
Personal and Home Assistance Total:							**2241130.97**
Personal and Home Assistance	☐	171039	169	1012.30	13.10	**2241130.97**	
Respite Breaks and Opportunities Total:							**2190266.68**
Respite Breaks and Opportunities	☐	189149	822	230.10	11.58	**2190266.68**	
Financial Management							**442391.00**

GRAND TOTAL: **56002378.19**

Total: Services included in capitation:

Total: Services not included in capitation: 56002378.19

Total Estimated Unduplicated Participants: **1073**

Factor D (Divide total by number of participants): **52192.34**

Services included in capitation:

Services not included in capitation: 52192.34

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Financial Management Services	☐	3391	349	9.70	130.68	**442391.00**	
Supports Brokerage Total:							**27571.00**
Supports Brokerage	☐	1413	349	4.00	19.75	**27571.00**	
Assistive Technology Total:							**45000.00**
Assistive Technology	☐	45	45	1.00	1000.00	**45000.00**	
Behavioral Support Consultation Total:							**30431.70**
Behavioral Support Consultation	☐	1302	45	28.90	23.40	**30431.70**	
Benefits and Work Incentive Counseling Total:							**23797.62**
Benefits and Work Incentive Counseling	☐	1683	34	49.50	14.14	**23797.62**	
Career Planning Total:							**118173.82**
Career Planning	☐	1733	21	82.50	68.21	**118173.82**	
Community Connections Assistance Total:							**2240538.82**
Community Connections Assistance	☐	321020	601	534.10	6.98	**2240538.82**	
Community Supported Living Total:							**1864508.18**
Community Supported Living	☐	276	33	8.40	6726.22	**1864508.18**	
Community Transition Case Management Total:							**10179.15**
Community Transition Case Management	☐	395	79	5.00	25.77	**10179.15**	
Community Transportation							**1987684.22**

GRAND TOTAL: **56002378.19**

Total: Services included in capitation:

Total: Services not included in capitation: *56002378.19*

Total Estimated Unduplicated Participants: **1073**

Factor D (Divide total by number of participants): **52192.34**

Services included in capitation:

Services not included in capitation: *52192.34*

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Community Transportation	☐	607891	1073	566.50	3.27	**1987684.22**	
Employment Exploration Total:							**45555.30**
Employment Exploration	☐	21	21	1.00	2169.30	**45555.30**	
Family Empowerment and Systems Navigation Total:							**71578.40**
Family Empowerment and Systems Navigation	☐	5604	27	207.60	12.77	**71578.40**	
Home-Based Independent Living Skills Training Total:							**238693.22**
Home-Based Independent Living Skills Training	☐	15015	132	113.80	15.89	**238693.22**	
Housing Counseling Total:							**10637.04**
Housing Counseling	☐	755	23	32.80	14.10	**10637.04**	
Housing Start-Up Assistance Total:							**8000.00**
Housing Start-Up Assistance	☐	8	8	1.00	1000.00	**8000.00**	
Individual Goods and Services Total:							**593300.00**
Individual Goods and Services	☐	349	349	1.00	1700.00	**593300.00**	
Integrated Employment Path Services Total:							**5640411.91**
Integrated Employment Path Services	☐	376531	215	1751.30	14.98	**5640411.91**	
Job Coaching Total:							**195265.69**
Job Coaching	☐	13040	98	133.10	14.97	**195265.69**	
Job/Career Development Plan and Outcome Total:							**73653.66**

GRAND TOTAL: **56002378.19**

Total: Services included in capitation:

Total: Services not included in capitation: 56002378.19

Total Estimated Unduplicated Participants: **1073**

Factor D (Divide total by number of participants): **52192.34**

Services included in capitation:

Services not included in capitation: 52192.34

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job/Career Development Plan and Outcome	☐	18	18	1.00	4091.87	73653.66	
Minor Home Modifications Total:							55000.00
Minor Home Modifications	☐	11	11	1.00	5000.00	55000.00	
Occupational Therapy (Maintenance) Total:							611.82
Occupational Therapy (Maintenance)	☐	54	2	27.00	11.33	611.82	
Peer Specialist Services Total:							18873.64
Peer Specialist Services	☐	1510	23	65.70	12.49	18873.64	
Physical Therapy (Maintenance) Total:							90.01
Physical Therapy (Maintenance)	☐	8	2	3.90	11.54	90.01	
Private Duty Nursing Total:							98074.39
Private Duty Nursing	☐	4361	23	189.60	22.49	98074.39	
Remote Monitoring and On-Call Response Service Total:							535342.50
Remote Monitoring and On-Call Response Service	☐	173250	33	5250.00	3.09	535342.50	
Self-Employment Start-Up Plan and Outcome Total:							55993.67
Self-Employment Start-Up Plan and Outcome	☐	3467	21	165.10	16.15	55993.66	
Shared Living Total:							3562922.02
Shared Living	☐	16092	68	236.70	221.36	3562922.02	
Speech Therapy (Maintenance) Total:							13699.95

GRAND TOTAL: 56002378.19

Total: Services included in capitation:

Total: Services not included in capitation: 56002378.19

Total Estimated Unduplicated Participants: 1073

Factor D (Divide total by number of participants): 52192.34

Services included in capitation:

Services not included in capitation: 52192.34

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy (Maintenance)	☐	1192	11	108.30	11.50	13699.95	

GRAND TOTAL: 56002378.19
Total: Services included in capitation:
Total: Services not included in capitation: 56002378.19
Total Estimated Unduplicated Participants: 1073
Factor D (Divide total by number of participants): 52192.34
Services included in capitation:
Services not included in capitation: 52192.34
Average Length of Stay on the Waiver: 355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Co-Worker Supports Total:							37068.72
Co-Worker Supports	☐	2267	16	141.70	16.35	37068.72	
Community and Relationship Connecting Total:							1859362.56
Community and Relationship Connecting	☐	106127	220	482.40	17.52	1859362.56	
Community Resource Coordination (CRC) Total:							6260025.24
Community Resource Coordination (CRC)	☐	15431	1466	10.50	406.68	6260025.24	
Facility-Based Day Program Services Total:							1752661.64

GRAND TOTAL: 83395538.40
Total: Services included in capitation:
Total: Services not included in capitation: 83395538.40
Total Estimated Unduplicated Participants: 1466
Factor D (Divide total by number of participants): 56886.45
Services included in capitation:
Services not included in capitation: 56886.45
Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility-Based Day Program Services	☐	310232	733	423.20	5.65	1752661.64	
Home Support Agency Per Diem Total:							36373442.00
Home Support Agency Per Diem	☐	53422	175	305.30	680.80	36373442.00	
Personal and Home Assistance Total:							5189339.68
Personal and Home Assistance	☐	396074	313	1265.60	13.10	5189339.68	
Respite Breaks and Opportunities Total:							3031481.88
Respite Breaks and Opportunities	☐	261803	1084	241.50	11.58	3031481.88	
Financial Management Services Total:							685129.10
Financial Management Services	☐	5261	514	10.20	130.68	685129.10	
Supports Brokerage Total:							43651.45
Supports Brokerage	☐	2192	514	4.30	19.75	43651.45	
Assistive Technology Total:							61000.00
Assistive Technology	☐	61	61	1.00	1000.00	61000.00	
Behavioral Support Consultation Total:							43963.92
Behavioral Support Consultation	☐	1878	61	30.80	23.40	43963.92	
Benefits and Work Incentive Counseling Total:							34343.23
Benefits and Work Incentive Counseling	☐	2430	46	52.80	14.14	34343.23	
Career Planning Total:							172885.07
Career Planning	☐	2533				172885.07	

GRAND TOTAL: ***83395538.40***

Total: Services included in capitation:

Total: Services not included in capitation: *83395538.40*

Total Estimated Unduplicated Participants: ***1466***

Factor D (Divide total by number of participants): ***56886.45***

Services included in capitation:

Services not included in capitation: *56886.45*

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			29	87.40	68.21		
Community Connections Assistance Total:							**3226316.54**
Community Connections Assistance	☐	462221	821	563.00	6.98	**3226316.54**	
Community Supported Living Total:							**3341586.10**
Community Supported Living	☐	495	54	9.20	6726.22	**3341586.10**	
Community Transition Case Management Total:							**13915.80**
Community Transition Case Management	☐	540	108	5.00	25.77	**13915.80**	
Community Transportation Total:							**2862869.30**
Community Transportation	☐	875454	1466	597.20	3.27	**2862869.30**	
Employment Exploration Total:							**62909.70**
Employment Exploration	☐	29	29	1.00	2169.30	**62909.70**	
Family Empowerment and Systems Navigation Total:							**103475.31**
Family Empowerment and Systems Navigation	☐	8104	37	219.00	12.77	**103475.31**	
Home-Based Independent Living Skills Training Total:							**552813.10**
Home-Based Independent Living Skills Training	☐	34729	245	142.00	15.89	**552813.10**	
Housing Counseling Total:							**15429.63**
Housing Counseling	☐	1093	31	35.30	14.10	**15429.63**	
Housing Start-Up Assistance Total:							**11000.00**

GRAND TOTAL: **83395538.40**

Total: Services included in capitation:

Total: Services not included in capitation: 83395538.40

Total Estimated Unduplicated Participants: **1466**

Factor D (Divide total by number of participants): **56886.45**

Services included in capitation:

Services not included in capitation: 56886.45

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Start-Up Assistance	☐	11	11	1.00	1000.00	11000.00	
Individual Goods and Services Total:							873800.00
Individual Goods and Services	☐	514	514	1.00	1700.00	873800.00	
Integrated Employment Path Services Total:							8132647.99
Integrated Employment Path Services	☐	542902	294	1846.60	14.98	8132647.99	
Job Coaching Total:							281438.99
Job Coaching	☐	18800	134	140.30	14.97	281438.99	
Job/Career Development Plan and Outcome Total:							98204.88
Job/Career Development Plan and Outcome	☐	24	24	1.00	4091.87	98204.88	
Minor Home Modifications Total:							75000.00
Minor Home Modifications	☐	15	15	1.00	5000.00	75000.00	
Occupational Therapy (Maintenance) Total:							1009.50
Occupational Therapy (Maintenance)	☐	89	3	29.70	11.33	1009.50	
Peer Specialist Services Total:							27296.90
Peer Specialist Services	☐	2187	31	70.50	12.49	27296.90	
Physical Therapy (Maintenance) Total:							145.40
Physical Therapy (Maintenance)	☐	13	3	4.20	11.54	145.40	
Private Duty Nursing Total:							132187.22
Private Duty Nursing	☐	5878	31	189.60	22.49	132187.22	

GRAND TOTAL: 83395538.40

Total: Services included in capitation:

Total: Services not included in capitation: 83395538.40

Total Estimated Unduplicated Participants: 1466

Factor D (Divide total by number of participants): 56886.45

Services included in capitation:

Services not included in capitation: 56886.45

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Monitoring and On-Call Response Service Total:							**758398.48**
Remote Monitoring and On-Call Response Service	☐	245438	44	5578.10	3.09	**758398.48**	
Self-Employment Start-Up Plan and Outcome Total:							**81820.74**
Self-Employment Start-Up Plan and Outcome	☐	5067	29	174.70	16.15	**81820.74**	
Shared Living Total:							**7179236.06**
Shared Living	☐	32428	117	277.20	221.36	**7179236.06**	
Speech Therapy (Maintenance) Total:							**19682.25**
Speech Therapy (Maintenance)	☐	1712	15	114.10	11.50	**19682.25**	

GRAND TOTAL: **83395538.40**

Total: Services included in capitation:

Total: Services not included in capitation: 83395538.40

Total Estimated Unduplicated Participants: **1466**

Factor D (Divide total by number of participants): **56886.45**

Services included in capitation:

Services not included in capitation: 56886.45

Average Length of Stay on the Waiver: 355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Co-Worker Supports Total:							**47513.10**
Co-Worker Supports	☐	2907	20	145.30	16.35	**47513.10**	
Community and Relationship Connecting Total:							**2427909.34**
Community and Relationship Connecting	☐	138577	279	496.70	17.52	**2427909.34**	
Community Resource Coordination (CRC) Total:							**8164995.70**
Community Resource Coordination (CRC)	☐	20147	1859	10.80	406.68	**8164995.70**	
Facility-Based Day Program Services Total:							**2288334.75**
Facility-Based Day Program Services	☐	405033	930	435.50	5.65	**2288334.75**	
Home Support Agency Per Diem Total:							**46305292.80**
Home Support Agency Per Diem	☐	68014	218	312.00	680.80	**46305292.80**	
Personal and Home Assistance Total:							**8284593.27**
Personal and Home Assistance	☐	632024	463	1365.90	13.10	**8284593.27**	
Respite Breaks and Opportunities Total:							**3842521.92**
Respite Breaks and Opportunities	☐	331786	1338	248.00	11.58	**3842521.92**	
Financial Management Services Total:							**966875.18**
Financial Management Services	☐	7364	698	10.60	130.68	**966875.18**	
Supports Brokerage Total:							**60656.20**
Supports Brokerage	☐	3068	698	4.40	19.75	**60656.20**	

GRAND TOTAL: **111545478.46**

Total: Services included in capitation:

Total: Services not included in capitation: *111545478.46*

Total Estimated Unduplicated Participants: **1859**

Factor D (Divide total by number of participants): **60002.95**

Services included in capitation:

Services not included in capitation: *60002.95*

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Total:							**77000.00**
Assistive Technology	☐	77	77	1.00	1000.00	**77000.00**	
Behavioral Support Consultation Total:							**57117.06**
Behavioral Support Consultation	☐	2438	77	31.70	23.40	**57117.06**	
Benefits and Work Incentive Counseling Total:							**44532.52**
Benefits and Work Incentive Counseling	☐	3150	58	54.30	14.14	**44532.52**	
Career Planning Total:							**223701.52**
Career Planning	☐	3279	36	91.10	68.21	**223701.52**	
Community Connections Assistance Total:							**4214068.90**
Community Connections Assistance	☐	603770	1042	579.40	6.98	**4214068.90**	
Community Supported Living Total:							**4972021.82**
Community Supported Living	☐	742	77	9.60	6726.22	**4972021.82**	
Community Transition Case Management Total:							**17652.45**
Community Transition Case Management	☐	685	137	5.00	25.77	**17652.45**	
Community Transportation Total:							**3737934.06**
Community Transportation	☐	1143018	1859	614.90	3.27	**3737934.06**	
Employment Exploration Total:							**78094.80**
Employment Exploration	☐	36	36	1.00	2169.30	**78094.80**	

GRAND TOTAL: **111545478.46**

Total: Services included in capitation:

Total: Services not included in capitation: 111545478.46

Total Estimated Unduplicated Participants: **1859**

Factor D (Divide total by number of participants): **60002.95**

Services included in capitation:

Services not included in capitation: 60002.95

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Empowerment and Systems Navigation Total:							**135402.86**
Family Empowerment and Systems Navigation	☐	10604	47	225.60	12.77	**135402.86**	
Home-Based Independent Living Skills Training Total:							**881809.19**
Home-Based Independent Living Skills Training	☐	55418	362	153.30	15.89	**881809.19**	
Housing Counseling Total:							**19906.38**
Housing Counseling	☐	1413	39	36.20	14.10	**19906.38**	
Housing Start-Up Assistance Total:							**14000.00**
Housing Start-Up Assistance	☐	14	14	1.00	1000.00	**14000.00**	
Individual Goods and Services Total:							**1186600.00**
Individual Goods and Services	☐	698	698	1.00	1700.00	**1186600.00**	
Integrated Employment Path Services Total:							**10607925.22**
Integrated Employment Path Services	☐	708133	372	1903.60	14.98	**10607925.22**	
Job Coaching Total:							**367738.05**
Job Coaching	☐	24560	170	144.50	14.97	**367738.05**	
Job/Career Development Plan and Outcome Total:							**126847.97**
Job/Career Development Plan and Outcome	☐	31	31	1.00	4091.87	**126847.97**	
Minor Home Modifications Total:							**95000.00**
Minor Home Modifications	☐	19	19	1.00	5000.00	**95000.00**	

GRAND TOTAL: **111545478.46**

Total: Services included in capitation:

