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.

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

1. Request Information

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

B. Program Title:
Elderly and Adults with Disabilities Waiver

C. Waiver Number:ME.0276
Original Base Waiver Number: ME.0276.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
06/30/26
Approved Effective Date of Waiver being Amended: 07/01/23

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The proposed changes include the following:

General
• Updates and includes new information related to the 2024 revised 1915(c) Home and Community Based Services (HCBS) Waiver Application, version 3.7 where applicable.
Waiver Appendix C
• The Department is updating requirements for Direct Care Worker staff to reflect changes in the certification curriculum and ongoing training requirements.
• The amendment also updates the monthly and annual limits (caps) on combined services in Appendix B-2 and C-4.

Waiver Appendix F-3
• The Department is updating its procedures for grievances by members who are served under any of the 1915(c) waivers, to comply with new Federal requirements Ensuring Access to Medicaid Services (CMS-2442-F) (Access Final Rule, CMS 2442-F). The Office of Aging and Disability Services (OADS) is promulgating rules related to the new grievance process.

Waiver Appendix I-2-a
• Clarifies how service rates for this waiver are contingent on available funding and subject to legislative approval.

Waiver Appendix J
• Updates Cost Neutrality and Derivation of Estimates for Waiver Years 3 through 5.

Finally, as part of this waiver submission, the Department made technical changes, formatting updates, and additional non-substantive changes to the application. Please see the accompanying draft application for a complete list of all proposed changes included in the waiver amendment.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A - Waiver Administration and Operation**	
☐ **Appendix B - Participant Access and Eligibility**	
☒ **Appendix C - Participant Services**	C-1, C-2, C-4, C-5
☒ **Appendix D - Participant Centered Service Planning and Delivery**	D-1-d-ii
☐ **Appendix E - Participant Direction of Services**	
☒ **Appendix F - Participant**	F-3

Component of the Approved Waiver	Subsection(s)
Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☒ Appendix I - Financial Accountability	I-2-a.
☒ Appendix J - Cost-Neutrality Demonstration	J-1, J-2-b, J-2-c, J-2-d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☒ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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*):

Elderly and Adults with Disabilities Waiver

C. Type of Request: amendment

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**

Original Base Waiver Number: ME.0276
Draft ID: ME.001.06.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/23
Approved Effective Date of Waiver being Amended: 07/01/23

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:

Not applicable

○ **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:

Not applicable

○ **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:

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

(Per CMS IRAI 6-5-23) The Maine Non-Emergency Transportation 1915(b) waiver renewal was approved March 1, 2023.

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.

The Section 19, Home and Community Benefits for the Elderly and Adults with Disabilities waiver offers Medicaid eligible individuals, who meet nursing facility and hospital levels of care, the quality care and direct supports necessary to remain in the least restrictive, most desired setting, at home and in their chosen communities. Participants would likely require nursing facility or rehab hospital services absent receipt of these waiver services. This waiver promotes Maine's goal of encouraging and facilitating home and community-based services, including options for self-direction, as effective and appropriate alternatives to the use of nursing facility and other institutional services.

The Maine Department of Health and Human Services (DHHS), Office of MaineCare Services (OMS) administers the Medicaid programs including this waiver. The Office of Aging and Disability Services (OADS) is responsible for the day-to-day operations of the waiver program, including oversight of evaluations, service delivery by qualified enrolled providers and contracted agents, as well as ongoing quality monitoring.

Individuals seeking access to the waiver must meet both financial eligibility criteria and medical eligibility criteria. The Office for Family Independence (OFI) determines financial eligibility, and a state-wide Assessing Services Agency (ASA) determines medical eligibility based on a level of care evaluation process. Service delivery options include a traditional agency model and/or self-direction of personal care or in-home respite services. In either case, a Service Coordination Agency (SCA) facilitates the selection, authorization, and delivery of waiver services.

In order to receive services under this waiver the Participant must be authorized at the time of assessment to receive at least one Section 19 waiver service. Once found eligible, Participants may access the following services, as available, under this waiver: Care Coordination, Home Health Services, Personal Care, Attendant Care Services, Respite Care (in home and institutional), Personal Emergency Response Systems, Assistive Technology, Home Delivered Meals, Living Well for Better Health, Matter of Balance, and Environmental Modifications as well as Skills Training, and Financial Management Services (FMS) for individuals who choose to self-direct Personal Care or in-home Respite Services.

Any provider wishing to deliver services under this waiver must be enrolled with the State Medicaid Agency and approved by the Office of Aging and Disability Services. The one exception is providers of atypical waiver services including Environmental Modifications, institutional Respite, Personal Emergency Response Service, and Assistive Technology Services. The Office of Aging and Disability Services maintains a contract with a statewide entity to act as the Waiver Services Provider (WSP) and they are responsible for subcontracting with providers who deliver these atypical services.

OMS conducts enrollment activities on a continuous and on-going basis. Providers enrolling as a Service Coordination Agency to deliver Care Coordination and Skills Training for self-directing Participants may not provide other direct care services to ensure conflict free service delivery. Skills training is not considered a direct service for purpose of this requirement. When there is more than one qualified provider enrolled as a SCA, the Participant is offered a choice of available SCA at the time of initial evaluation and upon reevaluation thereafter. Participants may request a change in SCA at any time. A SCA bills for its Care Coordination and Skills Training services directly through Maines MMIS system.

The SCA is responsible for implementing the Plan of Care with the Participant and assisting with locating and authorizing qualified direct service providers. The SCA submits the necessary authorizations for those services into MeCare, the medical eligibility determination (MED) electronic assessment and authorization system that interfaces with Maine’s MMIS system. Other than providers of atypical waiver services, the direct service providers bill directly through Maine’s MMIS system based on the service authorizations submitted by the SCA.

If atypical waiver services are authorized in the Plan of Care, the SCA contacts the WSP for implementation of those services. The atypical waiver services are coordinated by the WSP who then bills the State’s MMIS on behalf of those providers. The WSP is also responsible for maintaining a qualified provider network and conducting quality review activities to ensure that providers operate within applicable laws and rules. The WSP does not provide the atypical waiver service but is responsible for administrative functions such as coordinating the services and submitting claims as a fiscal agent for those atypical services through Maine’s MMIS system and reimbursing the atypical services providers.

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

* 2 (per IRAI 6.5.23) Due to character count limit - please see "Main-B, Optional Additional Information".

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 followed HCBS regulations in 42 CFR § 441.301 and requested public input on this waiver amendment from December 30, 2022, through January 30, 2023. Tribal Consultation was done during a meeting on December 1, 2022, and in writing on December 30, 2022. On, December 30, 2022, the waiver amendment was posted online. A provider listserv was done on that date to all MaineCare providers and interested parties. In addition, a notice appeared in five (5) newspapers with the highest circulation in the State on December 30, 2022. Public comments on the proposed changes were accepted until 11:59PM, January 30, 2023.

The State received timely comments from two (2) Commenters (thirteen distinct summarized comments). The comments ranged from suggested additions and enhancements to current programming under this benefit, to requests for clarification regarding particular requirements within Appendices C and I of the application, to comments the State considers to be technical or grammatical in nature. A comprehensive summary and response to comment document was sent to CMS as part of the waiver renewal.

(Per CMS IRAI 6.5.23)
The active link used to post the waiver renewal application is:
https://www.maine.gov/dhhs/oms/about-us/policies-rules/policy-waivers

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: Policy Director

Agency:

Office of MaineCare Services

Address:

11 State House Station

Address 2:

242 State Street

City:

Augusta

State: **Maine**

Zip:

04333-0011

Phone:

(207) 624-4068 **Ext:** ☐ **TTY**

Fax:

(207) 287-1864

E-mail:

thomas.leet@maine.gov

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

Last Name:

Toomey

First Name:

Allison

Title:

Manager for Community Programs

Agency:

Office of Aging and Disability Services

Address:

#11 State House Station

Address 2:

City:

Augusta

State: **Maine**

Zip:

04333-0011

Phone:

(207) 287-4208 **Ext:** ☐ **TTY**

Fax:

(207) 287-9229

E-mail:

allison.toomey@maine.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Maine**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

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

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

*1. Due to character count limit in I-2 d.
The State of Maine DHHS Service Center and the State of Maine Claim Processing System are programmed to ensure FFP recoupments. Annual audit reviews are part of the State of Maine Single Audit and cash management.

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

*2 Due to character count limit in Main Module 2 Brief Waiver Description:
(Per CMS IRAI 6.5.23)
Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, Maine will gather data and submit the quality review in addition to any outstanding 372 report[s] as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within 6 months of receiving the final quality review report and 372 report acceptance decision.

*3. Due to character count limit in I-2 d.
(Per CMS IRAI 6.5.23)
Providers delivering Personal Care, Attendant Care, and Respite Care Services in the home, and those delivering Home Health Services must comply with Maine DHHS Electronic Visit Verification system standards and requirements for these services.

*4. Due to character count limit in QIS-C Sub-assurance (a):
(Per CMS IRAI 6.5.23)
Numerator: Number of provider agencies that initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing waiver services. Denominator: Total number of provider agencies required to be licensed and/or certified.

*5 Due to character count limit in QIS-G Sub-assurance (c), 2nd PM:
(Per CMS IRAI 6.5.23)
Numerator: Number of unauthorized use of restrictive interventions (including restraints and seclusion) that were appropriately reported through critical incident management system. Denominator: Total number of restrictive intervention (including restraints and seclusion) incidents reported through critical incident management system.

*6 Numerator: Due to character count limit in QIS-C Sub-assurance (c) Total Number non-licensed providers whose non-licensed direct support staff have completed PSS training in accordance with state requirements and the approved waiver. Denominator: Total number of licensed/non-licensed providers reviewed.

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Office of Aging and Disability Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

DHHS, Office of Maine Care Services (OMS) is the single State Medicaid Agency (SMA) for Maine and responsible for the administration of the Medicaid Program and this waiver. OMS delegates day-to-day operational authority for all services provided to the target group in this waiver to the Office of Aging and Disability Services (OADS). As such, OADS is responsible for meeting the assurances and sub-assurances within the following Appendices: Appendix B – Participant Access and Eligibility; Appendix C – Participant Services; Appendix D – Participant Centered Service Planning and Delivery; Appendix F – Participant Rights; Appendix G – Participant Safeguards and Appendix H – Quality Improvement. OMS, as the SMA, retains ultimate authority and oversight for the waiver including the following appendices: Appendix A – Waiver Administration and Operation; Appendix I – Financial Accountability and Appendix J – Cost Neutrality Demonstration. In addition, OMS and OADS staff meet weekly to discuss the waiver, rule, and policies in an effort to improve services and supports. The OMS and OADS directors meet monthly to discuss program improvement strategy and resolve any issues that have been escalated by staff or stakeholders."

(Per CMS IRAI 6.5.23)
The state maintains a signed MOU with the Office of Aging and Disability Services. The document is in effect until amended or terminated. OMS and OADS review the document at least annually.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions

on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

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

The Assessing Services Agency conducts the level of care determination and develops a Proposed Plan of Care that is based on the needs identified through the assessment as well as the supports (including informal support, Medicare services, and other community resources) in place at the time of the determination.

The Waiver Service Provider coordinates the implementation of only atypical waiver services (Environmental Modifications, PERS, Assistive Technology, and Institutional Respite) as authorized by the Assessing Services Agency. When atypical services are needed, the SCA contacts the WSP and the WSP is responsible for:
* Connecting the consumer with the network of available providers,
* Issuing service orders,
* Monitoring delivery of services, and
* Billing MMIS and reimbursing subcontractors for delivery of service.

Both entities perform quality assurance activities as outlined by the Office of Aging and Disability Services in their respective contracts.

The state's contracted Fiscal Agent for the MMIS payment system, manages the Qualified Provider enrollment process.

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The Office of Aging and Disability Services and Office of MaineCare Services are responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions.

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

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

Appendix A: Waiver Administration and Operation

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

A monthly report of the Assessing Services Agency details the number of evaluations and reevaluations conducted, the number of level of care determinations completed, timeliness of completed assessments, the number of waiver plans authorized, and the number of revisions created. OADS conducts monthly reviews of completed assessment appeals to ensure level of care and care plan accuracy.

A WSP is required to submit monthly reports to the Office of Aging and Disability Services. These reports detail the number of persons served, the number of open referrals, and the number of closed referrals.

For Transportation Services Performance Measures included in the 1915b waiver (Me.19) : The contracts between the Broker and the State of Maine outline the performance measures that must be reported monthly. OMS reviews the Broker’s monthly reports for compliance with performance metrics.

The Provider Enrollment contracted entity has contract performance tracked and monitored by the Office of MaineCare Services on a monthly basis to ensure that waiver operational and administrative functions are conducted in accordance with waiver requirements. Additionally, the state monitors and reviews the service level agreement included in the MMIS contract on a monthly basis.

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

Data Source (Select one):
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**
☒ **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:

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 Office of Aging and Disability Services works closely with the Assessing Services Agency and the Service Coordination Agency and qualified direct service providers in the administration of the waiver. General methods for problem correction include reviewing level of care determinations and other reports to ensure compliance and that appropriate follow up occurred. This may include researching available documentation in the Participant's most recent assessment, case notes, and classification system, depending on the nature of the issue. Follow up phone calls are made to parties involved to gather necessary information for problem resolution. Payment may be withheld if contractual or regulatory requirements are not followed.

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**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐

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

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

None

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:

There is no maximum age limit, people who reach 64 who are disabled will transition to aged. The application WMS would not allow the state to click non applicable.

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

◉ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

◉ **Other**

Specify:

The State is currently using an individual cost limit of $$122,328 annually. The cost limits (total and monthly as outlined in Appendix C-4) will increase on an annual basis proportionately to the scheduled Appendix J and I-2-a reimbursement rate increases to ensure members do not lose access to eligible services as a unintended result of the scheduled rate increases.

○ **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:

At the time of the level of care (LOC) determination the individual's needs are identified, and a Proposed Plan of Care is developed, taking into consideration all sources of support. A LOC determination by an independent LPN/RN is conducted using the Department's Medical Eligibility Determination (MED) form. The MED captures core data on the need for ADL and IADL assistance, medical needs, behavior and cognition. The Proposed Plan of Care is authorized based on the amount and type of needs identified by the MED as well as the availability of informal supports and services provided by other public and private funding sources.

If it is determined that the individual's needs cannot be met through the waiver, the plan is not authorized, and alternative community and institutional options are discussed with the individual. At the time of the LOC determination individuals found not eligible for this waiver due to cost limits are issued a letter of denial including fair hearing rights that outlines their right to appeal the decision and request a fair hearing.

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

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

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

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

☒ **Other safeguard(s)**

Specify:

If there is a change in a Participant's condition or circumstances and the provision of services would exceed the individual cost limit, the Care Coordinator works with the Participant to consider alternative resources and options both within the community and within a facility setting. Institutional respite care may be used for a short period of time if the Participant is at risk and care is not available in the home. The Service Coordination Agency and the Office of Aging and Disability Services will consult with the Office of MaineCare Services to determine the best course of action depending on the Participant's circumstances and to assure the Participant's health and welfare.

The monthly program cap may be exceeded by no more than 20% for personal care or Attendant Services if a Participant meets either of the following criteria, provided that in no case shall a Participant receive more than eighty-six and a quarter (86.25) hours per week of personal care and/or Attendant Services:

1. The Participant requires Extensive Assistance with the following Activities of Daily Living, i.e., bed mobility, transfer, locomotion,
eating, and toilet use; or
2. The Department or its Authorized Entity determines based on medical necessity that the Participant faces significant risk to health,
welfare and safety; is at imminent risk of institutionalization; and there is no ability to meet the Participant's needs through other
resources or supports such that extraordinary measures are warranted.

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	3565
Year 2	3743
Year 3	3930
Year 4	4126
Year 5	4332

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

This waiver provides for the entrance of all eligible persons.
Currently there is not a waiting list for this waiver. If Maine needed to defer entrance to the waiver, waiver rules (Chapter II, Section 19.02-3 of MaineCare Benefits Manual) indicate that participants would be accepted on a combined priority and first-come, first-served basis, dependent on availability of funding. Priority, as described below, is based on the outcome of an MED by the Assessing Services Agency.

First priority would be given to Participants who meet the medical eligibility criteria set forth in Chapter II, Section 67.02- 3(A): daily skilled nursing need or need for extensive assistance with 5 of the listed ADLs. Within this category, applicants are served on a first-come, first-served basis.

Second priority would be given to Participants who meet the medical eligibility criteria set forth in Chapter II, Section 67.02- 3(A): daily skilled nursing need or need for extensive assistance with 3 of the listed ADLs. Within this category, applicants are served on a first-come, first-served basis.

Third priority would be given to Participants who meet the medical eligibility criteria set forth in Chapter II, Section 67.02-3(B) or (C). This eligibility is for individuals who require less frequent or less intense assistance with nursing and ADL needs but still meet institutional level of care. This need is based on a combination of three needs from skilled nursing, cognition, behavior, and at least limited assist in one ADL from the following ADLs: bed mobility, transfer, locomotion, eating and toileting.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **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)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

    Specify percentage: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in 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:

Parents and Other caretaker relative as specified in §435.110,
Pregnant Women as specified in §435.116,
Former Foster Care Children as specified in §435.150,
Children Aged 19 and 20 as specified in §435.222, and
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:

☒ **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:
- ○ **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:

The Assessing Services Agency conducts level of care evaluations and reevaluations under contract with the waiver operating agency, Office of Aging and Disability Services.

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:

Licensed Practical Nurse (LPN) or Registered Nurse (RN)

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.

MaineCare Benefits Manual Section 67.02 (Nursing Facility) outlines the level of care criteria used to determine eligibility for both nursing facility and waiver services. The Level of Care tool is referenced in Section 67 and referred to as Medical Eligibility Determination (MED) tool. The tool has been automated into the application referred to as MeCare.

The criteria scored for eligibility are as follows:
1) Daily skilled nursing need or extensive assistance and physical support in three of the following ADLs: bed mobility, transfer,
locomotion, eating and toileting, OR
2) A combination of three needs from: skilled nursing, cognition, behavior, and at least limited assist in one ADL from the following
ADLs: bed mobility, transfer, locomotion, eating and toileting.

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

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

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

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

The Level of Care evaluation and reevaluation are both conducted by the Assessing Services Agency using the Medical Eligibility Determination (MED) tool. This automated tool allows the LPN/RN to collect necessary clinical and functional information in order to determine waiver eligibility and to develop a Proposed Plan of Cares based on the needs of the participant and the availability of both informal and formal supports. The reevaluation process does not differ from the evaluation process. Additionally, evaluations and re-evaluations may be completed via in-person or other electronic means as approved by the department when necessary or appropriate to ensure timely access to services.

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):*

The Service Coordination Agency is responsible for requesting a reevaluation twenty-one days in advance of the end of eligibility period if services are expected to continue. Reevaluation referrals are sent electronically to the Assessing Services Agency prior to the reevaluation due date from the Service Coordination Agency. The Assessing Services Agency conducts the MED prior to the end of the eligibility period unless there are extenuating circumstances such as weather, absence of a guardian, or temporary hospitalization. In these cases, the MED is scheduled as soon as possible. Re-evaluations may be completed via in person or other electronic means when approved by the Department as necessary to ensure time access to services.

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

The State maintains level of care assessment data electronically on a server that houses the automated MED tool (MeCare application). The application and its data is protected by the State's system backup procedures.

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 waiver applicants who had a LOC determination completed for whom there is reasonable indication that services may be needed in the future. Numerator: Total number of waiver applicants who had a LOC determination completed for whom there is reasonable indication that services may be needed in the future. Denominator: Total number of waiver applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MeCare assessment data

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

	Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

Performance Measure:
Number and Percent of Waiver Level of Care determinations made where the LOC process and instrument (MED tool) were completed without error. Numerator: Total number of Waiver LOC determinations made where the LOC process and instrument (MED tool) were completed without error. Denominator: Total number of Waiver LOC assessments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MeCare assessment data

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Waiver LOC determinations completed by a qualified evaluator. Numerator: Total number of LOC determinations completed by a qualified evaluator. Denominator: Total number of Waiver LOC determinations.

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**
☒ **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 availability of the assessment database MeCare continues to increase accountability for all parties and allows the State the benefit of analyzing data that supports policy direction and change.

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 Office of Aging and Disability Services has daily access to the assessments in MeCare. OADS reviews assessment data and reports to assure timely and accurate level of care determinations. Remediation may include a reassessment and change in plan of care, additional evaluator training, and payment may be withheld.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Maine's state law Title 22 MRSA §3174-I mandates that every person wanting to access nursing facility care must a have level of care determination. The law also requires that each person must be provided information about community options and receive a Proposed Plan of Care enabling him/her to make an informed choice about where to receive care, regardless of funding source.

Individuals who apply for home care directly also indicate their choice between institutional or waiver services.

Following completion of the medical eligibility determination, each person found eligible for nursing facility level of care is asked to:
1) Make a choice between home and community-based services and nursing facility care; and
2) Indicate that choice by signing a choice letter.

(Per CMS IRAI 6.5.23)
The eligible individual must sign a “Choice Letter” selecting between community and institutional services. After establishing eligibility, the ASA will forward the Choice Letter to the Service Coordination Agency of the Participant’s choosing.

Both the Assessing Services Agency and the Service Coordination Agency are responsible
for providing information about feasible alternatives and informing the individual, or their guardian, about their freedom of choice between waiver and institutional services.

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

The Choice Letter is maintained in the Participant’s record with the Service Coordination Agency.

Appendix B: Participant Access and Eligibility

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

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

The Department of Health and Human Services interpreter guidelines under Chapter I of the MaineCare Benefits Manual and Policy #MB019 are followed to provide access to waiver services for Limited English Proficient persons.

At the time of referral for a level of care determination, the individual’s primary language and the need for interpreter services (as applicable) is documented in his/her record. The RN/LPN is able to access the interpreter phone service or arrange for on-site interpreter at the time of evaluation.

Eligibility and due process letters are translated, when necessary.

Care Coordinators are also able to access interpreter services to accommodate Limited English Proficient Participants.

(Per CMS IRAI 6.5.23)
All providers of waiver services must comply with Ch I, Section 1, General Administrative Policies and Procedures, of the MaineCare Benefits Manual. 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.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Care Coordination		
Statutory Service	Personal Care		
Statutory Service	Respite		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Skills Training		
Other Service	Assistive Technology		
Other Service	Attendant Care Services		
Other Service	Environmental Modifications		
Other Service	Home Delivered Meals S5170		
Other Service	Home Health Services		
Other Service	Living Well for Better Health (Chronic Disease Self-Management)		
Other Service	Matter of Balance (Falls Prevention)		
Other Service	Non-Medical Transportation (NMT)		
Other Service	Personal Emergency Response System (PERS)		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Coordination

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

Service Definition *(Scope):*

Care Coordination Services assist the Participant to access services in the Authorized Plan of Care including service delivery options, choice of provider(s), preferred frequency of service delivery based on the Participant's needs consistent with the timeframe of the service authorization (i.e., weekly/monthly), clarify issues, and answer questions.

The Care Coordinator ensures implementation of the Authorized Plan of Care and coordinating service providers who are responsible for delivering services. The Care Coordinator makes referrals and provides Service Orders to the qualified service provider(s) the Participant chooses; or if the Participant chooses Self-Direction, provides access to Skills Training and Financial Management Services to the Participant and the Representative (as applicable). For the Participant interested in Self-Direction, the Care Coordinator provides information and assistance to ensure the Participant is able to make an informed decision regarding the available self-directed service options.

The Care Coordinator monitors the Participant's receipt of services and advocates on behalf of the Participant for appropriate community resources and services, including employment and natural supports, by providing information, making referrals and otherwise facilitating access to these supports.

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

Care Coordination Services may be provided to a waiver Participant who has entered a hospital or nursing facility for sixty (60) days prior to discharge from the institution to assist with implementing the community Plan of Care needed for successful and seamless transition back to the community. Services may not be billed unless and until the Participant returns home.

Care Coordination Services requires contact with the Participant at minimum every 30 days and face to face contact at minimum annually.

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	Service Coordination Agency (SCA)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:

Agency

Provider Type:

Service Coordination Agency (SCA)

Provider Qualifications

License *(specify):*

Occupational Therapist – 32 MRSA §§2271-2306 (OTR/L)
Licensed Social Worker - 32 MRSA §§7001-7063 (LSW)

Certificate *(specify):*

Certified Occupational Therapist Assistant (COTA)

Other Standard *(specify):*

For the agency, a SCA may not be a provider of direct care services.

The care coordinator, providing care coordination (case management) to Participants, must be a licensed social worker, or health professional or possess 4 years of education in the health or social services field and 1 year of community experience.

Care Coordinators must have demonstrated leadership ability, strong clinical, problem solving, organizational, and interpersonal skills and possess an extensive knowledge of community resources and reimbursement systems for health and social services.

Verification of Provider Qualifications

Entity Responsible for Verification:

OADS verifies qualifications at time of enrollment with State Medicaid Agency and every three years thereafter
For individual care coordinators, verification is by Service Coordination Agency (SCA).

Frequency of Verification:

The Service Coordination Agency must enroll with the Medicaid agency and be approved by the Office of Aging and Disability Services at time of initial enrolment and every three years thereafter.
For individual care coordinators, upon employment and annually 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:

Personal Care

Alternate Service Title (if any):

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 Care Services involve assisting the Participant with activities of daily living such as eating, bathing, dressing, and personal hygiene. These services may include assistance with preparation of meals, but do not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

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

Personal Care Services may not exceed 86.25 hours per week.

An individual PCA/PSS may not be reimbursed for providing more than 40 hours per week of services delivered to an individual waiver participant.

Participants who are at risk of institutionalization may seek an exception to this limit.
The criteria the Department shall consider in evaluating the request include:
a. Availability of workers in the Participant's area;
b. Number of hours needed above the cap;
c. Whether the Participant's condition is unique as compared to other Section 19 Participants;
d. The length of time for which the exception is requested; and
e. The agencies or Participant's efforts to find other workers.

(Per CMS IRAI 6.5.23)
The delivery of personal care may occur outside the Participant's home so long as it represents choice by the Participant and delivery is not within a provider-owned or managed setting.

This waiver service is only provided to individuals aged 21 and over. All medically necessary personal care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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	Personal Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency must register with DHHS through the Division of Licensing and Certification pursuant to 22 MRSA §1717.

Effective January 1, 2021, the agency must comply with Maine DHHS Electronic Visit Verification system standards and requirements.

The Agency Employee providing personal care must:
1.Hold a valid certificate of training for nursing assistants and be listed on the Maine Registry of Certified Nursing Assistants; or

2.Hold a valid certificate of training, issued within the past three (3) years, for nurse's aide or home health aide training that meets the standards of the Maine State Board of Nursing assistant training program; or

3.If a CNAs status on the Maine Registry of Certified Nursing Assistants has lapsed, or an individual holds a valid certificate of training meeting the standards of the Maine State Board of Nursing assistant program issued more than three (3) years ago, the individual must pass the competency-based examination of didactic and demonstrated skills from the Departments approved personal support specialist curriculum. A certificate of training as a personal care assistant/personal support specialist will be awarded upon passing this examination.

4.Hold a valid certificate of training as a personal support specialist/personal care assistant issued as a result of completing the Department approved personal support specialist training curriculum and passing the competency-based examination of didactic and demonstrated skills. The training course must include formal classroom instruction, demonstration, return demonstration, and examination. Services provided must be covered in the training

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification occurs at time of provider enrollment with Medicaid agency. Verification may also occur through DHHS, Division of Program Integrity and/or DHHS Division of Licensing and Certification as both divisions monitor program compliance.

The Personal Care Agency must verify qualifications of individual employees hired to provide Personal Care Services upon hire and annually thereafter.

Frequency of Verification:

Verification occurs at time of enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Respite Care is provided to a waiver participant who is unable to care for him or herself, and who requires care on a short-term basis due to the temporary absence of, or to provide relief for, the caregiver who normally provides the care.

Respite Services shall be provided by a qualified staff person, in the Participant's home, or respite shall be provided in a licensed nursing facility. For respite services delivered in the Participant's home, the appropriate staff for meeting the Participant's needs (i.e., HHA/CNA or PSS) may be utilized and reimbursement shall be at that worker's regular rate.

Federal financial participation shall not be claimed for room and board except when provided as part of respite care in a licensed nursing facility.

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

Expenditures for respite care shall not exceed the allowed maximum, which is equal to the State average cost of thirty (30) days nursing facility services, per State fiscal year, per member.

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	Attendant
Agency	Personal Care Agency, Nursing Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Attendant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

In-home respite may be provided by an individual who meets Attendant requirements for self-directed personal care. The standards for training are set by the participant directing services. The self-directing Participant or their Representative is responsible for the hiring and training of the Attendant. As part of this process, the self-directing Participant or their Representative must maintain documentation that adequate orientation to the Attendant was provided to assure that the Attendant can meet the needs of the participant and the Attendant must demonstrate competency in all required tasks. The Participant or their Representative is required to undergo Skills Training to assist and prepare the Participant to fulfill these responsibilities. Attendants may be members of the individual's family except that payment will not be made for services furnished to a minor by the child's parent (or stepparent), or to an individual by that person's spouse. If a participant is using a Representative to direct services on his or her behalf, the Representative may not be paid to provide care to the Participant. When a Guardian acts as the Representative on behalf of the Participant, the Guardian my not provide personal care to the Participant.

Effective January 1, 2021, Attendant services must comply with Maine DHHS Electronic Visit Verification system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS facilitates background checks for the Participant or Representative (as applicable) choosing to self-direct services.

Frequency of Verification:

Verification occurs at time of hiring by Participant or Representative and annually thereafter. A Service Coordination Agency coordinates respite.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care Agency, Nursing Facility

Provider Qualifications

License *(specify):*

Department of Health & Human Services 10-144
Ch. 110 Regulations Governing the Lic. & Functioning of Skilled Nursing Facilities & Nursing Facilities;

Ch. 119 Reg. Gov. the Lic.& Functioning of Home Health Services;

Certificate *(specify):*

Ch. 128 Rules Governing the Functioning of the Maine Registry of Certified Nursing Assistants
Ch. 129 Rules & Regulations Governing In-Home Personal Care and Support Workers;

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

For institutional respite, the Waiver Services Provider verifies provider qualifications.
For non-institutional respite, verification is by the Medicaid agency at the time of provider enrollment.

Frequency of Verification:

Qualifications are verified prior to coordinating institutional respite stay for waiver participant.
Personal Care Agency respite providers are verified prior to provider agreement and verified every 3 years.
DHHS, Division of Program Integrity also verifies qualifications during audit procedures to assure compliance.

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 (FMS) are services delivered by a Fiscal Intermediary (FI) to assist and support the Participant who chooses to self-direct Attendant Care Services or in-home Respite.

The FI duties include, but are not limited to:
a) Assist Participants in verifying support worker citizenship status;
b) Collect and process timesheets of Attendants and disburse Attendant payments;
c) Process payroll, withholdings, filings and payment of applicable Federal, state and local employment-related taxes and insurances.
d) Establish and maintain Participant files in accordance with this section.
e) Coordinate Representative and Attendant criminal background checks; checks of Maine Registry of Certified Nursing Assistants and Direct Care Workers and checks with Office of Inspector General (OIG); and
f) Assist Participants with resolving questions and complaints and remediating as appropriate.

The FI may not authorize (increase or decrease units or add services to the Plan of Care) services beyond the services authorized by the Assessing Services Agency. The Department's electronic authorization system prevents the FMS from adding or increasing services. The State's electronic authorizations system interfaces with Maine's MMIS for provider billing and reimbursement. The Agency delivering FMS is enrolled with MaineCare as a provider and bills Maine's MMIS at the rate that is established by the Department and set within the MMIS.

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	Financial Management Services

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Management Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must demonstrate the ability to process timesheets and payroll, disburse Attendant Care payments and other needed management functions to support self-direction.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS agency must enroll with the Medicaid agency and be approved by the Office of Aging and Disability Services.

Frequency of Verification:

Verification occurs at initial enrollment with MaineCare and every 3 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Skills Training

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):*

Skills Training provides Participants who have chosen to self-direct personal care or in-home respite the information and skills necessary to carry out employer responsibilities. The Participant learns how to recruit, interview, hire, train, schedule, discharge, and direct an employee to deliver Personal Care Services/In-home Respite in accordance with the Plan of Care.

Skills training must occur prior to the start of services. Initial skills training must occur within thirty (30) calendar days of the determination of medical eligibility before services can start. A competency based assessment may be performed in lieu of skills training for Participants who have previously completed such training.

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

Skills Training Services shall not exceed 14.25 hours annually including the hours needed for initial instruction.

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	Service Coordination Agency (SCA)

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Skills Training

Provider Category:

Agency

Provider Type:

Service Coordination Agency (SCA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Skills training is provided by individuals able to teach the skills required for a Participant to successfully utilize Self-Direction. The individual must be an employee of the Service Coordination Agency and have a high school diploma or equivalent.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Service Coordination Agency must enroll with the Medicaid agency and be approved by the Office of Aging and Disability Services.

Frequency of Verification:

Verification occurs upon enrollment with the Medicaid Agency and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

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):*

A. Assistive Technology Device-A9279
Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of Participants. Assistive technology service means a service that directly assists a Participant in the selection, acquisition, or use of an assistive technology device.

Assistive technology includes:
(i) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for Participants;
(ii) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology device.

The service must improve or maintain the Participant’s level of independence, ability to access needed supports and services in the community or if required to ensure a Participant’s health and welfare. All other reimbursement sources must be explored and utilized, including the Medicaid State Plan services, prior to reimbursement of assistive technology services under this Section.
Documentation must describe how the waiver Participant's expected use, purpose and intended place of use have been matched to features of the products requested in order to achieve the desired outcome in an efficient and cost effective manner.

Examples of items that may be covered are voice-activated, motion-activated and electronic devices, communication devices and mobility devices. Vehicle modifications are excluded under this Section. Examples of other items that are excluded are recreation or quality of life item, such as televisions, microwave ovens and other general household appliances.

B. Assistive Technology-Remote Monitoring-A9279 QC This service includes real time remote support monitoring the Participant with electronic devices to assist them to safely remain in their home. Remote monitoring services may include a range of technological options including in-home computers, sensors and video cameras linked to a provider that enable 24/7 monitoring and/or contact as necessary.

A thorough evaluation of all assistive technology will be completed prior to the finalization of the Personal Plan with the assistance of the Waiver Services Provider and use of appropriate assistive technology consultants. The Participant’s plan

must document the Participant's consent and commitment to the plan elements including all assistive communication, environmental control and safety components.

Providers will comply with all federal, state and local regulations that apply to its business including but not limited to the Electronic Communications Privacy Act of 1986. Any services that use networked services will comply with HIPAA requirements.

Final approval must be made by the Department, Office of Aging and Disability Services upon a recommended authorization by the Assessing Services Agency or the Service Coordination Agency. In making such a recommendation, the ASA or SCA must consider and document the following information:

1) The number of hospitalizations in the past year,
2) The use of emergency room in the past year,
3) Whether the Participant has a limited or lacks formal or an informal support system,
4) a history of falls in the last six months resulting in an injury,
5) Whether the Participant lives alone or is home alone for significant periods of time, and
6) The Service access challenges for the Participant.

C. Assistive Technology-Transmission Service is Transmission of data required for use of the Assistive Technology Device.

This service supports the use of Remote Monitoring.

(Per CMS IRAI 6.5.23)
Assistive Technology-Remote Monitoring means real time remote support monitoring of the Participant with electronic devices to assist them to remain safely in their homes. Remote monitoring services may include a range of technological options including in-home computers, sensors, and video camera linked to a provider that enables 24/7 monitoring and/or contact as necessary.

Final approval for remote monitoring must be made by the Department, Office of Aging and Disability Services upon a recommendation by the ASA or SCA. In making such a recommendation the ASA or the SCA must consider and document the following information:

A. number of hospitalizations in the past year;
B. use of emergency room in the past year;
C. history of falls in the last six months resulting in injury;
D. Participant lives alone or is home alone for significant periods of time;
E. service access challenges and reasons for those challenges;
F. history of behavior indicating that a Participant's cognitive abilities put them at a significant risk of wandering; and
G. other relevant information for the request.

A thorough evaluation of all Assistive Technology will be completed prior to service delivery by the Waiver Services Provider (WSP) and appropriate Assistive Technology consultants. The Participant's record must document the Participant's consent and commitment to the Assistive Technology plan elements including all assistive communication, environmental control and safety components.

The provider will comply with all federal, state and local regulations that apply to its business including but not limited to "Electronic Communications Privacy Act of 1986." Any services that use networked services must comply with Health Insurance Portability and Accountability Act requirements.

Use of remote monitoring requires sufficient Back Up Plans and the SCA will be responsible for ensuring that the Participant has at least two adequate back-up plans prior to making a referral to the WSP for this service.

The state does not set regulations nor have oversight of Participants' private residences. The SCA is responsible for monitoring and ensuring health and safety for the Participant receiving waiver services in the home in accordance with applicable provisions set forth in Section 19 of the MaineCare Benefits Manual. Monitoring cameras are not permitted in the bedroom or the bathroom.

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

Assistive Technology Device-Component A is limited to $1500.00 per year. Assistive Technology Remote Monitoring-Component B is limited to $599.67 per month. Assistive Technology Transmission Component C is limited to $57.14 per

month. These costs are included as part of the Participants annual waiver cap. (Per CMS RAI follow up dated 8.4.23) Assistive Technology Transmission may not include reimbursement for an ongoing monthly charge of participant internet services.

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

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

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:

Waiver Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Minimum requirements may include compliance with:
Equipment must adhere to:
- Local and state codes
- Underwriters Laboratories
- FCC
- NFPA Life Safety Code
- ADA

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

Waiver Services Provider must assure the following for staff:
* Minimum age of 18
* Reportable Events Training

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS including Program Integrity, Finance/Rate-setting, Licensing & Regulatory services, and OADS. The Office of MaineCare Services, Provider Enrollment Unit, conducts final verification.

Frequency of Verification:

Verification occurs at enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Attendant Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Attendant Care Service is support and assistance for the Participant who has chosen to self-direct including, but not limited to, eating, bathing, dressing, personal hygiene, and/or activities of daily living. The service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the Plan of Care as essential to the Participant's health and welfare or incidental to the delivery of Attendant Care, this service may also include housekeeping chores including bedmaking, dusting and vacuuming. Attendants must meet State standards for this service. Individuals choosing to self-direct Attendant Care Services are responsible for hiring and training of their Attendants.

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

Attendant Care Services may not exceed 86.25 hours per week.
An individual Attendant shall not be reimbursed for providing more than 40 hours per week of services delivered to an individual waiver participant. Participants who are at risk of institutionalization may seek an exception to this limit.

The criteria the Department shall consider in evaluating the request include:
a. Availability of workers in the Participant's area;

b. Number of hours needed above the hourly limit;
c. Whether the Participant's condition is unique as compared to other Section 19 Participants;
d. The length of time for which the exception is requested; and
e. The efforts to find other workers by the agency or the Participant.

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	Attendant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services

Provider Category:

Individual

Provider Type:

Attendant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The standards for training are set by the individual directing services. The self-directing Participant or Representative, as applicable, is responsible for the hiring and training of the Attendant. As part of this process, the self-directing Participant or Representative must maintain documentation that the Attendant received adequate orientation to assure that the Attendant can meet the needs of the Participant and demonstrate competency in all required tasks. The Participant or Representative is required to undergo skills training which prepares and assists the Participant or Representative in fulfilling these responsibilities. Attendants may be members of the Participant's family except that payment will not be made for services furnished to a parent of a minor child's parent (or stepparent), or to the spouse of the Participant. If a Representative is directing services on behalf of the Participant, the Representative may not be paid to provide care. The Guardian may not be paid to provide care to the Participant.

Attendants must be 17 years of age or older.

Effective January 1, 2020, Attendant services must comply with Maine DHHS Electronic Visit Verification system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS facilitates required background checks for the Participant's prospective employees and for the Representative.

Frequency of Verification:

Verification occurs upon hire for the Attendant and when the Representative is selected.

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:

Environmental 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):*

Environmental Modifications are physical adaptations to the home that:
• Are required by and documented in the Participant's Plan of Care,
• Are necessary to ensure the health, welfare and safety of the Participant, or enable the Participant to function with greater independence within
the home, and
• Enable the Participant to remain in the home and to prevent an otherwise required institutional admission.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Modifications are allowed only for/to the private or family home of the Participant, not a provider-owned property or property where the landlord or another person has the responsibility to make the modification.

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

Services are limited to expenditures of $4500.00 per individual, 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
Individual	Building Contractors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Building Contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. The Waiver Services Provider must inspect and approve the work prior to reimbursement.
2. Inspection required by code enforcement officer, when required by law.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Services Provider

Frequency of Verification:

Verification occurs prior to finalizing a contract for the authorized modification.

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 Delivered Meals S5170

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Delivered Meals are meals that are either hot, cold, shelf stable, or frozen meals, and that are delivered to the Participant's home. In order to be eligible, the Participant cannot reside in an institution that meets the definition of a hospital or nursing facility, and the Participant is unable to prepare their own meals and no one else is responsible to prepare the meals.

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

Two meal per day and up to seven days 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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals S5170

Provider Category:

Agency

Provider Type:

OADS Approved Provider

Provider Qualifications

License *(specify):*

Licensed Dietician

Certificate *(specify):*

Other Standard *(specify):*

Approved provider agencies must:
1) Maintain and retain qualifications as an Area Agency on Aging that provides meals on wheels as part of the Older Americans Act;
2) Meet the requirements of the State of Maine Food Code, 10-144 C.M.R. ch. 200;
3) Demonstrate the ability to provide meals that meet the Participants' dietary needs;
4) Employ (Full, Part-time, or Per Diem) or retain on a consultant basis, a Maine Licensed Dietician;
5) Demonstrate the ability to produce and deliver meals to Participants' homes that meet The Dietary Guidelines for Americans, 2010; and
6) Demonstrate the ability to provide one meal (hot, cold, shelf stable or frozen) per day,7 days per week to eligible Participants, as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency must enroll with the Medicaid agency and be approved by the Office of Aging and Disability Services.

Frequency of Verification:

Verification occurs at time of enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Health Services

HCBS Taxonomy:

Category 1: 08 Home-Based Services

Sub-Category 1: 08020 home health aide

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Home Health Services are skilled nursing and home health aide services listed in the Plan of Care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Home Health Services also include physical and occupational therapy services, speech-language pathology services, and medical social services. Services are delivered according to the orders of a licensed physician or Advanced Practice Providers including; Physicians Assistants, Nurse Practitioners, and Clinical Nurse Specialists and an authorized plan of care.

Home Health Services offered under the waiver differ in nature and scope from home health services in the State Plan. The differences from the State Plan are as follows: 1) Home Health Services in the waiver may be provided by a state licensed MaineCare Home Health Agency that is not Medicare certified. 2) All home health staff must meet the specific provider qualifications appropriate to their profession as defined in State regulations.