Total: Services not included in capitation: 111545478.46

Total Estimated Unduplicated Participants: **1859**

Factor D (Divide total by number of participants): **60002.95**

Services included in capitation:

Services not included in capitation: 60002.95

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy (Maintenance) Total:							**1189.65**
Occupational Therapy (Maintenance)	☐	105	3	35.00	11.33	**1189.65**	
Peer Specialist Services Total:							**35315.47**
Peer Specialist Services	☐	2827	39	72.50	12.49	**35315.48**	
Physical Therapy (Maintenance) Total:							**173.10**
Physical Therapy (Maintenance)	☐	15	3	5.00	11.54	**173.10**	
Private Duty Nursing Total:							**166300.06**
Private Duty Nursing	☐	7394	39	189.60	22.49	**166300.06**	
Remote Monitoring and On-Call Response Service Total:							**983092.15**
Remote Monitoring and On-Call Response Service	☐	318150	56	5681.30	3.09	**983092.15**	
Self-Employment Start-Up Plan and Outcome Total:							**105931.08**
Self-Employment Start-Up Plan and Outcome	☐	6558	36	182.20	16.15	**105931.08**	
Shared Living Total:							**10981758.14**
Shared Living	☐	49606	168	295.30	221.36	**10981758.14**	
Speech Therapy (Maintenance) Total:							**25673.75**
Speech Therapy (Maintenance)	☐	2232	19	117.50	11.50	**25673.75**	

GRAND TOTAL: **111545478.46**

Total: Services included in capitation:

Total: Services not included in capitation: 111545478.46

Total Estimated Unduplicated Participants: **1859**

Factor D (Divide total by number of participants): **60002.95**

Services included in capitation:

Services not included in capitation: 60002.95

Average Length of Stay on the Waiver: 355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Co-Worker Supports Total:							**57996.72**
Co-Worker Supports	☐	3547	24	147.80	16.35	**57996.72**	
Community and Relationship Connecting Total:							**2996410.56**
Community and Relationship Connecting	☐	171027	338	506.00	17.52	**2996410.56**	
Community Resource Coordination (CRC) Total:							**10074276.96**
Community Resource Coordination (CRC)	☐	24863	2252	11.00	406.68	**10074276.96**	
Facility-Based Day Program Services Total:							**2824047.41**
Facility-Based Day Program Services	☐	499795	1126	443.90	5.65	**2824047.41**	
Home Support Agency Per Diem Total:							**56597831.44**
Home Support Agency Per Diem	☐	83135	263	316.10	680.80	**56597831.44**	
Personal and Home Assistance Total:							**11444953.86**
Personal and Home Assistance	☐	873320	614	1422.90	13.10	**11444953.86**	
Respite Breaks and Opportunities Total:							**4619841.00**
Respite Breaks and Opportunities	☐	399008	1580	252.50	11.58	**4619841.00**	
Financial Management							**1256096.16**

GRAND TOTAL: **140581769.92**

Total: Services included in capitation:

Total: Services not included in capitation: 140581769.92

Total Estimated Unduplicated Participants: **2252**

Factor D (Divide total by number of participants): **62425.30**

Services included in capitation:

Services not included in capitation: 62425.30

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Financial Management Services	☐	9624	890	10.80	130.68	**1256096.16**	
Supports Brokerage Total:							**79098.75**
Supports Brokerage	☐	4010	890	4.50	19.75	**79098.75**	
Assistive Technology Total:							**93000.00**
Assistive Technology	☐	93	93	1.00	1000.00	**93000.00**	
Behavioral Support Consultation Total:							**70073.64**
Behavioral Support Consultation	☐	2998	93	32.20	23.40	**70073.64**	
Benefits and Work Incentive Counseling Total:							**54735.94**
Benefits and Work Incentive Counseling	☐	3870	70	55.30	14.14	**54735.94**	
Career Planning Total:							**275213.71**
Career Planning	☐	4033	44	91.70	68.21	**275213.71**	
Community Connections Assistance Total:							**5201572.78**
Community Connections Assistance	☐	745265	1262	590.50	6.98	**5201572.78**	
Community Supported Living Total:							**6858726.53**
Community Supported Living	☐	1016	103	9.90	6726.22	**6858726.53**	
Community Transition Case Management Total:							**21389.10**
Community Transition Case Management	☐	830	166	5.00	25.77	**21389.10**	
Community Transportation							**4612834.66**