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

(Per CMS IRAI 6.5.23)
This waiver service is only provided to individuals aged 21 and over. All medically necessary home health services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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	Licensed Home Health Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Health Services

Provider Category:

Agency

Provider Type:

Licensed Home Health Agencies

Provider Qualifications

License *(specify):*

10-144 Ch. 119 Regulations Governing the Licensing and Functioning of Home Health Care Services
Professional staff (RN, LPN, CNA, MSW, PT, OT, ST) must be fully licensed, which license must be documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure and approval to practice conditions. The professional must be employed directly by or through a contractual relationship with a home health agency.

Certificate *(specify):*

A certified home health aide must have satisfactorily completed a training program for certified nurse assistants, consistent with the rules and regulations of the Maine State Board of Nursing. Home health aides employed by a home health agency must also have completed an agency orientation as defined by the Regulations Governing the Licensing and Functioning of Home Health Care Services.

Other Standard *(specify):*

Effective January 1, 2020, Provider Agency must comply with Maine DHHS Electronic Visit Verification system standards and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Home Health Agency must enroll with the Medicaid agency and be approved by the Office of Aging and Disability Services.
Home Health Agency is responsible for verifying professional licenses of those they employ.

Frequency of Verification:

Verification occurs at time of enrollment and every three years thereafter.
The Department of Health and Human Services, Division of Program Integrity (PI) may also conduct verification of providers as PI monitors the MaineCare Programs for fraud, abuse and inefficient use of funds, and also administers sanctions, recovers overpayments and applies penalties.

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:

Living Well for Better Health (Chronic Disease Self-Management)

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):*

Living Well for Better Health is an evidenced-based Chronic Disease Self-Management Program (CDSMP) developed by Stanford University to help older adults better manage their chronic conditions, improve their quality of life, and lower health care costs.

When fully documented within the Participants Plan of Care, the service is delivered to Participants outside of the home in weekly small-group, highly interactive workshops. The service promotes self-confidence for the Participant through understanding ways that health problems impact the Participant's life, as well as ways to manage symptoms more effectively.
Workshops are facilitated by a pair of leaders, one or both of whom are non-health professionals with chronic diseases themselves.

Workshop topics include:
• How to deal with frustration, fatigue, pain, and isolation
• Ways to maintain and improve strength, flexibility, and endurance
• Managing medications
• How to communicate more effectively with family, friends, and health professionals
• Healthy eating

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

The service is delivered over six weeks for 2.5 hours each week and limited to one 6-week occurrence in a calendar year, not to exceed three occurrences in a participant's lifetime.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Living Well for Better Health (Chronic Disease Self-Management)

Provider Category:

Agency

Provider Type:

OADS Approved Provider

Provider Qualifications

License *(specify):*

Licensed by Stanford University to provide Living Well classes.

Certificate *(specify):*

The staff offering the training must have a certificate from Stanford University.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and be approved by the Office of Aging and Disability Services.

Frequency of Verification:

Verification occurs at time of enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Matter of Balance (Falls Prevention)

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):*

Matter of Balance is a nationally recognized, evidence-based program developed by the Roybal Center at Boston University that emphasizes practical strategies to reduce fear of falling and increase activity levels.
When documented within the Participant's Plan of Care, this service is delivered outside of the home in weekly, two-hour structured group intervention classes led by a trained facilitator over eight weeks.
During the class, participants learn to:
• View falls as controllable
• Set goals for increasing activity
• Make changes to reduce fall risk at home
• Exercise to increase strength and balance

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

The service is limited to one, 8-week occurrence in a calendar year, not to exceed three occurrences in a participant's lifetime.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Matter of Balance (Falls Prevention)

Provider Category:

Agency

Provider Type:

OADS Approved Provider

Provider Qualifications

License *(specify):*

Licensed by Boston University to provide Matter of Balance classes.

Certificate *(specify):*

The staff offering the training must have a certificate from Stanford Boston.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The provider agency must enroll with the Medicaid agency and be approved by the Office of Aging and Disability Services.

Frequency of Verification:

Verification occurs at time of enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation (NMT)

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):*

Non-Medical Transportation (NMT) enables the Participant to gain access to waiver services, activities and resources, and other community services specified and documented in the Plan of Care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, the Participant will utilize family, neighbors, friends, or community agencies which can provide this service without charge. Non-Medical Transportation is provided through a 1915(b)/1915(c) combination and arranged by transportation brokers.
Relatives and Legal guardians may only be reimbursed by the broker if they indicate that they are unable to transport at no charge or there is no other viable option and there is a recommendation by the planning team.

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	Broker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation (NMT)

Provider Category:

Agency

Provider Type:

Broker

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Transportation services are managed through a 1915 (b) waiver run concurrently with this waiver and managed through a broker. The qualified broker, as selected through a request for proposal process, must maintain documentation of liability insurance, ability to obtain payment and performance bonds, and meet other specifications as detailed in the request for proposal. The State verifies the broker's qualifications through the RFP process and then through ongoing contract monitoring. The broker is enrolled with MaineCare.

Verification of Provider Qualifications

Entity Responsible for Verification:

The transportation broker must enroll with the Medicaid agency and verify the qualifications of each individual driver.

Frequency of Verification:

Verification occurs upon enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

PERS is an electronic device which enables Participants at high risk of institutionalization to secure help during an emergency. The Participant may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated.

The service is limited to Participants who live alone or are alone for significant parts of the day, and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

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

Reimbursement is limited to the installation fee and the monthly phone charge for the emergency response system and the home unit communicator.

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	Emergency Response System Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Emergency Response System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Capability of PERS provider to set up effective PERS system in the waiver Participant's home and monitor that system on a monthly basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Services Provider verifies capability of PERS provider in setting up PERS for the waiver Participants.

Frequency of Verification:

Waiver Services Provider contracts with agencies providing the setup and service and verifies effectiveness of service for the individual.

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:

Private agencies approved by OADS and enrolled as MaineCare providers deliver care coordination to waiver participants.

The Department provides initial training, continuing education, and other related educational activities that align and comply with the HCBS setting rule and other professional case management expectations to ensure case management providers meet high quality standards.

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
Care Coordination
Financial Management Services
Skills Training
Personal Emergency Response System (PERS)

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 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 Care Coordinator is responsible for monitoring and ensuring health and safety for the participant receiving waiver services in the home in accordance with applicable sections of the MaineCare Benefits Manual, including protecting individual rights and privacy.

☒ **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 waiver 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 Waiver Services Provider (WSP) to review technology needs specific to their functional assessment within the home environment. The WSP is responsible for training the participant regarding the use of all devices and equipment including the activation or deactivation of the equipment within the participant's home.

☒ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

The Care Coordinator is responsible for ensuring, monitoring and documenting the delivery and efficacy of the service through monthly contact with the participant and guardian. The Care Coordinator must maintain a safety/risk plan within the PCSP outlining the potential risks to the participant's health and welfare and the reasonable steps to alleviate those risks. The PCSP and safety/risk plan must be 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):

(a) Provider agencies must conduct criminal background checks for prospective employees including Personal Care Assistants/Personal Support Specialists and Certified Nursing Assistants.

(b) State Police Background checks will be conducted by the provider prior to employment of the direct care worker.

(c) The Provider agency will verify and attest that all staff have a criminal history check as required prior to enrollment and annually thereafter. For Participants who self-direct, the FMS facilitates a criminal background check on behalf of the Participant or Representative for all prospective employees. The FMS also conducts background checks when the self-directing Participant requires or chooses a Representative. Division of Licensing and Certification (DLC), Office of Program Integrity (PIU), and OADS provide oversight through ad hoc audit and by complaint. For those providers who are licensed, DLC routinely looks at personnel records to ensure that the background checks are conducted on all direct care workers. Program Integrity also 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 MRS §1812-G, the State of Maine must maintain a registry of Direct Care Workers who have criminal convictions in the last ten years and/or substantiated findings of abuse, neglect, or misappropriation of property which is maintained by the Department of Health and Human Services.

Additionally, the provider will contact the Child and Adult Protective Services units within DHHS to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a substantiated incident of abuse, neglect or exploitation by a prospective employee, it is the provider's responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with regulation.

(b) The registry must contain a listing of certified nursing assistants and direct care workers including, but not limited to, the following positions: Personal Support Specialists, Attendants, Nurses.

(c) The Provider agency will verify and attest that all staff have an abuse registry screening as required prior to enrollment and annually thereafter. Division of Licensing and Certification (DLC), Office of Program Integrity (PIU), and OADS provide oversight through ad hoc audit and by complaint. For those providers who are licensed, DLC routinely looks at personnel records to ensure that the background checks are conducted on all direct care workers. Program Integrity reviews credentials and background checks when conducting investigations or reviews.

Appendix C: Participant Services

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

Note: Required information from this page 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.*

The spouse of the eligible waiver Participant may be paid to furnish Personal Care services. The spouse must meet the qualifications for a Personal Support Specialist (PSS) in order to provide Personal Care to the Participant. Services must be approved through the service authorization process by the Service Coordination Agency and delivered as documented in the Participant's Plan of Care. If the spouse of the Participant provides Personal Care Services as a qualified PSS, the planning process must initially and on a regular and ongoing basis ensure that services by the spouse are in the best interests of the Participant, and this must be documented in the Plan of Care. The Department has several levels and types of oversight. The PCA conducts supervisory visits for the PSS to ensure competency and Participant satisfaction. The SCA holds monthly contact calls for health and welfare, satisfaction, and unmet needs assessments. Additionally, the SCA also reviews and tracks the provider complaint process.

Spouses may only be reimbursed for providing extraordinary care. Extraordinary care means care exceeding the range of activities that a spouse would ordinarily perform in the household on behalf of 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. If the spouse of the Participant provides Personal Care Services as a qualified PSS, the planning process must initially and on a regular and ongoing basis ensure that the spouse is reimbursed only for extraordinary services. Extraordinary services include Activities of Daily Living, and do not include Instrumental Activities of Daily Living.

Services are delivered in accordance with the authorized Plan of Care, and supervisory visits are required by the agency that employs that spouse as a Personal Support Specialist. A spouse serving as a Personal Support Specialist is held to the same standards as any other PSS, according to rules in the MaineCare Benefits Manual, Ch. II, Section 19.

The Service Coordination Agency (SCA) provides authorization to the Personal Care Agency, and it is the responsibility of those two agencies to ensure and confirm that a spouse (PSS) is only submitting instances of extraordinary care for reimbursement. Regular site visits help determine the extent to which the PSS is completing ADLs and IADLs in the home.

A spouse may not provide respite services.

(Per CMS IRAI 6.5.23)
Personal Care Services when delivered by a spouse are subject to the following criteria:
1) The Participant requires Extraordinary Care to maintain health and welfare and avoid institutional care.
2) The need for Extraordinary Care must be identified, documented, and regularly evaluated within the Person-Centered Planning process and authorized by the Service Coordination Agency (SCA).
3) Personal Care Services are limited to 86.25 hours per week.
4) One individual Personal Support Specialist may deliver only up to forty (40) hours of service per week to one individual Participant.
5) PCS, when delivered by a legally responsible person, is limited to Activities of Daily Living and do not include Instrumental Activities of Daily Living.
6) The spouse must meet the qualifications for a Personal Support Specialist and work for a Personal Care Agency (PCA).
7) The PCA must verify qualifications of individual employees upon hire and annually thereafter.
8) The SCA and PCA are responsible for ensuring that the spouse is delivering, documenting and submitting instances of Extraordinary Care for MaineCare reimbursement.

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.*

◉ **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.

Relatives: A family member who meets the qualifications for delivering personal care as a Personal Care Attendant or a Personal Support Specialist when employed by a Personal Care Agency (PCA) or Nursing Facility, may be paid for delivering personal care services or in-home respite to the Participant. A family member may also be reimbursed for providing Attendant Care Services or respite services to the Participant accessing Self-Directed Services. Services are delivered as authorized in the Participant's Plan of Care and approved through the service authorization process by the Service Coordination Agency.

A Guardian may not provide care as an Attendant under the self-directed option but may provide personal care to a Participant if they meet the qualifications for providing care as a Personal Care Attendant or a Personal Support Specialist and are employed by an agency.

Services are delivered as authorized in the Plan of Care and supervisory visits are required by either the agency or , for individuals self-directing, the Service Coordination Agency.

The state contracts out Transportation Services to a broker through a 1915(b) waiver and at times will reimburse relatives or legal guardians for Transportation Services if they indicate that they are unable to transport at no charge, if there is no other viable option or there is a recommendation by the planning team.

(Per CMS IRAI 6.5.23)
Personal Care Services or Attendant Care Services when delivered by a relative/legal guardian are subject to the following criteria:
1) Personal Care Services are limited to 86.25 hours per week.
2) One individual Personal Support Specialist may deliver only up to forty (40) hours of service per week to one individual Participant.
3) The family member must meet the qualifications for a Personal Support Specialist.
4) The PCA must verify qualifications of individual employees upon hire and annually thereafter.
5) The SCA and PCA are responsible for monitoring service delivery, ensuring that services delivered are documented in accordance with Ch I, Section 1 of the MBM and that services are rendered in the best interest of the Participant, and reimbursed 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, except for transportation 1915(b) brokers, may enroll as a provider so long as all necessary qualifications are met. The State has on-going open enrollment and State staff available to assist with the qualifications and enrollment process. OADS reviews and approves all provider applications. Provider recruitment is conducted by state DHHS staff. All provider requirements and procedures to qualify are on the Department's website. Verification that Providers meet these requirements must be provided prior to enrollment.

Further, Ch. I, Section 6 of the MaineCare Benefits Manual states, “To provide home and community-based waiver services, a provider must be enrolled in MaineCare as a provider by the Office of MaineCare Services, be in compliance with the Provider’s MaineCare Provider Agreement, and satisfy all provider qualification requirements set forth in the applicable HCBS waiver regulations.”

Finally, the provider agency must have:
1. Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS)
2. Received addition approval from OADS for provision of waiver services as required in MIHMS Provider.
3. Copies of contracts or service agreements when the provider manages services delivered by another provider, thereby documenting the cooperative, affiliated service, or the subcontracting agreement. This agreement shall be updated and renewed at least annually.
4. Outlined the business structure in an organizational chart, identifying management, staff and other individuals compensated by the provider for assisting in the care of Member (s) and illustrating the supervisory responsibilities; include credentials as required for the service delivery.

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 that initially and continually meet required licensure/certification standards and adhere to other standards prior to furnishing waiver services. (Due to Character Count limit please see *4 within "Main, Optional-Additional Information" for Numerator and Denominator)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment and Division of Licensing and Certification

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**	☒ **Annually**	☐ **Stratified**

Specify: Division of Licensing and Certification		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 non-licensed agency providers whose direct support staff had CNA Registry checks prior to service provision. Numerator: Number of non-licensed agency providers whose direct support staff had CNA Registry checks prior to service provision. Denominator: Total number of non-licensed agency providers (PCA agencies) 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:

Performance Measure:
Number and % of non-licensed/non-certified providers conducting criminal background checks on non-licensed/non-certified providers prior to service provision.
Numerator: Number of non-licensed/non-certified providers conducting criminal background checks on non-licensed/non-certified providers prior to service provision.
Denominator: Total number of non-licensed/non-certified providers 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:

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 Fiscal Intermediary (FI) providers who conducted criminal background checks on attendants prior to delivering services to the self-directing Participant. Numerator: Number of FI providers who conducted criminal background checks on attendants prior to delivering services to the self-directing Participant. Denominator: Total number of FI providers 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:

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 % of Participants and Representatives who received and completed Initial Skills Training in accordance with state requirements and the approved waiver. Numerator: Number of Participants/Representatives who received and completed Initial skills Training in accordance with state requirements and the approved waiver. Denominator: Total number of Initial skills training referrals 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**

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:

Performance Measure:
Number and Percent of Waiver Service Provider staff who meet training requirements in accordance with state requirements and the approved waiver. Numerator: Number of WSP staff who meet training requirements in accordance with state requirements and the approved waiver. Denominator: Number of WSP staff 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:

Performance Measure:
Number and Percent of licensed/non-licensed providers whose non-licensed direct support staff have completed PSS training in accordance with state requirements and the approved waiver. (Due to Character Count limit please see *6 within "Main, Optional-Additional Information" for Numerator and Denominator)

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 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**	☒ **Annually**

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

The Medicaid agency enrollment process verifies licensure and registration in accordance with state law and services may only be provided by an actively enrolled agency. The Division of Licensing & Certification conducts certification and licensing renewal activities on all certified and licensed Home Health Agencies in Maine as required under state statute and licensing regulations. Any deficiencies or change in licensing to provisional status are reported to the Office of Aging and Disability Services and to the Medicaid agency enrollment division.
Maine has a state statute that requires all Personal Care Agencies to submit an application and a $25 annual fee to Licensing and Certification.
Entities that are engaged in the business of hiring and employing individuals who provide personal care services must register with the Departments Division of Licensing and Regulatory Services and must file an application disclosing information about the entity and the services provided. An agency must have completed the registration process in order to be enrolled as a Medicaid provider. The Operating Agency must approve all new waiver providers.

(Per CMS IRAI 6.5.23)
The Participant will communicate concerns to their Care Coordinator, who will advise the Participant of their options and assist with problem resolution as needed. The SCA will contact OADS if further assistance is needed. At any time a Participant may request a change in providers, make a complaint regarding an action of the provider agency, make or file a complaint regarding any aspect of services or service delivery to licensing and/or the provider agency/direct care staff, select a different service, involve an advocate, or file a formal complaint with the Department. The state ensures timely response in accordance with individual provider contract requirements and monitoring resolutions to identified problems. The Care Coordinator must document resolution in the Participant's record.

As a condition of applying to the State Medicaid Agency, a provider agency or individual entity (as applicable) must first apply to the operating agency. The operating agency verifies the provider’s policies, procedures and standards prior to approval as an OADS-approved agency. The agency then completes enrollment with the State Medicaid Agency. On an annual basis the state reviews a sample of providers to verify the state’s promulgated rules for agency requirements have been met.

(Per CMS RAI 7.17.23)
When OADS discovers individual problems or deficiencies in state requirements and the approved waiver, the state works

with providers on informal resolution such as seeking an informal plan regarding how the provider will remediate deficiencies in the immediate and long-term prior to issuing a formal notice of deficiency requiring a Plan of Correction in accordance with Chapter II, Section 19 of the MaineCare Benefits Manual (MBM). The State may also give notice to the Office of MaineCare Service's Program Integrity Unit that may lead to sanctions in accordance with Chapter I, Section 1 of the MBM.

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 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.

There is a monthly cap of $10,194 for a combination of Personal Care, Attendant Care, Respite, Home Delivered Meals, Living Well and Matter of Balance.

(Per CMS IRAI 6.5.23)
All covered services are subject to the combined limit except Assistive Technology, Home Delivered Meals, Environmental Modifications, Living Well for Better Health, Matter of Balance, FMS, and Skills Training as these services are not considered direct care.

Additionally, the following applies:
a. The cost limit will increase on an annual basis proportionately to the scheduled Appendix J and I-2-a reimbursement rate increases to ensure participants do not lose access to eligible services as an unintended result of the scheduled rate increases.
b. The Department of Health and Human Services looked at historical claims costs and used averages as the limit for the services.
c. If utilization and unmet needs data indicate a need for changing the combined limit over the waiver period, and the financial situation allows, DHHS will consider making changes via amendment.
d. The Participant is fully engaged in the budgetary process. The Care Coordinator and planning team will work with the Participant to make adjustments when necessary. Safeguards may include referral to a state plan service(s), referral to state-funded programs, or increased use of natural/informal supports. The individual budget amount is derived from the Medical eligibility Determination assessment. The assessing services agency then identifies the services for which the participant is eligible, the planning process is initiated to identify choices, personal goals and planning needs. The final budget authority lies with the Department of Health and Human Services. The individual services and associated caps are in the state promulgated rule for transparency.
e. Home Support or Personal Care is the one service that is most critical in responding to inadequacies of service in other areas of the Participant’s life. This service can serve as a buffer if the Participant has issues with other services, the provider and the Participant will work together to ensure health and safety.
f. Any limit(s) on services needed by an individual Participant is discussed at the planning meeting and the PCSP is written accordingly.

☐ **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.

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.)*

1. Participants receive services in their own homes and in communities of their own choosing and therefore presumed to be compliant with the HCBS Setting Rule and the State's Global Rule.

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.)*

For settings the state presumes compliant with the 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 conduct IEAs. OADS will review and assess all IEAs to ensure that the participant’s experience in that setting is consistent with the 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:

Proposed Plan of Care

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:

☐ **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.

At the time of initial evaluation or reevaluation, the Participant may invite people of the Participant's choosing to the MED evaluation process. The RN/LPN conducting the MED actively engages the Participant throughout the process regarding the Participant's strengths and need for support services. Once eligibility has been determined, the RN/LPN describes the community options and services that are available under the waiver. The Participant may make a choice of waiver services at the time of the MED and the development of the Proposed Plan of Care or soon thereafter. The Service Coordination Agency ensures continuing active engagement by the participant, family member(s) identified by the Participant, and/or the Guardian as the Plan of Care is implemented.

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):

The Person-Centered Service Plan (PCSP), and the planning for the PCSP, must comply with the requirements of the Global HCBS Waiver Person-Centered Planning and Settings Rule ("Global HCBS Rule"), MaineCare Benefits Manual, Chapter 1, Section 6.

(a) The person-centered planning process begins at the time of MED evaluation resulting in a Proposed Plan of Care. The planning process is directed by the participant and may include family member(s) identified by the Participant, the Guardian (if applicable), and providers who contribute to the development of this initial plan. When there is a reevaluation, the Care Coordinator also becomes involved in the PCP development, along with those involved based on the Participant's request. Unscheduled reevaluations may occur as a result of a record review, multi- disciplinary team review, or a revision request based on a change in the Participant's needs. The Participant has ample opportunity to express his or her goals, needs and preferences during the assessment and while participating in the program.

(b) The Proposed Plan of care is authorized by the Assessing Services Agency (ASA). It specifies all waiver services to be delivered to a Participant, including the number of hours and type of provider for each authorized service. The Proposed Plan of Care is based upon the Participant's scores recorded in the Medical Eligibility Determination (MED) form, Participant's stated goals, and the professional clinical judgment of the RN/LPN. The Proposed Plan of Care reflects the needs identified by the MED considering the participant's living arrangement, informal supports, and services provided by other public and private funding sources.

(c) The RN/LPN or the Care Coordinator informs the Participant of services available under the waiver and community resources that may be available to meet his or her needs. The Participant is given a copy of his or her plan when it is developed.

(d) The Proposed Plan of Care lists each need, who will help the Participant with that need, and how often they will help. The plan also lists the other sources of assistance such as Medicare and family and friends. The outcome tab in Mecare (the automated assessment) shows the final outcome of the MED based on the participant's choice of community services, nursing facility placement, or advisory only. It also indicates if there was a service denial or reduction and key dates related to hearing rights. In addition, there is a field that tells whether the Participant would like more information about self-directed options.

(e)&(f) The authorization and Proposed Plan of Care are forwarded to the Service Coordination Agency for implementation.

The Care Coordinator of the Service Coordination Agency:
1) Contacts the participant within two business days of receipt of the level of care determination and Proposed Plan of Care;
2) Assists the participant with finalizing the Plan of Care and locating providers and obtaining authorized services based on
his or her choice of provider.
3) Implements and coordinates services with the provider agency or independent contractor using service authorizations; and
4) Monitors service utilization each month to assure effectiveness of plan in meeting participant's needs and compliance of service delivery with waiver requirements.

(g)The Plan of Care is evaluated at least annually or upon a change in service need. In addition, the Plan of Care is updated, when indicated, when a reevaluation occurs as a result of a record review, multi-disciplinary team review, or revision request based on a change in the Participant's needs.

The Department assumes ultimate responsibility to assure appropriateness of Plans of Care.

The Department adopted 10-144 C.M.R., ch 101, MaineCare Benefits Manual, Chapter I, Section 6, Global HCBS Waiver Person-Centered Planning and Settings Rule ("Global HCBS Rule") to comply with federal HCBS Settings rule as set forth in 42 C.F.R. § 441.301(c). The state's response to D-1-d includes requirements that providers comply with the Global HCBS Rule by reference including the requirement that all providers responsible for implementation of the PCSP must sign the PCSP and that the Participant receives a finalized copy of the same.

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.

Several items in the MED that help determine functional eligibility for the waiver may also point to potential risks for/to the Participant. These items include frequency of falls, availability of informal supports, medication administration and compliance, cognitive and behavioral issues, and potential environmental hazards. Additionally, the RN/LPN documents issues of concern and observations that may indicate potential risk directly in the MED form. Services authorized and information about community resources (such as caregiver support, pharmacy assistance) may help to mitigate the risks identified. The Service Coordination Agency is advised of the risks when they receive the assessment. They discuss arrangements for backup with the participant when support services are not available and review the efficacy of risk mitigation strategies, as documented in the Proposed Plan of Care, at regular intervals directly with the Participant.

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.

At the time of assessment, the Assessing Services Agency describes the service options available to Participants and gives them a resource booklet that lists the qualified providers. This includes information about self-direction of personal care and in-home respite services.

When contacted by the Service Coordination Agency, participants are given additional information about self-direction of services and the availability of qualified providers in their area.

Neither the Assessing Services Agency nor the Service Coordination Agency advocates for any particular provider(s). Rather, they share information about services offered in an objective manner, so participants can make informed choices. The Service Coordination Agency helps participants access the services from the provider(s) they have chosen.

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):

In order for services to be reimbursed, a completed and approved Medical Eligibility Determination form must be received by the Maine Department of Health and Human Services. The Department designates the Assessing Services Agency, as the authority for medical eligibility determination. The classification for waiver services is entered into the MMIS system by the Office of Aging and Disability Services. The completed MED form, the signed choice letter, and the Plan of Care are submitted to the Service Coordination Agency. There is a review of service plans by the operating agency. A sample of care plans are reviewed for appropriateness and compliance with state requirements. The operating agency also participates in care planning review meetings with the SCAs. The Department assumes ultimate responsibility for appropriate Plans of Care.

(Per CMS IRAI 6.5.23)
OADS staff conduct a quarterly quality review of the Person-Centered Plans (PCSP). The quality review evaluates whether PCSPs are being conducted consistent with the Department’s standards.

Annually, the operating agency provides Quality Reports (that include appeals outcomes to assess trends in the fair hearings process and proper service planning) to the SMA. OADS and OMS meet quarterly specific to review of Quality Reports and identify trends that may require action. Additionally, OADS and OMS meet weekly to review and discuss operational aspects of the waiver to identify and address individual problems that may arise.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, 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:

Proposed and Authorized Plans of Care are maintained within the MeCare database system as part of each waiver Participant's eligibility determination.

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) The Service Coordination Agency is responsible for monitoring the implementation of the service plan and Participant health and welfare.

(b) The Service Coordination Agency uses the following comprehensive care coordination and follow-up methods:
1) Ensuring implementation of the authorized Plan of Care and coordinating service providers responsible for delivering services under that plan;
2) Monitoring services and support;
3) Evaluating the effectiveness of the plan with the Participant and/or Guardian (as applicable) and the providers of services or support;
4) Monitoring the Participant's receipt of services and overall health status;
5) Coordinating and requesting the required annual reassessments and any other reassessments based on significant change in the Participant’s health status or service needs.

(c) The Service Coordination Agency reviews the Participant's Plan of Care at least quarterly, or more frequently when documented in the Plan of Care or when the Participant experiences a significant change in health status or service needs.

Telephone contact occurs with each participant at least once a month. If the participant requests not to receive monthly calls and there is documentation in the record to support this choice, the calls may be reduced to quarterly.

The waiver participant is seen in their home first by the RN assessor who authorizes the plan of care, then again within 30 days of when the Service Coordination Agency is provided the authorized plan of care by the care coordinator, to evaluate effectiveness of plan and assess unmet needs, and then annually thereafter. For individuals who choose to receive services through self-direction, the waiver participant is seen at least every six months. The person is also seen again at time of reassessment by the RN assessor which typically happens annually after the first year of waiver services. When the participant is experiencing problems, the care coordinator follows up in a timely manner to help resolve the problems and to address any unmet needs that are not covered under the authorized plan of care.

Note: In limited circumstances, the SCA may revise the authorized Plan of Care according to the following parameters:
1) In the event a Participant experiences a change in the need for services, the Service Coordination Agency may adjust the frequency of services in order to address the needs.
2) In the event a Participant experiences an emergency or acute episode (MBM, Ch II, Section 19.01-2), the Service Coordination Agency may adjust the authorized services by no more than 15% of the monthly authorized amount, and in no case to exceed the monthly cap. Services added or changed due to an emergency or acute episode may not continue beyond fourteen (14) days.

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:
Number and Percent of PCSPs that address the Participant's assessed needs and personal goals, either by the provision of waiver services or through other means.
Numerator: Number of PCSPs that address the Participant's assessed needs and personal goals, either by the provision of waiver services or through other means.
Denominator: Total number of PCSPs reviewed.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:
onsite review of Service Coordination Agency

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**

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

Performance Measure:
Number and Percent of service plans that address the Participant's health and safety risk factors in the home visit evaluation. Numerator: Number of service plans that address the Participant's health and safety risk factors in the home visit evaluation. Denominator: Total number of Participant service plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 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.

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:
Number and Percent of all service plans that were revised due to a change in the participant's service need. Numerator: Total number of all service plans that were revised due to a change in the participant's service need. Denominator: Total number of participant service plans requiring a revision due to a change in need.

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**	☐ **Other**

	Ongoing	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 all participant service plans that were updated on or before the participant's annual review date. Numerator: Total number of all participant service plans that were updated on or before the participant's annual review date. Denominator: Total number of participant service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MeCare Assessment data

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 receiving the type of services described in their authorized care plan. Numerator: Total number of participants receiving the type of services described in their authorized care plan. Denominator: Total number of Participant records 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:

Performance Measure:

Number and Percent of Participants who received services in duration and frequency in accordance with the authorized care plan. Numerator: Total number of participants who received the services in duration and frequency in accordance with the authorized care plan. Denominator: Total number of participant records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 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:

Performance Measure:
Number and Percent of participants receiving the scope and amount of services as described in their authorized care plan. Numerator: Number of participants receiving the scope and amount of services as described in their authorized care plan. Denominator: Total number of participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MIHMS Claims Data

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

		95% 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:

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.

Performance Measure:
Number and Percent of participants or guardians who signed a choice of waiver services and provider letter. Numerator: Number of participants or guardians who signed a choice of waiver service and provider letter. Denominator: Total number of participant records 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: Service Coordination Agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Participants who were offered a choice of traditional or participant-directed service delivery options at initial or re-assessment. Numerator: Number of participants who were offered a choice of traditional or participant-directed service delivery options at initial or re-assessment. Denominator: Total number of participants reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 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**

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.

Transportation is provided through a brokerage system in Maine, via a 1915b waiver. The transportation broker collects extensive data on performance measures for reporting on the 1915b waiver. The data will be provided to the 1915c waiver administrators for inclusion in the quality review process on an annual basis. Office of MaineCare Services and the program offices responsible for 1915c waiver administration will work together to discover, identify and remediate any problems as they arise.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

Monitoring of the service plan is a critical component in the administration of the waiver. All parties (Assessing Services Agency, Service Coordination Agency, Office of Aging and Disability Services) share responsibility for assuring its effectiveness in meeting participant's needs. Individual problems are addressed and documented in the participant's record.

(Per CMS IRAI 6.5.23)
When individual problems are discovered the SCA may support the Participant to revise the PCSP, to make referrals for community services, or to recommend a redetermination, depending upon the individual problem. The SCA will review available options with the Participant to determine the best course of action.

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 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.

(a) At the time of evaluation, the RN/LPN gives the Participant and the Representative (as applicable) information about opportunities for self-direction under this waiver. If the Participant or Representative states an interest in self-direction, the RN/LPN with clearly document the interest within the Proposed Plan of Care.

(b) The Service Coordination Agency provides additional information and training about self-direction to the Participant and/or Representative (if applicable). The Participant may choose to self-direct at any time while receiving this waiver benefit. When services are managed by a Representative (on behalf of the Participant), the Representative must be at least 18 years of age or older and may manage the services of no more than two Participants.

(c) The self-directing Participant or Representative must select and work with a Fiscal Management Services (FMS) provider to coordinate payroll services for Attendants. The FMS provides administrative and payroll services including, but not limited to, preparing payroll and withholding taxes, making payments to suppliers of goods and services, and ensuring compliance with applicable state and federal tax and labor regulations and requirements. Any willing and qualified provider may enroll with the State Medicaid Agency to provide FMS.

(d) Additional information regarding the state's approach to Self-Directed Services:

1) The Service Coordination Agency must:

a) Establish a monthly cost limit based on the authorized plan of care;

b) Manage professional and/or other waiver services other than Attendant Services; and

c) Coordinate services with the Fiscal Management Services Provider.

2) The participant or representative:

a) Must coordinate a CNA Registry and criminal history background check through the FMS for any individual hired as an Attendant and not employ that individual if that individual would otherwise not be employable by an agency under 22 MRSA §1717.

b) May not be paid to provide care to the participant.

c) Must select a Fiscal Intermediary to deliver FMS approved by the Medicaid agency as a payroll agent.

d) Must provide adequate orientation for the Attendant to meet the needs of the participant(s), as specified by Service Coordination Agency.

e) Must document the provision of orientation, including specific dates and the content matter of the orientation, in the employee's personnel file.

f) Must document the competency of the Attendant demonstrated in all required tasks.

3) A Participant who does not have cognitive capacity may not self-direct but may have a Representative to direct services on their behalf. The Representative must meet, and document required expectations for face-to-face contact with the Participant.

4) FMS is the minimum required service for accessing self-direction within this waiver benefit. The FMS acts as an agent of the employer (the Participant or Representative) in accordance with Federal Internal Revenue Service Codes and procedures in matters related to the employment of support workers.

5) The FMS facilitates the background checks and conducts an OIG check on all Attendants.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may

function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Self-direction allows for a Representative to manage the Attendant Care Services and in-home respite on behalf of the Participant. The SCA provides skills training and support to the Participant or Representative to assist with this process. Other waiver services are provided through the traditional agency model of service delivery facilitated through the Service Coordination Agency.

A Participant choosing to self-direct Attendant Care and In-home Respite Services must demonstrate the cognitive capacity to do so as determined by the MED form. If a Participant does not meet cognitive capacity, a Representative must be designated to support self-direction of services on behalf of the Participant. The guardian, power of attorney or health care surrogate may act as Representative on behalf of the Participant. The guardian may also appoint a Representative for the Participant. In these instances, the Guardian retains decision-making authority. The Representative supports the Participant with the duties associated with self-direction. Conversely, a Participant meeting cognitive capacity on the MED form may choose to designate a Representative for additional assistance in managing and directing services. In either case, a Representative may not manage services for more than two participants.

Any waiver participants who decide not to direct their Attendant Care or In-Home Respite Services are able to access Personal Care and Respite Services through the traditional agency model of service delivery facilitated through the Service Coordination Agency.

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.

a) The RN/LPN at time of level of care evaluation provides FAQ sheets and discusses self-direction describing the opportunities for self-direction of Attendant Care and In-Home Respite Services. Similar information is provided by the Service Coordination Agency. If the Participant or Representative expresses an interest in this option, the Service Coordination Agency will assist in accessing this option.
b) The Service Coordination Agency and the Assessing Services Agency are responsible for providing information concerning the election of participant direction.
c) The information is provided at the time of the level of care determination and as a part of service implementation and monitoring.

(Per CMS IRAI 6.5.23)
The RN/LPN at time of level of care determination provides written material and discusses self-direction describing the opportunities and potential risks associated with self-direction as well as the Participant’s responsibilities to self-direct services. Similar information is provided by the Service Coordination Agency.

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:

The MBM, Ch. II, Section 19.01 defines Self-Direction and describes the role and responsibilities of the Representative. Additionally, Section 19.08 of the MBM outlines the scope and safeguards for the designated Representative providing support to the Participant electing self-directed service options including the following:

The Representative must:
1) Be at least 18 years of age;
2) Have the ability to understand and perform tasks required to manage an Attendant as determined by the SCA;
3) Have the ability to communicate effectively with the SCA, FMS and Attendant(s) in performing the tasks required to employ an
Attendant;
4) Agree to visit the member in person at least once a month and contact the member in person, by phone or other means at least
weekly; and
5) Not be an Attendant reimbursed for providing care to the member.

Further, the designated Representative shall not be compensated for the services provided to/on behalf of the Participant and may not actively manage the care for more than two Participants accessing Self-Directed services under this or another MaineCare or state funded long term care program.

(Per CMS IRAI 6.5.23)
For a Participant to direct his or her own services under the Participant-Directed Option without the use of a Representative, the Participant must have Cognitive Capacity, as assessed on the MED form, to be able to self-direct his or her Attendant(s). The ASA will assess Cognitive Capacity as part of each Participant's eligibility determination using the MED findings.

Minimum MED form scores are:
A. decision making skills: a score of 0 or 1;
B. making self-understood: score of 0, 1 or 2;
C. ability to understand others: score of 0, 1 or 2;
D. self-performance of managing finances: a score of 0, 1, or 2; and
E. support for managing finances: a score of 0, 1, 2 or 3.

A Participant not meeting the specific scores detailed above during his or her eligibility determination will be presumed not able to self-direct without the use of a Representative under this waiver.

A Representative may manage Attendant Services for a Participant under the Participant-Directed Option in this waiver and shall not be compensated for the services provided.
The Representative must be able to manage and direct program Attendant Services for the Participant in accordance with the Participant's preferences and meet all program requirements.

The Representative may not actively manage the care for more than two Participant accessing the Participant-Directed Option under this Section or another MaineCare or state funded long term care program.

Specifically, the Representative must:
a. Be at least 18 years of age;
b. Have the ability to understand and perform tasks required to manage an Attendant as determined by the SCA;
c. Have the ability to communicate effectively with the SCA, FMS and Attendant(s) in performing the tasks required to
employ an Attendant;
d. Agree to visit the Participant in person at least once a month and contact the Participant in person, by phone or other
means at least weekly; and
e. Not be an Attendant reimbursed for providing care to the Participant.

Additionally, The ASA, SCA or Department, as appropriate, may deny or terminate Participant-Directed Services for any of the reasons (A. through E.) set forth below. Prior to and as part of denying or terminating services specific to the Participant-Directed Option, the SCA will work to transition the Participant to another Representative or to agency services, as appropriate:

A. The Representative provides fraudulent or repeatedly inaccurate information to the Department, ASA, SCA or Fiscal
Intermediary in connection with obtaining or receiving services, including the submission of time sheets that are not
accurate of the services provided;
B. The Department, the SCA or the ASA documents that the Representative harasses, threatens or endangers the safety of the
Participant or individuals delivering services;
The SCA documents that the Participant or the Representative fails to hire or manage an Attendant consistent with the
requirements of this Section, including directing an Attendant to provide services that are inconsistent or not covered
by the Authorized Plan of Care or hiring an Attendant who does not have the ability to provide Attendant Services as
defined by the Authorized Plan of Care;
C. The Participant or the Representative fails to successfully complete the initial Skills Training within the required
time frame from the date of the referral for Skills Training;
D. The Participant or the Representative a) fails to hire an Attendant within sixty (60) days from the completion of Skills
Training or b) has not employed an Attendant for a consecutive (60) day period, not counting days where services may
have been suspended; or
E. The Participant no longer has Cognitive Capacity and there is no willing and appropriate person meeting the requirements
of this Section to act as Representative.

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
Respite	☒	☒
Attendant Care Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

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 a Financial Management Service (FMS) provider. Participants/Representatives who are self-directing services must use an FMS provider as a payroll agent enrolled with the Medicaid agency.

The FMS provider acts as an agent of the employer (the Participant or Representative) in accordance with Federal Internal Revenue Service Codes and procedures in matters related to the employment of support workers.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Compensation for FMS is through MMIS. The FI is paid a set per person/per month reimbursement rate for the delivery of Financial Management Services.

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:

Facilitates criminal background checks, Adult Protective and Child Protective checks, and OIG checks for prospective employees and the Representative.

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:

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:

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.

a. Billing of personal support hours is based on the authorized Plan of Care. The SCA submits service authorizations, based on the Plan of Care, to MMIS. The FMS provider agency requires financial and medical eligibility, as well a service authorization, in order to submit and receive payment on a claim. The Participant survey includes questions related to the Participant's experience working with the FMS provider agency.

b.& c. The Operating Agency is responsible for monitoring FMS provider entities through review of quarterly complaint logs and reports, annual surveys, and ad hoc reviews and inquiries based on complaint.

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:

☒ **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
Home Health Services	☐
Care Coordination	☒
Respite	☐
Home Delivered Meals S5170	☐
Non-Medical Transportation (NMT)	☐
Living Well for Better Health (Chronic Disease Self-Management)	☐
Assistive Technology	☐
Attendant Care Services	☒
Personal Care	☐
Financial Management Services	☒
Skills Training	☒
Matter of Balance (Falls Prevention)	☐
Environmental Modifications	☐
Personal Emergency Response System (PERS)	☐

☐ **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:

Participants are informed of support available to them through Legal Services for the Elderly and the Long-Term Care Ombudsman Program. These contacts are listed on the due process notice issued at the time of reduction, denial or termination of services. They are also provided by the Service Coordination Agency when a waiver Participant first enrolls.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a Participant or a Representative chooses to stop self-direction the case manager will assist in accessing personal care or in-home respite services for the Participant through the appointment of another Representative or through the traditional agency model, whichever is appropriate. All efforts will be made to transition the person without any gap in service.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If a Participant or Representative does not complete skills training or fails to hire an Attendant, or if the Participant or Representative is unable to manage the Attendant consistent with program requirements, the use of self-direction may be involuntarily terminated for that Participant.

If the State terminates self-direction for a Participant, the case manager will assist the Participant in accessing their personal care services and/or respite through the traditional agency model, or if appropriate through a Representative or a change in Representative. All efforts will be made to transition the person without any gap in service. If the state involuntarily terminates the service, the state will issue due process notice allowing the Participant access to a fair hearing regarding the decision to terminate this service delivery option.

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		1168

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 2		1226
Year 3		1287
Year 4		1352
Year 5		1419

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The FMS provider assists Participants by conducting criminal background checks for all potential employees of the Participant, as well as required checks for the Representative. Conducting the criminal background checks are included in the reimbursement rate for FMS and not separately billable to the Participant.

☒ **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:

The FMS provider’s responsibilities include conducting necessary background checks including the following:
1) The Certified Nursing Assistant (CNA) Registry,
2) The Office of Inspector General (OIG) Exclusion’s list,
3) Criminal background checks, and
4) Adult and Child Protective Services checks.
Financial Management Services (FMS) are those services provided by a Fiscal Intermediary to Participants who elect the Self-Directed Option.

☒ **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:

Decide to have a Representative to assist in decision making and in conducting employer responsibilities.

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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Medical Eligibility Determination (MED) also includes “Task Time Guidelines” to capture not only the level of care needs but the Participant’s ADL and IADL needs as well. These scores, coupled with the Participant’s self-identified needs for services and supports and the availability of natural supports, inform the individual budget allocation for Attendant Services.

Each Participant receives a monthly budget allocation based on the assessed functional needs as reflected in the completed MED assessment and Task Time Guidelines. The information provided by the Participant during the determination helps determine the number of service hours required to adequately meet the participant’s needs. A preliminary plan based on personal care service hours is expressed in a dollar amount, using 80% of the state’s current PSS agency fee-for-service rate. This individual dollar amount is the maximum amount available if the Participant elects self-direction.