GRAND TOTAL: ***140581769.92***

Total: Services included in capitation:

Total: Services not included in capitation: *140581769.92*

Total Estimated Unduplicated Participants: ***2252***

Factor D (Divide total by number of participants): ***62425.30***

Services included in capitation:

Services not included in capitation: *62425.30*

Average Length of Stay on the Waiver: *355*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Community Transportation	☐	1410581	2252	626.40	3.27	**4612834.66**	
Employment Exploration Total:							**95449.20**
Employment Exploration	☐	44	44	1.00	2169.30	**95449.20**	
Family Empowerment and Systems Navigation Total:							**167341.91**
Family Empowerment and Systems Navigation	☐	13104	57	229.90	12.77	**167341.91**	
Home-Based Independent Living Skills Training Total:							**1218063.84**
Home-Based Independent Living Skills Training	☐	76575	480	159.70	15.89	**1218063.84**	
Housing Counseling Total:							**24453.63**
Housing Counseling	☐	1733	47	36.90	14.10	**24453.63**	
Housing Start-Up Assistance Total:							**17000.00**
Housing Start-Up Assistance	☐	17	17	1.00	1000.00	**17000.00**	
Individual Goods and Services Total:							**1513000.00**
Individual Goods and Services	☐	890	890	1.00	1700.00	**1513000.00**	
Integrated Employment Path Services Total:							**13085657.66**
Integrated Employment Path Services	☐	873540	451	1936.90	14.98	**13085657.66**	
Job Coaching Total:							**453938.30**
Job Coaching	☐	30320	206	147.20	14.97	**453938.30**	
Job/Career Development Plan and Outcome Total:							**151399.19**

GRAND TOTAL: **140581769.92**

Total: Services included in capitation:

Total: Services not included in capitation: 140581769.92

Total Estimated Unduplicated Participants: **2252**

Factor D (Divide total by number of participants): **62425.30**

Services included in capitation:

Services not included in capitation: 62425.30

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job/Career Development Plan and Outcome	☐	37	37	1.00	4091.87	151399.19	
Minor Home Modifications Total:							115000.00
Minor Home Modifications	☐	23	23	1.00	5000.00	115000.00	
Occupational Therapy (Maintenance) Total:							1404.92
Occupational Therapy (Maintenance)	☐	124	4	31.00	11.33	1404.92	
Peer Specialist Services Total:							43322.81
Peer Specialist Services	☐	3467	47	73.80	12.49	43322.81	
Physical Therapy (Maintenance) Total:							203.10
Physical Therapy (Maintenance)	☐	18	4	4.40	11.54	203.10	
Private Duty Nursing Total:							200412.89
Private Duty Nursing	☐	8911	47	189.60	22.49	200412.89	
Remote Monitoring and On-Call Response Service Total:							1216678.85
Remote Monitoring and On-Call Response Service	☐	393750	68	5790.40	3.09	1216678.85	
Self-Employment Start-Up Plan and Outcome Total:							130252.98
Self-Employment Start-Up Plan and Outcome	☐	8067	44	183.30	16.15	130252.98	
Shared Living Total:							14978457.22
Shared Living	☐	67657	222	304.80	221.36	14978457.22	
Speech Therapy (Maintenance) Total:							31634.20

GRAND TOTAL: 140581769.92

Total: Services included in capitation:

Total: Services not included in capitation: 140581769.92

Total Estimated Unduplicated Participants: 2252

Factor D (Divide total by number of participants): 62425.30

Services included in capitation:

Services not included in capitation: 62425.30

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy (Maintenance)	☐	2752	23	119.60	11.50	**31634.20**	

GRAND TOTAL:	**140581769.92**
Total: Services included in capitation:	
Total: Services not included in capitation:	*140581769.92*
Total Estimated Unduplicated Participants:	**2252**
Factor D (Divide total by number of participants):	**62425.30**
Services included in capitation:	
Services not included in capitation:	*62425.30*
Average Length of Stay on the Waiver:	355