(Per CMS IRAI 6.5.23)
The Medical Eligibility Determination (MED) includes “Task Time Guidelines” to capture not only the level of care needs but the Participant’s ADL and IADL needs as well. These scores, coupled with the Participant’s self-identified needs for services and supports and the availability of natural supports, inform the individual budget allocation for Attendant Services.

Each Participant receives a monthly budget allocation based on the assessed functional needs as reflected in the completed MED assessment and Task Time Guidelines. The information provided by the Participant during the determination helps determine the number of service hours required to adequately meet the participant’s needs. A preliminary plan based on personal care service hours is expressed in a dollar amount, using 80% of the state’s current PSS agency fee-for-service rate. This individual dollar amount is the maximum amount available if the Participant elects self-direction.”

Information about the methods used to establish the amount of the participant-directed budget for waiver goods and services over which the Participant has authority is available in the MaineCare Benefits Manual, Section 19, Ch II.

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.

Person-Centered Planning is the foundation for individual budgeting. At the time of the MED, the RN/LPN works with the Participant to develop a plan that takes into consideration identified needs, goals, preferences, need for skilled services, assistive technology, environmental modifications and availability of natural supports. The Participant will know the maximum individual budget amount for waiver services at the end of their level of care determination. The maximum individual budget amount for Attendant Personal Care and Respite services is calculated for all people assessed for the waiver. A final budget determination is calculated during the service planning process with the Care Coordinator for those who choose to access Self-Direction for their personal support services.

The budget allocation limits apply only to Attendant Services and in-home Attendant Respite Services over which a Participant exercises decision-making authority. The upper limit of the individual budget amount is dependent on other needed services and the overall program cap.

(Per CMS IRAI 6.5.23)
If a Participant, guardian, or Representative believes an adjustment is needed in the PCSP prior to the end of the eligibility period, they may inform the SCA. The SCA will conduct a Significant Change evaluation based upon a significant service change in the Participant's condition.

A Significant Service Change means a major change in the Participant's status that is not self-limiting, impacts more than one area of the Participant's health status, and requires multidisciplinary review or revision of the Authorized PCSP.

The SCA may temporarily modify the Authorized PCSP up to fifteen (15) percent of the monthly authorized amount (not to exceed the monthly program cap) in the event a Participant experiences an emergency or acute medical episode. Any service adjustments (e.g., additions or changes to authorized hours) due to the emergency or acute medical episode may not continue beyond fourteen (14) days.

As part of the level of care determination process, the ASA provides written notice to the Participant regarding eligibility as well as an explanation of his or her right to request a fair hearing.

Additionally, as part of the service delivery process, the SCA provides written notice regarding service changes, reductions, or termination as well as an explanation of his or her right to request a fair hearing to the Participant.

Notices are provided in accordance with MaineCare Benefits Manual (MBM), Chapter I, Section 1.24. Participants may appeal a denial, reduction or termination of services and also may appeal the adequacy of the authorized Plan of Care. A Participant has 60 days from the date of the notice to request an appeal. If the Participant requests an appeal within 10 days of the date of a reduction or termination notice, services to the Participant are maintained until a final decision is rendered through the appeals process."

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:

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 Service Coordination Agency is responsible for monitoring the implementation and effectiveness of the Plan of Care. For people accessing Self-Direction, this includes home visit and completion of case review (Health and Welfare) form with the participant every 6 months.

The Participant is responsible for tracking their individual budget; there will be no reimbursement if the Participant exceeds the expected monthly allocation.

(Per CMS IRAI 6.5.23)
Prior authorization is required for all services under this waiver to prevent premature depletion of the Participant's budget.

If a Participant is refusing services and therefore underutilizing authorized services due to choice, the SCA may request a reevaluation of service needs to ensure appropriateness of Participant services. The SCA is responsible for monitoring Participant health and safety on a monthly basis to identify service gaps, unmet needs, or identify available resources.

The state's processing system flags the SCA and OADS staff of PCSPs that are over program limits. The SCA may request a reevaluation to ensure the current array of authorized services are appropriate for the Participant's needs. OADS staff may follow up with the SCA to ensure the issue is resolved timely.

The operating agency routinely runs reports to determine if any active Participants have been authorized services in excess of program limits identified in this waiver.

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.

As part of the level of care determination process, the Participant is provided written notice by the Assessing Services Agency regarding eligibility as well as an explanation of his or her right to request a fair hearing (referred to as Hearing Rights Notice).

As part of the service delivery process, the Participant is provided written notice regarding service changes, reductions, or termination as well as an explanation of his or her right to request a fair hearing (referred to as Hearing Rights Notice).

Notices are provided in accordance with MaineCare Benefits Manual, Chapter I, §1.22. Participants may appeal a denial, reduction or termination of services and also may appeal the adequacy of the authorized Plan of Care. A Participant has 60 days from the date of the notice to request an appeal. If the Participant requests an appeal within 10 days of the date of a reduction or termination notice, services to the Participant are maintained until a final decision is rendered through the appeals process.

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:

The Office of Aging and Disability Services (OADS) administers the Grievance Process. 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 and timelines and mechanisms used for grievance resolution.

• **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).

The rule defines a grievance as a complaint or expression of dissatisfaction by a Person Receiving Services and may address the performance by the Department or a MaineCare Provider of a HCBS waiver services. Grievance may be related to Person-Centered Service Planning; the grievant's person centered service plan; review and revision of the grievant's person centered service plan; or a setting where the grievant receives an HCBS Waiver Service.

The rule further stipulates that Recipients of Services and/or their Representatives have the right to submit a grievance in writing or orally, to the Department. A Provider may not act as the Grievant's Representative if doing so would represent a conflict of interest. The Recipient of Services or their guardian, if applicable, must consent to any grievance submitted to the Department on their behalf. Neither any Provider nor the Department may threaten or take any punitive or retaliatory action against a Person Receiving Services for filing or causing to be filed a grievance against a Provider or the Department. Information collected about grievances made to OADS are documented in a state data system.

The rule requires the Department to plainly state, on all notices or decisions made or issued, including notices relating to the personal planning process or under a personal plan of the Person Receiving Services, that the Person Receiving Services has a right to bring a grievance. There is no deadline for filing a grievance related to person centered service planning, the service plan, review or revision of the service plan or a setting where HCBS services are provided. Upon receipt of the grievance, the Department issues a written Notice of Decision within ninety (90) days of receipt of the grievance. The grievant and the Department may agree to extend this deadline up to 14 calendar days.

OADS or its designee is responsible for attempting to resolve grievances. Upon receipt of the grievance, OADS or its designee will acknowledge receipt in writing and then assign the grievance for investigation and resolution by an individual who (1) has not been involved in any prior attempt to resolve the grievance, and is not a subordinate of any such individual, and (2) has the appropriate expertise needed to attempt to resolve the Grievance. OADS or its designee will consider all comments, documents, records, and other information provided by or on behalf of the Grievant and in response to Department requests for such information. OADS or designee will also provide the grievant the opportunity to meet to discuss the grievance, as well as alternatives that may be available to resolve the grievance and must include any Representative in such discussions.

The written Notice of Decision summarizes the nature of the grievance, OADS position and understanding and the reason for the decision. The Notice of Decision also includes the grievant's right to request a hearing administered by the Division of Administrative Hearings regarding the Notice of Decision (when applicable), and how and when to make that request. The hearing will be held in accordance with 10-144 C.M.R. ch. 1, Administrative Hearings Regulations. All final decisions on administrative hearings must include notice of the aggrieved party's right to judicial review, including the requisite timeframe for filing an appeal.

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).

All providers under the HCBS program must comply with the state's mandatory reporting statute. Contracts with the Assessing Services Agency negotiated with the Department repeat the language from the state statute. Waiver service providers are required to inform OADS of certain events known as Reportable Events within 1 business day of the event.

Reportable events include death, suicide acts/attempts/threats, medication error, medical treatment beyond first aid, serious injury, lost or missing individual, physical plant disaster, law enforcement intervention, dangerous situation or event posing and imminent risk of harm to the participant, physical assault, emergency restraint, and rights violations. Required reporters include any individual involved in the support of an individual receiving services, including, but not limited to mandated reporters.

Waiver service providers enter reportable events directly into an electronic database system. OADS expects all providers to conduct follow-up reviews on all reportable events to determine and record the cause of critical incidents and develop strategies to reduce or mitigate the risk of future occurrences.

(Per CMS IRAI 6.5.23)
Abuse: Includes actions which result in bodily harm, pain or mental distress. Examples include, but not limited to pushing, hitting, shaking, pulling hair, administering incorrect, too much or withholding medication, tying to a bed or chair, or locking in a room, denying visits with friends or family, name calling, harassment and verbal threats.

Neglect: A failure to provide care and services when an adult is unable to care for themselves. Neglect may be at the hands of someone else, or it may be self-inflicted. Neglect includes, but not limited to failure to provide adequate shelter, clothes, food, personal care, medical care including necessary medication, and necessities such as glasses, dentures, hearing aids, and walkers.

Exploitation: The illegal or improper use of an adult's money or property for another person's profit or advantage. Examples include, but not limited to forcing an adult to change a will or sign over control of assets, forcing an adult to sell or give away property or possessions, keeping the adult's pension or social security check, using a person to do work for you without paying a fair wage, manipulating an individual to hurt another, or offering to give a person who cannot understand the value of money.

Incidents of Abuse, Neglect, and Exploitation are required to be reported for review and follow-up action by Adult Protective Services in accordance with the mandated reporting statute.

In addition to the requirement of reporting abuse, neglect and exploitation, the operating agency requires waiver services providers to report the following within one business date of report as stated earlier in this waiver renewal submission:

Reportable events include death, suicide acts/attempts/threats, medication error, medical treatment beyond first aid, serious injury, a lost or missing individual, physical plant disaster, law enforcement intervention, dangerous situation or event posing an imminent risk of harm to the Participant, physical assault, emergency restraint, and rights violations. Required reporters include any individual involved in the support of an individual receiving services, including, but not limited to mandated reporters.

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.

The Service Coordination Agency provides written, plain language information in a Welcome Packet to the waiver participant regarding protection from abuse, neglect, and exploitation that includes the statewide toll-free reporting hotline number. This information may also be shared at the time of the level of care determination or during any Care Coordination visit and is a required component of Skills Training for Participants or Representatives who self-direct.

Additionally, as mandated reporters, the RNs/LPNs, Care Coordinators, and direct care providers must report any suspicion of abuse, neglect or exploitation to the State in accordance with 14-197, Ch. 12, Reportable Events System.

(Per CMS IRAI 6.5.23)
Initially and annually the ASA and the SCA must educate and inform the Participant and guardian about identifying and reporting Abuse, Neglect, and Exploitation.

Mandated Reporters are required by law (22 M.R.S. § 3477) to call 1-800-624-8404 to make a report to Adult Protective Services. Individuals who are not mandated reporters can call 1-800-624-8404 (24-hour, Toll Free) or Maine Relay 711 to report abuse, neglect, or exploitation or complete the online form at the following link: https://www.maine.gov/dhhs/oads/get-support/aps/report-abuse-neglect-exploitation.

The Service Coordination Agency provides written, plain language information to the Participant upon enrollment and annually thereafter regarding protection from abuse, neglect, and exploitation that includes the statewide toll-free reporting hotline number and link to the web-based reporting form. This information may also be shared at the time of the level of care determination or during any Care Coordination visit and is a required component of Skills Training for Participants or Representatives who self-direct. Additionally, as mandated reporters, the RNs/LPNs, Care Coordinators, and direct care providers must report any suspicion of abuse, neglect or exploitation to the state in accordance with 14-197, Ch. 12, Reportable Events System.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Service Coordination Agency must have written policies and procedures to review and respond to all critical incidents that have been reported to them.

The Office of Aging and Disability Services is notified of each critical incidents requiring 24-hour notification and follow-up to the Department.

Maine's Adult Protective Services (APS) Program, administered by OADS, must review and respond to all critical incidents reported by the contracted agents who deliver services within this waiver. Sixty-seven APS staff throughout the state, serve people who are incapacitated and dependent, 18 years and older, and in danger of abuse, neglect, or exploitation. The APS mandate is to protect incapacitated or dependent adults, promote their independence, and respect their right to self-determination. APS receives and investigates reports of abuse, neglect, or exploitation. APS takes appropriate action based on findings of its investigations, including arranging for services and making referrals to law enforcement. APS also petitions for guardianship or a protective order when all other less restrictive alternatives have been tried such as including family or friends who are able and willing to serve as private guardian or conservator. The Department of Health and Human Services, through APS, is the authorized Public Guardian/Conservator for incapacitated adults.

(Per CMS IRAI 6.5.23)
With respect to Adult Protective Services (APS) investigations involving Participants receiving Section 19 services, APS assesses whether to "screen in" a report at the Intake stage by reviewing whether a client is 1) in Maine, 2) 18 years old or older, 3) allegedly incapacitated or dependent (which would always be the case for a Section 19 recipient), and 4) alleged to be abused, neglected, or exploited or at risk of same (this can include allegations of self-neglect). If these criteria are met, the case is screened in within the APS data system, Evergreen, and sent to a district office for supervisor review and assignment to a caseworker and an investigation takes place. An APS investigation is focused on whether an individual perpetrator has abused, neglected, or exploited a client and/or whether a client is experiencing self-neglect and in need of assistance as a result. APS casework and investigation
processes are outlined further in rule, available at the following link:
https://www.maine.gov/sos/cec/rules/10/149/149c001.docx.

Incidents that meet the criteria for an APS investigation (i.e., alleging abuse, neglect/self-neglect, or exploitation) require that final written findings are entered in the electronic APS system no later than thirty (30) days from the date of assignment to the APS caseworker (assignment occurs no later than five business days from the date a report is received). In the event an investigation cannot be completed within thirty (30) days of assignment, the reasons therefore shall be documented along with an estimate of the number of days needed to complete the investigation. This extension (and any subsequent extensions) is reviewed by a supervisor and approved as appropriate.

Due to the confidentiality provisions within Maine's Adult Protective Services Act, 22 M.R.S. ch. 958-A, information on the results of an APS investigation is confidential and subject to certain mandatory and optional disclosures. Disclosures to Participants, family or guardians is within the optional category and decisions regarding what information to share are made on a case-by-case basis.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Office of Aging and Disability Services (OADS) is responsible for oversight of critical incidents that affect waiver Participants. Each report is reviewed within 24 hours of receipt and the appropriate follow up is taken. OADS collects, compiles and summarizes the information, indicating the nature of each mandated report and the actions taken.

(Per CMS IRAI 6.5.23)
The state requires that providers submit critical incident reports within one business day from notification using a secure online form that automatically populates the information into a secure database. The QA supervisor is notified when a critical incident is logged into the system. The supervisor reviews and performs follow-up with APS or service providers as necessary.

On a quarterly basis, the QA supervisor generates reports and reviews the critical incident data to identify trends/patterns which may result in provider training or corrective action. The QA supervisor monitors and reviews the reports daily.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints or seclusion is not allowed under this waiver. Detection of the use of this prohibited intervention, through home visits, the complaint process, Adult Protective Services investigations, or provider audits, constitutes and may result in termination from employment of the worker or termination of the provider agreement with the State Medicaid Agency. Maine's Office of Licensing and Certification oversees provider licensure and may become involved if a provider is found to be out of compliance with state regulations.

○ **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:

Use of restrictive interventions is not allowed under this waiver. Detection of the use of this prohibited intervention, through home visits, the complaint process, Adult Protective Services investigations, or provider audits, constitutes and may result in termination from employment of the worker or termination of the provider agreement with the State Medicaid Agency. Maine's Office of Licensing and Certification oversees provider licensure and may become involved if a provider is found to be out of compliance with state regulations.

A Personal Support Specialist employed by a provider agency must receive on-site supervision by an agency supervisor at least quarterly to verify competency in completion of the tasks authorized in the plan of care. For Participants who self-direct, the Service Coordination Agency conducts announced and/or unannounced supervisory visits. The Operating Agency and the Service Coordination Agency conduct home visits and, whenever appropriate, speak to the Participant outside the presence of the caregiver. These visits assist in the monitoring to detect unauthorized use of restrictive interventions.

○ **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.

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:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Office of Aging and Disability Services (the State Operating Agency) has responsibility to detect the unauthorized use of seclusion. This is not permitted at any time, and it is reported through reportable events system and/or through reports to APS system. Seclusion is defined as the solitary involuntary confinement of a Person for any period of time in a room or a specific area from which egress is denied by a locking mechanism, barrier or other imposed physical limitation. This is a Prohibited Practice. Any use of a prohibited intervention must be reported in accordance with 14-197 C.M.R. ch. 12, Reportable Events System.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

Do not complete this section

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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

• **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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **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.

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 unexplained deaths that are reviewed by the state's Death and Mortality Review Committee. Numerator: Total Number of Unexplained Deaths reviewed by the state's Death and Mortality Review Committee. Denominator: Total Number of Unexplained Deaths.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of Participants and guardians who received information and education about how to report abuse, neglect, and exploitation and unexplained deaths. Numerator: Number of Participants and guardians who received information and education about how to report abuse, neglect, and exploitation and unexplained deaths. Denominator: Total number of Participants and guardians 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:

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):
Record reviews, off-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

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

Performance Measure:
Number and Percent of critical incident trends that resulted in a systemic intervention being implemented. Numerator: Total number of critical incident trends that resulted in a systemic intervention being implemented. Denominator: Total number of critical incidents trends identified for system interventions 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:

Performance Measure:
Number and Percent of systemic interventions that resulted in a change in policy/procedure. Numerator: Total number of system interventions resulting in a change of policy/procedure. Denominator: Total number of systemic interventions 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:

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

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 unauthorized use of restrictive interventions (including restraints and seclusion) that were appropriately reported through critical incident management system. *5 Due to character count limit please see Main-Optional, Additional Information for Numerator and Denominator.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of participant records with no instances of restraints, restrictive interventions or seclusion. Numerator: Total number of participant records with no instances of restraints, restrictive interventions, or seclusion. Denominator: Total number of waiver participant records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☒ **Other** Specify: Service Coordination Agency	☐ **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 report having a medication review or annual healthcare exam within the last 6 mos. Numerator: Number of Participants who report having a medication review or annual healthcare exam within the last 6 mos. Denominator: Total number of waiver participants required to have a medication review or annual healthcare exam within the last 6 mos. who were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Home visit interview

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: Service Coordination Agency	☐ **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:

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.

Adult Protective Services database indicates source of referral and whether referral is open for investigation thus showing degree of APS activity with waiver participants.

For other reportable events and Health and Welfare Monitoring tools, the action steps taken are documented in participant's record and on form. Actions may include reassessment, multi-disciplinary team meeting, referral for additional services, according to needs being addressed.
Remediation may include additional training around Health and Welfare and in-service training by Adult Protective Services.

ii. Remediation Data Aggregation

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

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

The criteria for selecting priority areas of improvement will be based on the following factors: prevalence (i.e., would improvement affect many participants); relevance (i.e., to what extent would improvement affect participant outcomes); probability of success (i.e., have improvement strategies been tested and documented); and available resources (i.e., are there sufficient staff, funds and other resources to sufficiently address the issue). As part of this work, within the first six months of the waiver renewal, the Operating Agency will review and update its Quality Management (QM) Plan that sets forth the purpose of the QM plan; its governing values and principles; roles and responsibilities for QM activities; core domains and measures for assessing performance; discovery methods, criteria for selecting priority areas for improvement; and a work plan. As part of this, the Operating Agency will review and update memoranda of agreement between and among the Office of Aging and Disability Services, the Office of MaineCare Services, the Division of Licensing and Certification, and the Office of Program Integrity to ensure that roles and responsibilities for oversight and improvement functions are clearly delineated.

The Office of Aging and Disability Services will identify at least one area of quality improvement to address each year. The areas to be addressed will be identified by the end of each waiver year and remediation actions will occur during the following year.

Additionally, the Department developed, and plans to promulgate in rule, 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 may require the provider to submit a Plan of Corrective Action.

The plan of corrective action must meet specific criteria including, but not limited to, the following:
a) The POCA must be a specific plan which describes how the deficiency (event, incident or risk) will be corrected, including the actions which will be taken to bring about correction.
b) The POCA must address correction of the specific event(s) cited.
c) The POCA must identify actions steps to prevent the deficiency/risk from recurring/occurring.
d) The POCA must clearly delineate the frequency each element of the plan is to occur.
e) The POCA must identify by title the individual(s) responsible for the implementation and monitoring of the plan.
f) The POCA must provide date(s) by which all components of the plan will be implemented, and the corrections completed.

(Per CMS IRAI 6.5.23)
OMS and OADS work together to ensure the health, safety and welfare of the individuals receiving services and supports through this waiver. The Operating Agency and Medicaid Agency have monthly meetings for system monitoring.

OADS has a waiver Performance Measure dashboard and a secure SharePoint site for Reportable Events that allows for data collection and analysis: The Reportable Events website includes all reportable events as reported by Service Coordination Agencies and includes date of incident, critical incidents by provider, location of incident, number of incidents by individual, incidents by type, timeliness of reporting, and trends over time. On a quarterly basis the information is reviewed with the LTSS provider network to discuss the reduction or prevention of incidents as well as opportunities for improvement.

Participant deaths are matched quarterly against the State’s Death registry and critical incidents are matched against emergency department Medicaid Claims data to ensure providers are complying with applicable reporting requirements.

OADS has also developed a performance measures workplan identifying the data source, the staff responsible for the individual PM oversite, and the status of performance on each identified PM. OADS identifies and addresses areas of improvement by comparing current progress on PMs (calculated monthly) to minimum standards of performance.

Additionally, in accordance PL 2021, Ch. 398, part MMMM, Maine has established a multidisciplinary Aging and Disability Mortality Review Panel to review the patterns of death of and serious injury to all Maine adults receiving Home and Community Based Services. The Panel will analyze mortality trends to identify strengths and weaknesses of the system of care and recommend ways to decrease the rate of mortality and improve the system of protection for adults receiving services, including modifications to law, rules, training, policies, and procedures. The Panel convened November 1, 2022, and is actively drafting rule to, among other things, implement operational procedures and responsibilities of the Panel and clarify collection and reporting of HCBS mortality information through the development of a state database for HCBS Participant death and serious injury reviews. Currently, Adult Protective Services reviews all mortality events and screens for incidents or indications of abuse, neglect, or exploitation.

Beginning in 2023, OADS plans to resume collecting experience of care data by piloting a new survey. The new survey is the Consumer Assessment of Healthcare Provider and Systems, Home and Community Based Services version. Results from future surveys will be shared with both internal and external stakeholder groups. OADS will consider survey findings as part of our overall future quality improvement efforts.

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.

The Office of Aging and Disability Services has been reviewing certain performance measures and aggregate data on set time schedules, but there is a strong interest in being more mindful and deliberate in reviewing this information for management purposes as the State strives to have a properly balanced system of long term-care services. The Department solicits feedback on quality improvement activities from stakeholders who are members of the Quality Assurance Review Committee. This Committee is established by statute to review the provision of home and community based long term services and supports for elders and adults with disabilities.

The committee membership includes participants of home care services; advocacy organizations, including the long-term care ombudsman program; health care and service providers; representatives from each area agency on aging; and staff of each agency that provides service coordination services. The Committee provides input on and reviews findings of the annual survey to all waiver participants. The Operating Agency also holds systems meetings at least quarterly with the Assessing Services Agency and the Service Coordination Agencies to monitor current protocols and need for system improvements.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Operating Agency will review the Quality Improvement Strategies for the waiver on a continuous basis to assess adequacy of discovery and remediation activities. Quality data is reviewed at least annually.

(Per CMS IRAI 6.5.23)
Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, Maine will gather data and submit the quality review in addition to any outstanding 372 report[s] as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within 6 months of receiving the final quality review report and 372 report acceptance decision.

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):*

10-144 Chapter 101, Maine Care Benefits Manual, Section 19.08 requires its assessing services agency, service coordination agency, fiscal intermediary and waiver service provider to conduct annual Participant surveys approved by the Department addressing satisfaction, choice and quality of services provided.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Integrity of payments at the individual level:

Maine has developed a subsystem to its MMIS system that provides checks and balances to assure that medical eligibility determination and prior authorization have occurred and are valid for the dates of services billed. The classification dates entered 1) match the time period of medical eligibility determined as part of the assessment for waiver services and 2) provide system authorization to assure the participant has been determined eligible for a specific MaineCare program to allow claims to be paid for specific procedure codes. Medical eligibility classification codes are not entered into the subsystem without verification that financial eligibility has been determined. Claims are rejected for any date where both medical and financial eligibility are not in place. The subsystem also tracks persons under appeal to assure continued payment of services if a timely appeal was filed. Each program requiring medical eligibility determination and/or prior authorization of the service has an individual classification code.

Overall Medicaid program integrity:

Chapter I of the MaineCare Benefits Manual (MBM), (https://www.maine.gov/sos/cec/rules/10/ch101.htm) Section 1.16 for Audits states that The Division of Audit or duly Authorized Agents appointed by the Department of Health and Human Services (DHHS) have the authority to monitor payments to any MaineCare provider by an audit or post-payment review. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements. Additionally, on an annual basis, the MaineCare (Medicaid) Program is wholly subjected to a Single State Audit conducted by the Office of the State Auditor.

The Division of Audit conducts audits and issues final cost settlements on all MaineCare cost reimbursed programs. MaineCare's Program Integrity Unit (PIU), as a duly authorized agent, is tasked with identifying fraud, waste and abuse within the MaineCare program and reviews MaineCare providers to ensure compliance with the MaineCare Benefits Manual including documentation, medical necessity, coding, and billing compliance.

For this waiver, rates are published by the Department and the services are subject to compliance reviews. The Department may recover any amounts due the State based on MBM, Chapter I. Unless the services are of an institutional nature, a yearly independent financial audit is not required. Under Chapter III (Allowances for Services) of the MBM, providers are responsible for maintaining adequate financial and statistical records and making them available when requested for inspection by authorized representatives of DHHS, Maine Attorney General's Office, or the Federal Government. Providers shall maintain accurate financial records for the services provided separate from other financial records.

The Program Integrity Unit conducts continuous and on-going audits on providers through post-payment reviews of MaineCare providers based on complaints, referrals, and/or data analytics. The methods that are used to audit include the use of statistically valid random samples, complaint-focused reviews, and full reviews. Data-driven reviews may not require a review of records or may require the provider to do a self-audit. The scope can vary from a short

timeframe to a full 5-year review. An annual work plan determines the services to be reviewed, in addition to complaints and other referrals received.

Program Integrity uses a confidence interval 90% and +/- 5% for SVRS.

When the Program Integrity Unit does a review based on a statistically valid random sample (SVRS), it starts with a well-defined universe of claims and uses the RAT-Stats v. 2010 program to obtain the SVRS by claim line. A statistician developed an extrapolation tool for use by the Program Integrity Unit (implemented in 2016) which determines the overpayment amount using a 5% margin of error. All reviews in which the Program Integrity Unit uses a SVRS are done following this process.

The Program Integrity Unit (PIU) does not currently have the ability to run a report that captures the number of cases done based on a SVRS, but an estimate of the frequency would be approximately 20-35% of the time. For certain services, MaineCare needs to look at all participants in a specific location in order to determine staff to client ratios, therefore a SVRS would not be appropriate.

In the event that the Department of Health and Human Services (DHHS) is aware that a new provider will be providing a service that has a high capacity for fraud and abuse (such as personal care services), Program Integrity will prioritize that agency. This may range from a desk-level review of claims data to a full review of provider records. Additionally, the Department (DHHS) conducts routine statistical analysis of provider claims data in order to identify billing outliers. The Department then further investigates these outliers. Finally, the Department has engaged in targeted reviews of certain

Medicaid services, in response to concerns about potential widespread deficiencies across providers.

Outliers are determined based on a variety of factors, such as the number of services, amount paid, units per participant, or services per participant. Factors are reviewed across the same service type or provider type to compare providers against their peers, using a specified standard deviation above the mean. Some services may require a different factor to be considered an outlier, such as an absence of care (e.g., DME prescribed with no prior relationship, or non-emergency transportation without a corresponding medical claim); where another service may require looking at factors to determine overutilization or upcoding, such as a percentage of what was billed (e.g., percentage of high-level office visits to total office visits). The frequency in which these analyses typically occur is annually, based on an annual work plan.

Provider types with high capacities for fraud and abuse are prioritized in Program Integrity's annual work plan. Program Integrity Unit (PIU) uses a data-driven approach, and the outcome helps determine the type of review. If the provider has also been the subject of complaints or other concerns, that may warrant a full review. If the provider's claims are homogenous, PIU would tend to use a SVRS. Otherwise, PIU would do a desk-level or full review. In some instances, PIU does not need to review records, such as for coding or limits issues, and that information can be used to strengthen claims edits processing. Program Integrity strives to make the most of PIU resources, including utilizing the Unified Program Integrity Contractor (for the State of Maine, this contractor is Safeguard Services, LLC) for reviews of high-risk provider types.

The State has not engaged in targeted reviews because of widespread deficiencies, but rather, has engaged in targeted reviews to look for such deficiencies. Some services that have been reviewed using this type of approach are Home and Community Based Services and Personal Care Services. Deficiencies noted (though not necessarily widespread) included lack of or untimely background checks on employees, staffing ratios not being met (HCBS services), overbilling units (PCS), and general documentation deficiencies. The actions taken to resolve these issues include recouping overpayments from providers, referrals to Licensing, and recommendations brought forth for policy and system enhancements.

On-site reviews are conducted. Typical reasons for conducting an on-site review include whether there are concerns of fraud, if the provider is not cooperating with record requests by mail, or there is a need to see where records are secured or to review a provider's electronic health record system.

Maine's Program Integrity Unit plans to use EVV during post-payment review/audits. Program Integrity staff will compare the information in the EVV to the records submitted by the provider and the claims paid by MaineCare.
Program Integrity will utilize the EVV reports to inform decision-making regarding providers that should be selected for post-payment review. Providers with a high number of exceptions per employee, per consumer, or agency-wide will be prioritized. The Program Integrity sampling approach will include using statistically valid random samples (confidence interval 90% and +/- 5%) of claims for some providers but may also include looking at specific claims based on exceptions for other providers.

(Per CMS IRAI 6.5.23)
Providers delivering Personal Care, Attendant Care, and Respite Care Services in the home, and those delivering Home Health Services must comply with Maine DHHS Electronic Visit Verification system standards and requirements for these services.

Maine's Program Integrity Unit (PIU) plans to use EVV during post-payment review/audits starting July 1, 2023.

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 coded and paid in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
Numerator: Total number of claims coded and paid in accordance with reimbursement methodology specified in the approved waiver and only for services rendered.
Denominator: Number of claims coded and paid.

Data Source *(Select one):*
Financial records (including expenditures)
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:*

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 service rates that are consistent with approved rate methodology.
Numerator: Number of rates that are consistent with approved rate methodology.
Denominator: Total number of service rates.

Data Source *(Select one):*
Financial records (including expenditures)

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:*

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.*

When individual claims are denied, the classification dates are verified in relation to the service dates in question. OADS works with the Service Coordination Agency and providers to rectify authorization problems.

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 Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Office of MaineCare Services (OMS) of the Maine Department of Health and Human Services' (Department), in collaboration with the Office of Aging and Disability Services (OADS), is responsible for establishing provider payment rates for waiver services. Historically, the Department has established payment rates through a variety of mechanisms, including consideration of historic cost and budget data, comparisons to rates paid for similar services in other programs, and targeted rate studies. Rates for this waiver are subject to review and amendment by the State legislature. The Maine Administrative Procedure Act (APA) applies uniform requirements to state agencies with rulemaking power and sets minimum standards for agencies to follow in adopting and implementing changes to rule. All MaineCare policies are posted on the Department's website for access at any time. The provider fee schedule is published in the MaineCare Benefits Manual, Chapter III, Section 19, https://www.maine.gov/sos/cec/rules/10/ch101.htm. Additionally, please see section Main 6-I of this approved Waiver for more information on how the state solicits public input for waiver amendments and renewals.

Waiver services are reimbursed on a prospective, fee-for-service basis, with a few exceptions. All rates were last updated by the Department in January 2022, to accomplish two aims: (1) ensure compliance with the requirements of with P.L. 2021, ch. 398 section AAAA (as described below), and (2) provide the COLA authorized by P.L 2021, section AAAA (as described below).

Rates based on 2015 rate study:
Burns & Associates, Inc. completed a rate study in 2015 that included multiple ME.0276 services. These rates were subsequently published by the Department. The rate models used to establish the rates (below) were based on data from a number of different sources, including:

- *A provider survey conducted in 2014-2015;*
- *Maine-specific wage data from May 2014 Bureau of Labor Statistics for comparable positions;*
- *Employee benefits data from BLS' 2013 National Compensation Survey and health insurance cost data from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey; and*
- *The Internal Revenue Services' standard mileage rate.*

The ME.0276 rates that were revised and updated by the rate study included the services listed below.
- *Personal Care*
- *Respite care, in the home delivered by PSS*
- *Respite care, in the home delivered by an Attendant (self-directed)*
- *Attendant Care services (self-directed)*
- *Home Health Services*
- *Skills Training*

Rates not covered by the Burns & Associates rate study are reimbursed as follows:
- *Care Coordination (Per Member Per Month): The State used actual MaineCare claims data and service utilization of members when developing the rate and units per year for Care Coordination. Additionally, the rate was based on a provider survey comparing service components to service tasks, and to the rate paid for a similar service under the State Plan. The survey considered salaries, benefits, travel, productivity and administrative costs.*
- *Respite Care (not in the home) is based on the cost of one month in a nursing facility.*
- *Financial Management Services (per month) is based on a previously completed provider survey.*
- *Assistive Technology-Device (per unit) is reimbursed per invoice based on actual costs, subject to prior approval and up to the approved limit.*
- *Assistive Technology-Remote Monitoring (per month)*
- *Assistive Technology-Transmission (per month) is reimbursed on a monthly basis based on provider cost data*
- *PERS service fee (monthly) is reimbursed at the provider's usual and customary charge up to a maximum amount per month.*
- *Environmental Modifications are reimbursed at cost with prior approval. The Department requires at least two estimates for this service and approves the most cost-effective estimate.*

- *Home Delivered Meals (per meal) are based on current community provider rates for the same service.*
- *Living Well for Better Health (1/2 hour) is reimbursed based on current community provider rates for similar services.*
- *Matter of Balance (1/2 hour) is reimbursed based on current community provider rates for similar service.*
- *Non-Medical Transportation is reimbursed on a per-member per-month basis, according to a full risk capitation model. The rates were calculated by Deloitte Consulting LLP and are consistent with CMS requirements that the capitation rates be actuarially sound and appropriate. The database variables (by region) included paid amount, number of rides, rides per thousand, average cost per ride, miles, miles per ride, cost per ride, and base per member per month.*

Additionally, rate changes have resulted from specific legislation. For example, retroactive rate and cap increases that were effective July 1, 2020, resulted from the Maine Legislature's passage of P.L. 2019 ch. 616, An Act Making Supplemental Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2020, and June 30, 2021. The Act provided funding for rate adjustments for specific services, to reflect the rate models prepared for the Department by Burns & Associates, Inc.

Recent legislation will systematize rate setting on an ongoing basis. This will enhance the Department's ability to ensure that rates are regularly reviewed for economy, efficiency, and quality of care, and that rates are sufficient to enlist enough providers. LD 1867 was enacted in 2022 and took effect August 8, 2022. As passed, LD 1867 creates a new stand-alone section of Maine law (22 MRSA §3173-J) that codifies the processes and principles for the MaineCare Rate System. These processes and principles include setting a schedule for regular rate review and adjustment, to be reviewed annually in consultation with a Technical Advisory Panel (TAP); reviewing relevant state and national data to inform rate amounts and payment models, with an emphasis on models that promote high value services by connecting reimbursement to performance; and formalizing a clear and transparent process for rate determination that includes public notice and comment.

On an ongoing basis, the Department's rate-setting unit will regularly review and adjust rates in compliance with PL 2021, ch. 398, AAAA. The new law requires that, effective January 1, 2022, the labor components of MaineCare reimbursement rates for specified services delivered by essential support workers must equal at least 125% of the minimum wage established in Title 26, section 664, subsection 1. Essential support workers are individuals who by virtue of employment generally provide to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or have direct access to provide care and services to clients, patients or residents regardless of the setting. 22 M.R.S. 7401. In addition, Part AAAA states that the reimbursement rate must include an amount necessary to reimburse the provider for taxes and benefits related to the wages. 22 M.R.S. 7402(2). Section AAAA-2 of the Act specifies that the 125% of minimum wage requirement for essential support workers applies to ME.0276 services.

PL 2021, ch. 398, OOO authorizes the Department to implement cost of living increases (COLAs) for services provided under ME.0276. 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 MRS Section 664. Services that received an increase to their rate within the previous 12-month period will not receive the annual COLA increase effective the following January 1. Pursuant to 22 M.R.S. § 7402(2), the legislation requires annual January ME.0276 COLA updates to ensure that reimbursement rates continue to comply with 22 M.R.S. Chapter 1627 going forward.

(Per CMS IRAI 6.5.23)
Recognizing that it has been many years since the above service rates have been comprehensively reviewed and that current rates lack thorough documentation, the State intends to undertake a rate rebasing for ME0276 services not previously included in the 2015 rate study as part of the current MaineCare Rate System Reform project.

The source of nursing facility costs used to develop the Respite Care service rate MaineCare is the Nursing Home Average Daily Case Adjusted Rate Calculation – SFY 2017.

All payment rates for ME.0276 can be viewed at https://mainecare.maine.gov/default.aspx

(Per CMS RAI dated 7-17-2023) The state does not have record of when the last formal rebasing occurred for these services. However, the services have received annual reimbursement rate updates approved by the Maine State Legislature along with ongoing cost of living increases (COLAs) approved under PL 2021, ch.398.

In August 2022 the Maine State Legislature passed LD 1867. As passed, LD 1867 created a new stand-alone section of Maine law codifying future MaineCare rate reform efforts. These efforts include service rebasing and annual rate review and adjustments
to be completed in this waiver cycle. For additional detailed information on the MaineCare Rate System Reform project and current rate reform schedule please see https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-reform.

Rates do not vary by geography or provider.

The state will be making proportionate increases to Self-Directed Services in compliance with PL 2021, ch. 398, AAAA, requiring the labor components of MaineCare reimbursement rates for specified services delivered by essential support workers must equal at least 125% of the minimum wage.

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:*

Other than payments to the WSP, billing for waiver services flows through the State's claims management system. For atypical waiver services, the WSP acts as billing agent and submits claims for these services through the MMIS and reimburses the atypical service provider. The WSP is paid through a contract with OADS for this service. The FMS bills through the MMIS. Atypical waiver services include institutional respite, environmental modifications, PERS and Homemaker Services. The WSP is paid under contract. It is an administrative cost.

For Transportation Services-The Broker shall receive a monthly capitated per-member per month payment for each member whose eligibility for the current month has been confirmed by the Department regardless of the members NEMT service use. This is a full risk contract outside of the MMIS system.

(Per CMS IRAI 6.5.23)
The Waiver Services Provider (WSP) subcontracts with providers who deliver atypical waiver services to include only the following four (4) sets of services: Environmental Modifications, institutional Respite, Personal Emergency Response Service, and Assistive Technology Services.

All providers, other than Transportation Services providers and Attendants, are allowed to bill MaineCare directly.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with

42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

(a) A participant is not eligible for waiver services until both financial and medical eligibility have been established. Claims would not be processed without establishing eligibility as well as classification for services.

(b) Upon assessment of the participant, the medical eligibility data is entered into 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 member 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 Electronic Visit Verification (EVV) for 1915(c) Authority waiver programs delivering personal care services within the home. Maine contracted with its Fiscal Agent, Gainwell, for an EVV solution. Gainwell has subcontracted with Sandata for the following EVV solution components: mobile and telephony applications that allow providers to create EVV records, a "3rd party aggregator" that allows providers with other EVV systems to submit data into Sandata, a portal to allow provider staff to manage accounts and records, and claims editing within the MMIS to match claims for PCS services with EVV records. The system requires that all visit records include member ID, caretaker ID, date of service, start and end times of the service, location, and CPT or HCPCS code.

The Maine EVV system includes a pre-payment validation process as well as post-payment review process. Pre-payment validation includes a 30-day pend process such that claims for services subject to EVV will pend for up to 30 days while the system searches for a matching EVV record and deny when no verified EVV record is found. The post-payment process includes ongoing monitoring and surveillance of claims data as described below.

(c) Ongoing monitoring is conducted by the operating agency and includes on-site visits to monitor compliance with the waiver document, regulations and contract performance. If, at any time, the services provided do not conform, OADS will notify the Medicaid agency which will then audit claims for wrongful payment.

Payment for services provided is a multistep process. This is specifically outlined in the Maine MaineCare Benefits Manual, Chapter I- Section 1 General Administrative Policies and Procedures, Chapter II-Specific Policies by Service, and Chapter III, Allowances for Services describes in detail the reimbursement, payment process, and audit oversight including utilization review. Chapter I of the MaineCare Benefits Manual, Section 1.17 Utilization Review states the following:

The Department or its Authorized Agent is responsible for carrying out a series of safeguarding measures. These measures safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assessing the quality of such services available under MaineCare. The Department may use consultants and peer reviewers with expertise appropriate to the medical care or services to be reviewed.

The Department has the authority to request medical records and other records as necessary to support utilization review, utilization management, concurrent review, or other service review activities. Providers must respond to requests in a timely manner and at no charge to the Department.

Chapter I of the MaineCare Benefits Manual, Section 1.18 Program Integrity states the following:
The Program Integrity Unit, Division of Audit and /or the Department's Authorized Agent are responsible for surveillance and referral activities that may include, but are not limited to:
A. A continuous sampling review of the utilization of care and services for which payment is claimed;
B. An on-going sample evaluation of the necessity, quality, quantity and timeliness of the services provided to members;
C. An extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare;
D. A post-payment review that may consist of member utilization profiles, provider services profiles, claims, all pertinent professional and financial records, and information received from other sources;
E. The implementation of the Restriction Plans;
F. Referral to appropriate licensing boards or registries; and
G. Referral to the Maine Attorney General's Office, Healthcare Crimes Unit, for those cases in which fraudulent activity is suspected.

The Department and its professional advisors regard the maintenance of adequate clinical and other required financial

and product-related records as essential for the delivery of quality care. In addition, providers should be aware that comprehensive records, including but not limited to treatment/service plans, progress notes, product and/or service order forms, invoices, and documentation of delivery of services and /or products provided are key documents for post-payment reviews. In the absence of proper and comprehensive records, no payment will be made and/or payments previously made may be recouped.

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

*Due to the character count limit, please see *1 and *3 in "Additional Needed Information" for the remainder of this section.*

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a. The waiver services not paid directly through MMIS are Transportation Services, Attendant Services (under the Self-Directed option), and Atypical Waiver Services. Transportation to MaineCare covered appointments and waiver services is reimbursed through a 1915b Me.19 Maine Non-emergency Transportation Waiver capitated system with contracted brokers outside the MMIS system. Attendants delivering Attendant Services are reimbursed by the FMS who submits claims directly to MMIS. Atypical Waiver Services (Environmental Modifications, institutional Respite, Personal Emergency Response Service, and Assistive Technology Services) providers are reimbursed by the Waiver Service Provider (administrative costs incurred by the WSP are paid directly via a negotiated contract with OADS) which submits claims directly to MMIS. b. The process for making the payments is through contracted services, the entity that processes these payments is the Department of Administration and Finance. c. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data. d. The basis of the draw is through the Maine Medicaid chart of accounts. The appropriation and unit / Object codes for entry onto line 19A of the CMS64 report are as follows:
Appropriation: 0147-
Unit for waivered services: 3618
Object codes: 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.

(Per CMS IRAI 6.5.23)
Providers receive payment directly through the selected Financial Management Services provider.

○ ***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:

Direct payment for atypical waver services is made through Senior's Plus, the Waiver Services Provider who acts as a limited fiscal agent through contract with the Medicaid agency. The Waiver Services Provider verifies qualifications of individuals and agencies delivering atypical services.

Maine utilizes the following mechanisms to exercise oversight over the Waiver Service Provider (WSP):
- *Contract requirement to complete annual Consumer Satisfaction Survey which shows:*
- *75% Participants will report that their ability to stay at home was enhanced by the provision of Atypical Services.*
- *85 % of Participants will report that they are satisfied with the performance and quality of the Atypical Service Provider.*
- *85 % of Participants will report that they are satisfied with the quality of the services that they receive from the WSP.*
- *Monthly reports include:*
- *Program Census Reporting*
- *Complaint Log*

The Provider understands that the reports are due within the timeframes established and that the Department will not make subsequent payment installments under this Agreement until such reports are received, reviewed and accepted.
For Transportation Services- The limited fiscal agent is selected through an RFP process. The waiver services that the fiscal agent will make payment for are Transportation Services. The fiscal agent pays through a capitated system. Chapter I of the MaineCare Benefits Manual authorizes audits for Services. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data. The broker for transportation is one of 3 contracted entities for the 8 regions depending upon the region in the state. Region 3 is served by Penquis Community Action Program, Region 8 is served by Logisticare Solutions, LLC, and Regions 1,2,4,5,6,and 7 are served by Coordinated Transportation Solutions, Inc.

(Per CMS IRAI 6.5.23)
When a new provider completes enrollment process, a report is generated and distributed to the Provider Relations (PR) staff. The PR covering the specific policy will outreach the newly enrolled provider to provide essential OMS contact and resource information. Additionally, OMS sends all newly enrolled providers a welcome letter with available resources and essential information regarding OMS processes. Finally, the MaineCare Portal (https://mainecare.maine.gov/default.aspx) houses resources for providers (including the Provider Manual and Billing Instructions) detailing the necessary requirements, steps, and forms for the MaineCare billing process. The MaineCare Portal also has numerous other manuals and information for prospective and currently enrolled.

☐ ***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:*

Do not complete this item.

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: Hospital, Nursing Facility

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	32472.95	41329.55	73802.50	84676.53	2572.97	87249.50	13447.00
2	33175.45	43809.32	76984.77	89757.12	2727.35	92484.47	15499.70
3	32505.86	46437.88	78943.74	95142.55	2890.99	98033.54	19089.80
4	31685.83	49224.16	80909.99	100851.10	3064.45	103915.55	23005.56
5	31722.31	52177.60	83899.91	106902.20	3248.32	110150.52	26250.61

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	3565	589	2976
Year 2	3743	618	3125

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: Hospital	Level of Care: Nursing Facility
Year 3	3930	649	3281
Year 4	4126	681	3445
Year 5	4332	715	3617

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 251 days based on waiver episode start and end dates derived from the SFY 2021 372 report.

The ALOS = 263 from the 2016 372 report; The ALOS = 263 in 2017; ALOS = 250 in 2018; ALOS = 267 in 2019; and ALOS = 244 in 2020. ALOS = 251 in 2021. The average ALOS for a 6 year period was ALOS = 256.33.

It was decided to use the most recent ALOS of 251 days due to the influence of covid on the ALOS.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

D Derivation: For Services in the Waiver, actual utilization was analyzed from SFY 2022 as well as SFY 2022 numbers of users, average usage per user, and the most recent approved rates for the Schedule D estimates by procedure code. In addition, the 372 Report from July 1, 2021, to June 30, 2022, was reviewed and used as the "base line".

An estimate of 250 members was used. In addition, the detailed query information to generate the 372 report is reviewed annually. Utilization information is periodically reviewed during budget reviews. The CMS 372 report contains important utilization information such as percentages of utilization for specific services which can be compared to the total current waiver population. The information was used to make future predictions of services. Years 1-5 utilization by members is expected to remain constant.

The Transportation estimates are based the new PMPM's and added to waiver Years 1 - 5 for the Concurrent 1915 (b) Non-Emergency Transportation Waiver.

Rates for WY1 were based on the most recent fee schedule published by MaineCare which is effective July 1, 2024. For WYs 2-5 we projected an increase in rates year over year of 3.1%. This increase is based on the inflation rate from the CPI Index for All Urban Consumers for the 12-month period ending November 2023.

(Per IRAI 7/12/2024)

The source for actual utilization including numbers of users, average usage per user and the services paid amounts are from MaineCare database (DSS). The date span for analyzing actual utilization is July 1, 2021, through June 30, 2022 (SFY 2022).

The state used the numbers of users and the average units per user from the 372 Report dated July 1, 2021, to June 30, 2022, as well as the reimbursement rates from the state's most recently approved Provider Fee Schedule to calculate the total cost of the services.

The state notes that utilization has been stable since using the 372 Report dated July 1, 2021, to June 30, 2022.

8/29/2024 Service rate changes for WY1 -WY5

The State of Maine determined to reduce the rates for Home Support, career planning, employment specialist, clubhouse and work support services. The new rates will be effective on 1/1/2025. Since the first 6 months (7/1/2024-12/31/2024, WY1) total service cost is based on the old rate and the second 6 months (1/1/2025-6/30/2025, WY1) total service cost will be on reduced new rate, we used the average of the two rates to calculate the revised total cost for WY1 (7/1/2024-6/30/2025). Using revised WY1's rate as a base trending up 3.1% year over year for the costs of WY2, WY3, WY4 and WY5. This increase is based on the inflation rate from the CPI Index for All Urban Consumers for the 12-month period ending November 2023.

Dec. 23, 2024, Service rate changes for WY1 - WY5

The services subject to the elimination of the Service Provider Tax and therefore receiving a 6% reduction in rates include the following:

Career Planning
Employment Specialist
Home Support-Per Diem (Level II, 2-4 Beds and Level II, 5-8 Beds)
Home Support-Quarter Hour (agency controlled and self-directed)
Home Support Level I
Home Support-Remote Support (Monitor only and Interactive)
Work-Ordered Day Support (Clubhouse)
Work Support

In this amendment submission the state used 6 months of the actual 2024 reimbursement rates and 6 months of the actual 2025 reimbursement rates to calculate WY1 rates. The state used actual 2025 rates for WYs 2-5.

The COLA was removed from WYs 1-5 of this amendment whereas the currently approved waiver included a projected increase of approximately 3%

Jan. 8, 2026, Rates for WY3 - WY5:

The Avg/Cost Unit in this amendment submission are based on the service reimbursed rates effective January 1, 2026 (published on the MaineCare Provider portal website).

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Included in the D' calculation is the cost of all State Plan services furnished while the participant was on the waiver. Also included is the cost of short-term institutionalization which began after the person's first day of waiver services and ended before the end of the waiver year if the person returned to the waiver after institutionalization.

Factor D' Projections were based the July 1, 2021, to June 30, 2022, 372 Report recently compiled which shows a $27,879.37 total Factor D' amount per client. This amount was trended up by 3.1% over two years to meet our starting date of this renewal of July 1, 2024, making our starting D' amount $30,553.36. This amount was used for Waiver Year 1 and trended by 3.1% for WYs 2-5. The rate of 3.1% was used as it is the most recent inflation rate from the CPI Index for All Urban Consumers (12-month period ending November 2023).

Costs for prescribed drugs were not included in the calculation.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G for WY 1 was calculated by looking at actual established yearly caps established for ICFs and specialized brain injury nursing facilities for SFY 2024 (July 2023 – June 2024) plus 3.1% inflation rate from the most current CPI Index. This calculation used the following formula:

80% ICF Yearly Cap + 20% specialized brain injury NF yearly CAP = Total Annual Comparison CAP

Total Annual Comparison CAP – G' = Factor G WY1 Projection

*80% of ICF Yearly Cap = $312,676.61 * .80 = $250,141.29*

*20% of specialized brain injury NF yearly CAP = $226,615.01 * .20 = $45,323.00*

Total Annual Comparison CAP = $295,464.29

G' factor for other services / drug costs WY1 = $9,254.93

$295,464.29 - $9,254.93= $286,209.36

Total WY1 projection for G = $286,209.36

This total was then trended up by 3.1% inflation rate for WYs 2-5. The rate of 3.1% was used as it is the most recent inflation rate from the CPI Index for All Urban Consumers (12-month period ending November 2023).

(Per IRAI 7/12/2024)
The established yearly caps for ICFs and the specialized brain injury nursing facilities are from the most recent as filed Provider Cost Report. The annual cost per member is calculated by the daily per member rate multiplied by 365 days.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' projection for WY1 was determined by starting with the most recent 372 report dated July 1, 2021 to June 30, 2022. This value of $8,444.95 was trended up year over year at 3.1% for three years to reach the starting point of the WY1 of July 1, 2025. The total for WY1 was set at $9,254.93 as a result and then trended upwards year over year at 3.1% for WYs 2-5. The rate of 3.1% was used as it is the most recent inflation rate from the CPI Index for All Urban Consumers (12-month period ending November 2023).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Care Coordination	
Personal Care	
Respite	
Financial Management Services	
Skills Training	
Assistive Technology	
Attendant Care Services	
Environmental Modifications	
Home Delivered Meals S5170	
Home Health Services	
Living Well for Better Health (Chronic Disease Self-Management)	
Matter of Balance (Falls Prevention)	
Non-Medical Transportation (NMT)	
Personal Emergency Response System (PERS)	

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
Care Coordination Total:							**3441042.00**
Care Coordination - Month	☐	month	2700	8.25	154.48	**3441042.00**	
Personal Care Total:							**65037007.74**
Personal Care (Agency PSS)	☐	1/4 hour	1900	4200.00	8.15	**65037000.00**	
Personal Care (Agency PSS) - 2 Members Served	☐	1/4 hour	1	1.00	4.48	**4.48**	
Personal Care (Agency PSS) - 3 Members Served	☐	1/4 hour	1	1.00	3.26	**3.26**	
Respite Total:							**2667237.28**
Respite at Home (PSS)	☐	1/4 hour	448	508.00	8.15	**1854809.60**	
Respite at Home (PSS) - 2 Members Served	☐	1/4 hour	1	1.00	4.48	**4.48**	
Respite at Home (PSS) - 3 Members Served	☐	1/4 hour	1	1.00	3.26	**3.26**	
Respite at Home (Patient Directed)	☐	1/4 hour	200	508.00	6.64	**674624.00**	
Respite at Home (Patient Directed) - 2 Members Served	☐	1/4 hour	1	1.00	3.65	**3.65**	
Respite at Home (Patient Directed) - 3 Members Served	☐	1/4 hour	1	1.00	2.65	**2.65**	
Respite at Home (CNA)	☐	1/4 hour	26	453.00	8.15	**95990.70**	
Respite at Home (CNA) - 2 Members Served	☐	1/4 hour	1	1.00	4.48	**4.48**	
Respite at Home (CNA) - 3 Members Served	☐	1/4 hour	1	1.00	3.26	**3.26**	
Respite, Not in the Home	☐					**41791.20**	

GRAND TOTAL: ***115766068.96***

Total: Services included in capitation: *29117.14*

Total: Services not included in capitation: *115736951.82*

Total Estimated Unduplicated Participants: ***3565***

Factor D (Divide total by number of participants): ***32472.95***

Services included in capitation: *8.17*

Services not included in capitation: *32464.78*

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		per diem	11	15.00	253.28		
Financial Management Services Total:							**931319.40**
Financial Management Services	☐	Monthly	1168	8.25	96.65	**931319.40**	
Skills Training Total:							**91756.80**
Skills Training	☐	1/4 hour	480	12.00	15.93	**91756.80**	
Assistive Technology Total:							**582998.73**
Assistive Technology A9279	☐	per invoice	43	1.00	6815.22	**293054.46**	
Assistive Technology Device A9279 QC	☐	per invoice	43	12.00	524.70	**270745.20**	
Assistive Technology Transmission T2035	☐	monthly	43	8.25	54.12	**19199.07**	
Attendant Care Services Total:							**40328704.00**
Attendant Care Services	☐	1/4 hour	1168	5200.00	6.64	**40328704.00**	
Environmental Modifications Total:							**539035.20**
Environmental Modifications	☐	per invoice	166	1.00	3247.20	**539035.20**	
Home Delivered Meals S5170 Total:							**1015264.88**
Home Delivered Meals S5170	☐	per meal	466	251.00	8.68	**1015264.88**	
Home Health Services Total:							**511730.18**
Home Health Aide - 1 Member Served - Per Visit	☐	per visit	1	1.00	32.52	**32.52**	
Home Health Aide - 2 Members Served - Per Visit	☐	per visit	1	1.00	17.88	**17.88**	

GRAND TOTAL: 115766068.96

Total: Services included in capitation: 29117.14

Total: Services not included in capitation: 115736951.82

Total Estimated Unduplicated Participants: 3565

Factor D (Divide total by number of participants): 32472.95

Services included in capitation: 8.17

Services not included in capitation: 32464.78

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide - 3 Members Served - Per Visit	☐	per visit	1	1.00	13.01	13.01	
Home Health Aide - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.15	8.15	
Home Health Aide - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.48	4.48	
Home Health Aide - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.26	3.26	
Skilled Nursing Visit (RN) - 1 Member Served - Per Visit	☐	per visit	1	1.00	60.89	60.89	
Skilled Nursing Visit (RN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	33.49	33.49	
Skilled Nursing Visit (RN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	24.35	24.35	
Skilled Nursing Visit (RN) - 1 Member Served - 1/4 HR	☐	1/4 hour	409	80.00	15.61	510759.20	
Skilled Nursing Visit (RN) - 2 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.58	8.58	
Skilled Nursing Visit (RN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.25	6.25	
Other Nursing (LPN) - 1	☐	per visit	1	1.00	44.36	44.36	

GRAND TOTAL: 115766068.96

Total: Services included in capitation: 29117.14

Total: Services not included in capitation: 115736951.82

Total Estimated Unduplicated Participants: 3565

Factor D (Divide total by number of participants): 32472.95

Services included in capitation: 8.17

Services not included in capitation: 32464.78

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Member Served - Per Visit							
Other Nursing (LPN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	24.40	24.40	
Other Nursing (LPN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	17.74	17.74	
Nursing Visit (LPN) - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	11.07	11.07	
Nursing Visit (LPN) - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.10	6.10	
Nursing Visit (LPN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.43	4.43	
Physical Therapy Visit - Per Visit	☐	per visit	1	1.00	105.57	105.57	
Occupational Therapy Visit - Per Visit	☐	per visit	1	1.00	112.18	112.18	
Speech Therapy Visit - Per Visit	☐	per visit	1	1.00	110.57	110.57	
Certified Physical Therapy Assistant - Per Visit	☐	per visit	1	1.00	74.65	74.65	
Occupational Therapy Assistant - Per Visit	☐	per visit	1	1.00	79.32	79.32	
Physical Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	14.04	14.04	
Occupational Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	14.62	14.62	
Speech Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	14.62	14.62	
Certified Nurse Aid - 1	☐					8.15	

GRAND TOTAL: ***115766068.96***

Total: Services included in capitation: *29117.14*

Total: Services not included in capitation: *115736951.82*

Total Estimated Unduplicated Participants: ***3565***

Factor D (Divide total by number of participants): ***32472.95***

Services included in capitation: *8.17*

Services not included in capitation: *32464.78*

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Member Served - 1/4 HR		1/4 hour	1	1.00	8.15		
Certified Nurse Aid - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.48	4.48	
Certified Nurse Aid - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.26	3.26	
Medical Social Services Visit - Per Visit	☐	per visit	1	1.00	95.52	95.52	
Medical Social Services Visit - 1/4 HR	☐	1/4 hour	1	1.00	13.04	13.04	
Living Well for Better Health (Chronic Disease Self-Management) Total:							3027.96
Living Well for Better Health (Chronic Disease Self-Management)	☐	30 minutes	13	12.00	19.41	3027.96	
Matter of Balance (Falls Prevention) Total:							2627.04
Matter of Balance (Falls Prevention)	☐	30 minutes	13	12.00	16.84	2627.04	
Non-Medical Transportation (NMT) Total:							29117.14
Non-Medical Transportation - PMPM	☒	PMPM	3565	8.25	0.99	29117.14	
Personal Emergency Response System (PERS) Total:							585200.61
Monthly Service Fee	☐	month	1720	8.25	39.76	564194.40	
Installation and Testing	☐	yearly	411	1.00	51.11	21006.21	

GRAND TOTAL: 115766068.96

Total: Services included in capitation: 29117.14

Total: Services not included in capitation: 115736951.82

Total Estimated Unduplicated Participants: 3565

Factor D (Divide total by number of participants): 32472.95

Services included in capitation: 8.17

Services not included in capitation: 32464.78

Average Length of Stay on the Waiver: 251

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*
Care Coordination Total:							***3793655.25***
Care Coordination - Month	☐	*month*	*2835*	*8.25*	*162.20*	***3793655.25***	
Personal Care Total:							***68308808.12***
Personal Care (Agency PSS)	☐	*1/4 hour*	*1900*	*4200.00*	*8.56*	***68308800.00***	
Personal Care (Agency PSS) - 2 Members Served	☐	*1/4 hour*	*1*	*1.00*	*4.70*	***4.70***	
Personal Care (Agency PSS) - 3 Members Served	☐	*1/4 hour*	*1*	*1.00*	*3.42*	***3.42***	
Respite Total:							***2939934.61***
Respite at Home (PSS)	☐	*1/4 hour*	*470*	*508.00*	*8.56*	***2043785.60***	
Respite at Home (PSS) - 2 Members Served	☐	*1/4 hour*	*1*	*1.00*	*4.70*	***4.70***	
Respite at Home (PSS) - 3 Members Served	☐	*1/4 hour*	*1*	*1.00*	*3.42*	***3.42***	
Respite at Home (Patient Directed)	☐	*1/4 hour*	*210*	*508.00*	*6.97*	***743559.60***	
Respite at Home (Patient Directed) - 2 Members Served	☐	*1/4 hour*	*1*	*1.00*	*3.83*	***3.83***	
Respite at Home (Patient Directed) - 3 Members Served	☐	*1/4 hour*	*1*	*1.00*	*2.78*	***2.78***	

GRAND TOTAL: ***124175691.11***

Total: Services included in capitation: *30562.78*

Total: Services not included in capitation: *124145128.33*

Total Estimated Unduplicated Participants: ***3743***

Factor D (Divide total by number of participants): ***33175.45***

Services included in capitation: *8.17*

Services not included in capitation: *33167.28*

Average Length of Stay on the Waiver: *251*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite at Home (CNA)	☐	1/4 hour	27	453.00	8.56	104697.36	
Respite at Home (CNA) - 2 Members Served	☐	1/4 hour	1	1.00	4.70	4.70	
Respite at Home (CNA) - 3 Members Served	☐	1/4 hour	1	1.00	3.42	3.42	
Respite, Not in the Home	☐	per diem	12	15.00	265.94	47869.20	
Financial Management Services Total:							1026419.46
Financial Management Services	☐	Monthly	1226	8.25	101.48	1026419.46	
Skills Training Total:							101183.04
Skills Training	☐	1/4 hour	504	12.00	16.73	101183.04	
Assistive Technology Total:							612152.62
Assistive Technology A9279	☐	per invoice	43	1.00	7155.98	307707.14	
Assistive Technology Device A9279 QC	☐	per invoice	43	12.00	550.94	284285.04	
Assistive Technology Transmission T2035	☐	monthly	43	8.25	56.83	20160.44	
Attendant Care Services Total:							44435144.00
Attendant Care Services	☐	1/4 hour	1226	5200.00	6.97	44435144.00	
Environmental Modifications Total:							593263.44
Environmental Modifications	☐	per invoice	174	1.00	3409.56	593263.44	
Home Delivered Meals S5170 Total:							1118152.29
Home Delivered Meals S5170	☐	per meal	489	251.00	9.11	1118152.29	
Home Health							564835.52

GRAND TOTAL: 124175691.11

Total: Services included in capitation: 30562.78

Total: Services not included in capitation: 124145128.33

Total Estimated Unduplicated Participants: 3743

Factor D (Divide total by number of participants): 33175.45

Services included in capitation: 8.17

Services not included in capitation: 33167.28

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Home Health Aide - 1 Member Served - Per Visit	☐	per visit	1	1.00	34.15	**34.15**	
Home Health Aide - 2 Members Served - Per Visit	☐	per visit	1	1.00	18.77	**18.77**	
Home Health Aide - 3 Members Served - Per Visit	☐	per visit	1	1.00	13.66	**13.66**	
Home Health Aide - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.56	**8.56**	
Home Health Aide - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.70	**4.70**	
Home Health Aide - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.42	**3.42**	
Skilled Nursing Visit (RN) - 1 Member Served - Per Visit	☐	per visit	1	1.00	63.93	**63.93**	
Skilled Nursing Visit (RN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	35.16	**35.16**	
Skilled Nursing Visit (RN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	25.57	**25.57**	
Skilled Nursing Visit (RN) - 1 Member Served - 1/4 HR	☐	1/4 hour	430	80.00	16.39	**563816.00**	
Skilled Nursing Visit (RN) - 2	☐	1/4 hour	1	1.00	9.01	**9.01**	

GRAND TOTAL: **124175691.11**

Total: Services included in capitation: 30562.78

Total: Services not included in capitation: 124145128.33

Total Estimated Unduplicated Participants: **3743**

Factor D (Divide total by number of participants): **33175.45**

Services included in capitation: 8.17

Services not included in capitation: 33167.28

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Member Served - 1/4 HR							
Skilled Nursing Visit (RN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.56	**6.56**	
Other Nursing (LPN) - 1 Member Served - Per Visit	☐	per visit	1	1.00	46.58	**46.58**	
Other Nursing (LPN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	25.62	**25.62**	
Other Nursing (LPN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	18.63	**18.63**	
Nursing Visit (LPN) - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	11.62	**11.62**	
Nursing Visit (LPN) - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.41	**6.41**	
Nursing Visit (LPN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.65	**4.65**	
Physical Therapy Visit - Per Visit	☐	per visit	1	1.00	110.85	**110.85**	
Occupational Therapy Visit - Per Visit	☐	per visit	1	1.00	117.79	**117.79**	
Speech Therapy Visit - Per Visit	☐	per visit	1	1.00	116.10	**116.10**	
Certified Physical Therapy Assistant - Per Visit	☐	per visit	1	1.00	78.38	**78.38**	
Occupational Therapy Assistant - Per Visit	☐	per visit	1	1.00	83.29	**83.29**	

GRAND TOTAL: ***124175691.11***

Total: Services included in capitation: *30562.78*

Total: Services not included in capitation: *124145128.33*

Total Estimated Unduplicated Participants: ***3743***

Factor D (Divide total by number of participants): ***33175.45***

Services included in capitation: *8.17*

Services not included in capitation: *33167.28*

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	14.74	**14.74**	
Occupational Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	15.35	**15.35**	
Speech Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	15.35	**15.35**	
Certified Nurse Aid - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.56	**8.56**	
Certified Nurse Aid - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.70	**4.70**	
Certified Nurse Aid - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.42	**3.42**	
Medical Social Services Visit - Per Visit	☐	per visit	1	1.00	100.30	**100.30**	
Medical Social Services Visit - 1/4 HR	☐	1/4 hour	1	1.00	13.69	**13.69**	
Living Well for Better Health (Chronic Disease Self-Management) Total:							**3423.84**
Living Well for Better Health (Chronic Disease Self-Management)	☐	30 minutes	14	12.00	20.38	**3423.84**	
Matter of Balance (Falls Prevention) Total:							**2970.24**
Matter of Balance (Falls Prevention)	☐	30 minutes	14	12.00	17.68	**2970.24**	
Non-Medical Transportation (NMT) Total:							**30562.78**
Non-Medical Transportation - PMPM	☒	PMPM	3742	8.25	0.99	**30562.78**	
Personal Emergency Response System (PERS) Total:							**645185.90**

GRAND TOTAL: ***124175691.11***

Total: Services included in capitation: *30562.78*

Total: Services not included in capitation: *124145128.33*

Total Estimated Unduplicated Participants: ***3743***

Factor D (Divide total by number of participants): ***33175.45***

Services included in capitation: *8.17*

Services not included in capitation: *33167.28*

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monthly Service Fee	☐	month	1806	8.25	41.75	622054.12	
Installation and Testing	☐	yearly	431	1.00	53.67	23131.77	

GRAND TOTAL: 124175691.11
Total: Services included in capitation: 30562.78
Total: Services not included in capitation: 124145128.33
Total Estimated Unduplicated Participants: 3743
Factor D (Divide total by number of participants): 33175.45
Services included in capitation: 8.17
Services not included in capitation: 33167.28
Average Length of Stay on the Waiver: 251

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
Care Coordination Total:							4005776.77
Care Coordination - Month	☐	month	2977	8.25	163.10	4005776.78	
Personal Care Total:							68707808.17
Personal Care (Agency PSS)	☐	1/4 hour	1900	4200.00	8.61	68707800.00	
Personal Care (Agency PSS) - 2 Members Served	☐	1/4 hour	1	1.00	4.73	4.73	
Personal Care (Agency PSS) - 3 Members Served	☐	1/4 hour	1	1.00	3.44	3.44	
Respite Total:							3108963.56

GRAND TOTAL: 127748012.06
Total: Services included in capitation: 32090.11
Total: Services not included in capitation: 127715921.95
Total Estimated Unduplicated Participants: 3930
Factor D (Divide total by number of participants): 32505.86
Services included in capitation: 8.17
Services not included in capitation: 32497.69
Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite at Home (PSS)	☐	1/4 hour	494	508.00	8.61	2160696.72	
Respite at Home (PSS) - 2 Members Served	☐	1/4 hour	1	1.00	4.73	4.73	
Respite at Home (PSS) - 3 Members Served	☐	1/4 hour	1	1.00	3.44	3.44	
Respite at Home (Patient Directed)	☐	1/4 hour	221	508.00	7.01	786998.68	
Respite at Home (Patient Directed) - 2 Members Served	☐	1/4 hour	1	1.00	3.85	3.85	
Respite at Home (Patient Directed) - 3 Members Served	☐	1/4 hour	1	1.00	2.80	2.80	
Respite at Home (CNA)	☐	1/4 hour	29	453.00	8.61	113109.57	
Respite at Home (CNA) - 2 Members Served	☐	1/4 hour	1	1.00	4.73	4.73	
Respite at Home (CNA) - 3 Members Served	☐	1/4 hour	1	1.00	3.44	3.44	
Respite, Not in the Home	☐	per diem	12	15.00	267.42	48135.60	
Financial Management Services Total:							1083435.21
Financial Management Services	☐	Monthly	1287	8.25	102.04	1083435.21	
Skills Training Total:							106773.36
Skills Training	☐	1/4 hour	529	12.00	16.82	106773.36	
Assistive Technology Total:							698574.86
Assistive Technology A9279	☐	per invoice	47	1.00	7195.85	338204.95	
Assistive Technology Device A9279	☐	per invoice	47	12.00	599.67	338213.88	

GRAND TOTAL: 127748012.06

Total: Services included in capitation: 32090.11

Total: Services not included in capitation: 127715921.95

Total Estimated Unduplicated Participants: 3930

Factor D (Divide total by number of participants): 32505.86

Services included in capitation: 8.17

Services not included in capitation: 32497.69

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
QC							
Assistive Technology Transmission T2035	☐	monthly	47	8.25	57.14	**22156.04**	
Attendant Care Services Total:							**46913724.00**
Attendant Care Services	☐	1/4 hour	1287	5200.00	7.01	**46913724.00**	
Environmental Modifications Total:							**627631.44**
Environmental Modifications	☐	per invoice	183	1.00	3429.68	**627631.44**	
Home Delivered Meals S5170 Total:							**1179469.08**
Home Delivered Meals S5170	☐	per meal	513	251.00	9.16	**1179469.08**	
Home Health Services Total:							**595623.63**
Home Health Aide - 1 Member Served - Per Visit	☐	per visit	1	1.00	34.34	**34.34**	
Home Health Aide - 2 Members Served - Per Visit	☐	per visit	1	1.00	18.88	**18.88**	
Home Health Aide - 3 Members Served - Per Visit	☐	per visit	1	1.00	13.74	**13.74**	
Home Health Aide - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.61	**8.61**	
Home Health Aide - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.73	**4.73**	
Home Health Aide - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.44	**3.44**	
Skilled Nursing Visit (RN) - 1	☐	per visit	1	1.00	64.30	**64.30**	

GRAND TOTAL: **127748012.06**

Total: Services included in capitation: 32090.11

Total: Services not included in capitation: 127715921.95

Total Estimated Unduplicated Participants: **3930**

Factor D (Divide total by number of participants): **32505.86**

Services included in capitation: 8.17

Services not included in capitation: 32497.69

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Member Served - Per Visit							
Skilled Nursing Visit (RN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	35.36	**35.36**	
Skilled Nursing Visit (RN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	25.71	**25.71**	
Skilled Nursing Visit (RN) - 1 Member Served - 1/4 HR	☐	1/4 hour	451	80.00	16.48	**594598.40**	
Skilled Nursing Visit (RN) - 2 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	9.06	**9.06**	
Skilled Nursing Visit (RN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.60	**6.60**	
Other Nursing (LPN) - 1 Member Served - Per Visit	☐	per visit	1	1.00	46.84	**46.84**	
Other Nursing (LPN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	25.77	**25.77**	
Other Nursing (LPN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	18.73	**18.73**	
Nursing Visit (LPN) - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	11.69	**11.69**	
Nursing Visit (LPN) - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.43	**6.43**	

GRAND TOTAL: **127748012.06**

Total: Services included in capitation: 32090.11

Total: Services not included in capitation: 127715921.95

Total Estimated Unduplicated Participants: **3930**

Factor D (Divide total by number of participants): **32505.86**

Services included in capitation: 8.17

Services not included in capitation: 32497.69

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Visit (LPN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.68	4.68	
Physical Therapy Visit - Per Visit	☐	per visit	1	1.00	111.46	111.46	
Occupational Therapy Visit - Per Visit	☐	per visit	1	1.00	118.44	118.44	
Speech Therapy Visit - Per Visit	☐	per visit	1	1.00	116.75	116.75	
Certified Physical Therapy Assistant - Per Visit	☐	per visit	1	1.00	78.82	78.82	
Occupational Therapy Assistant - Per Visit	☐	per visit	1	1.00	83.75	83.75	
Physical Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	14.83	14.83	
Occupational Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	15.43	15.43	
Speech Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	15.43	15.43	
Certified Nurse Aid - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.61	8.61	
Certified Nurse Aid - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.73	4.73	
Certified Nurse Aid - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.44	3.44	
Medical Social Services Visit - Per Visit	☐	per visit	1	1.00	100.86	100.86	
Medical Social Services Visit - 1/4 HR	☐	1/4 hour	1	1.00	13.77	13.77	
Living Well for Better Health (Chronic Disease Self-							3688.20

GRAND TOTAL: 127748012.06

Total: Services included in capitation: 32090.11

Total: Services not included in capitation: 127715921.95

Total Estimated Unduplicated Participants: 3930

Factor D (Divide total by number of participants): 32505.86

Services included in capitation: 8.17

Services not included in capitation: 32497.69

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Management) Total:							
Living Well for Better Health (Chronic Disease Self-Management)	☐	30 Minutes	15	12.00	20.49	**3688.20**	
Matter of Balance (Falls Prevention) Total:							**3202.20**
Matter of Balance (Falls Prevention)	☐	30 Minutes	15	12.00	17.79	**3202.20**	
Non-Medical Transportation (NMT) Total:							**32090.11**
Non-Medical Transportation - PMPM	☒	PMPM	3929	8.25	0.99	**32090.11**	
Personal Emergency Response System (PERS) Total:							**681251.46**
Monthly Service Fee	☐	month	1896	8.25	41.99	**656807.58**	
Installation and Testing	☐	yearly	453	1.00	53.96	**24443.88**	

GRAND TOTAL: **127748012.06**

Total: Services included in capitation: 32090.11

Total: Services not included in capitation: 127715921.95

Total Estimated Unduplicated Participants: **3930**

Factor D (Divide total by number of participants): **32505.86**

Services included in capitation: 8.17

Services not included in capitation: 32497.69

Average Length of Stay on the Waiver: 251

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
Care Coordination Total:							**4206267.45**
Care Coordination - Month	☐	month	3126	8.25	163.10	**4206267.45**	
Personal Care Total:							**68707808.17**
Personal Care (Agency PSS)	☐	1/4 hour	1900	4200.00	8.61	**68707800.00**	
Personal Care (Agency PSS) - 2 Members Served	☐	1/4 hour	1	1.00	4.73	**4.73**	
Personal Care (Agency PSS) - 3 Members Served	☐	1/4 hour	1	1.00	3.44	**3.44**	
Respite Total:							**3265394.07**
Respite at Home (PSS)	☐	1/4 hour	519	508.00	8.61	**2270043.72**	
Respite at Home (PSS) - 2 Members Served	☐	1/4 hour	1	1.00	4.73	**4.73**	
Respite at Home (PSS) - 3 Members Served	☐	1/4 hour	1	1.00	3.44	**3.44**	
Respite at Home (Patient Directed)	☐	1/4 hour	232	508.00	7.01	**826170.56**	
Respite at Home (Patient Directed) - 2 Members Served	☐	1/4 hour	1	1.00	3.85	**3.85**	
Respite at Home (Patient Directed) - 3 Members Served	☐	1/4 hour	1	1.00	2.80	**2.80**	
Respite at Home (CNA)	☐	1/4 hour	30	453.00	8.61	**117009.90**	
Respite at Home (CNA) - 2 Members Served	☐	1/4 hour	1	1.00	4.73	**4.73**	
Respite at Home (CNA) - 3 Members Served	☐	1/4 hour	1	1.00	3.44	**3.44**	
Respite, Not in the Home	☐					**52146.90**	

GRAND TOTAL: **130735729.68**

Total: Services included in capitation: 33682.77

Total: Services not included in capitation: 130702046.91

Total Estimated Unduplicated Participants: **4126**

Factor D (Divide total by number of participants): **31685.83**

Services included in capitation: 8.16

Services not included in capitation: 31677.67

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		per diem	13	15.00	267.42		
Financial Management Services Total:							**1138154.16**
Financial Management Services	☐	Monthly	1352	8.25	102.04	**1138154.16**	
Skills Training Total:							**112223.04**
Skills Training	☐	1/4 hour	556	12.00	16.82	**112223.04**	
Assistive Technology Total:							**743164.75**
Assistive Technology A9279	☐	per invoice	50	1.00	7195.85	**359792.50**	
Assistive Technology Device A9279 QC	☐	per invoice	50	12.00	599.67	**359802.00**	
Assistive Technology Transmission T2035	☐	monthly	50	8.25	57.14	**23570.25**	
Attendant Care Services Total:							**49283104.00**
Attendant Care Services	☐	1/4 hour	1352	5200.00	7.01	**49283104.00**	
Environmental Modifications Total:							**658498.56**
Environmental Modifications	☐	per invoice	192	1.00	3429.68	**658498.56**	
Home Delivered Meals S5170 Total:							**1239247.24**
Home Delivered Meals S5170	☐	per meal	539	251.00	9.16	**1239247.24**	
Home Health Services Total:							**625946.83**
Home Health Aide - 1 Member Served - Per Visit	☐	per visit	1	1.00	34.34	**34.34**	
Home Health Aide - 2 Members Served - Per Visit	☐	per visit	1	1.00	18.88	**18.88**	

GRAND TOTAL: 130735729.68

Total: Services included in capitation: 33682.77

Total: Services not included in capitation: 130702046.91

Total Estimated Unduplicated Participants: 4126

Factor D (Divide total by number of participants): 31685.83

Services included in capitation: 8.16

Services not included in capitation: 31677.67

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide - 3 Members Served - Per Visit	☐	per visit	1	1.00	13.74	13.74	
Home Health Aide - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.61	8.61	
Home Health Aide - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.73	4.73	
Home Health Aide - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.44	3.44	
Skilled Nursing Visit (RN) - 1 Member Served - Per Visit	☐	per visit	1	1.00	64.30	64.30	
Skilled Nursing Visit (RN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	35.36	35.36	
Skilled Nursing Visit (RN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	25.71	25.71	
Skilled Nursing Visit (RN) - 1 Member Served - 1/4 HR	☐	1/4 hour	474	80.00	16.48	624921.60	
Skilled Nursing Visit (RN) - 2 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	9.06	9.06	
Skilled Nursing Visit (RN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.60	6.60	
Other Nursing (LPN) - 1	☐	per visit	1	1.00	46.84	46.84	

GRAND TOTAL: 130735729.68

Total: Services included in capitation: 33682.77

Total: Services not included in capitation: 130702046.91

Total Estimated Unduplicated Participants: 4126

Factor D (Divide total by number of participants): 31685.83

Services included in capitation: 8.16

Services not included in capitation: 31677.67

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Member Served - Per Visit							
Other Nursing (LPN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	25.77	**25.77**	
Other Nursing (LPN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	18.73	**18.73**	
Nursing Visit (LPN) - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	11.69	**11.69**	
Nursing Visit (LPN) - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.43	**6.43**	
Nursing Visit (LPN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.68	**4.68**	
Physical Therapy Visit - Per Visit	☐	per visit	1	1.00	111.46	**111.46**	
Occupational Therapy Visit - Per Visit	☐	per visit	1	1.00	118.44	**118.44**	
Speech Therapy Visit - Per Visit	☐	per visit	1	1.00	116.75	**116.75**	
Certified Physical Therapy Assistant - Per Visit	☐	per visit	1	1.00	78.82	**78.82**	
Occupational Therapy Assistant - Per Visit	☐	per visit	1	1.00	83.75	**83.75**	
Physical Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	14.83	**14.83**	
Occupational Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	15.43	**15.43**	
Speech Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	15.43	**15.43**	
Certified Nurse Aid - 1	☐					**8.61**	

GRAND TOTAL: ***130735729.68***

Total: Services included in capitation: *33682.77*

Total: Services not included in capitation: *130702046.91*

Total Estimated Unduplicated Participants: ***4126***

Factor D (Divide total by number of participants): ***31685.83***

Services included in capitation: *8.16*

Services not included in capitation: *31677.67*

Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Member Served - 1/4 HR		1/4 hour	1	1.00	8.61		
Certified Nurse Aid - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.73	4.73	
Certified Nurse Aid - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.44	3.44	
Medical Social Services Visit - Per Visit	☐	per visit	1	1.00	100.86	100.86	
Medical Social Services Visit - 1/4 HR	☐	1/4 hour	1	1.00	13.77	13.77	
Living Well for Better Health (Chronic Disease Self-Management) Total:							3688.20
Living Well for Better Health (Chronic Disease Self-Management)	☐	30 Minutes	15	12.00	20.49	3688.20	
Matter of Balance (Falls Prevention) Total:							3202.20
Matter of Balance (Falls Prevention)	☐	30 Minutes	15	12.00	17.79	3202.20	
Non-Medical Transportation (NMT) Total:							33682.77
Non-Medical Transportation - PMPM	☒	PMPM	4124	8.25	0.99	33682.77	
Personal Emergency Response System (PERS) Total:							715348.24
Monthly Service Fee	☐	month	1991	8.25	41.99	689717.24	
Installation and Testing	☐	yearly	475	1.00	53.96	25631.00	

GRAND TOTAL: 130735729.68

Total: Services included in capitation: 33682.77

Total: Services not included in capitation: 130702046.91

Total Estimated Unduplicated Participants: 4126

Factor D (Divide total by number of participants): 31685.83

Services included in capitation: 8.16

Services not included in capitation: 31677.67

Average Length of Stay on the Waiver: 251

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*
Care Coordination Total:							***4416177.15***
Care Coordination - Month	☐	*month*	*3282*	*8.25*	*163.10*	***4416177.15***	
Personal Care Total:							***72324008.17***
Personal Care (Agency PSS)	☐	*1/4 hour*	*2000*	*4200.00*	*8.61*	***72324000.00***	
Personal Care (Agency PSS) - 2 Members Served	☐	*1/4 hour*	*1*	*1.00*	*4.73*	***4.73***	
Personal Care (Agency PSS) - 3 Members Served	☐	*1/4 hour*	*1*	*1.00*	*3.44*	***3.44***	
Respite Total:							***3426087.49***
Respite at Home (PSS)	☐	*1/4 hour*	*545*	*508.00*	*8.61*	***2383764.60***	
Respite at Home (PSS) - 2 Members Served	☐	*1/4 hour*	*1*	*1.00*	*4.73*	***4.73***	
Respite at Home (PSS) - 3 Members Served	☐	*1/4 hour*	*1*	*1.00*	*3.44*	***3.44***	
Respite at Home (Patient Directed)	☐	*1/4 hour*	*243*	*508.00*	*7.01*	***865342.44***	
Respite at Home (Patient Directed) - 2 Members Served	☐	*1/4 hour*	*1*	*1.00*	*3.85*	***3.85***	
Respite at Home (Patient Directed) - 3 Members Served	☐	*1/4 hour*	*1*	*1.00*	*2.80*	***2.80***	

GRAND TOTAL: ***137421026.81***

Total: Services included in capitation: *35365.28*

Total: Services not included in capitation: *137385661.53*

Total Estimated Unduplicated Participants: ***4332***

Factor D (Divide total by number of participants): ***31722.31***

Services included in capitation: *8.16*

Services not included in capitation: *31714.14*

Average Length of Stay on the Waiver: *251*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite at Home (CNA)	☐	1/4 hour	32	453.00	8.61	124810.56	
Respite at Home (CNA) - 2 Members Served	☐	1/4 hour	1	1.00	4.73	4.73	
Respite at Home (CNA) - 3 Members Served	☐	1/4 hour	1	1.00	3.44	3.44	
Respite, Not in the Home	☐	per diem	13	15.00	267.42	52146.90	
Financial Management Services Total:							1194556.77
Financial Management Services	☐	Monthly	1419	8.25	102.04	1194556.77	
Skills Training Total:							117874.56
Skills Training	☐	1/4 hour	584	12.00	16.82	117874.56	
Assistive Technology Total:							772891.34
Assistive Technology A9279	☐	per invoice	52	1.00	7195.85	374184.20	
Assistive Technology Device A9279 QC	☐	per invoice	52	12.00	599.67	374194.08	
Assistive Technology Transmission T2035	☐	monthly	52	8.25	57.14	24513.06	
Attendant Care Services Total:							51725388.00
Attendant Care Services	☐	1/4 hour	1419	5200.00	7.01	51725388.00	
Environmental Modifications Total:							692795.36
Environmental Modifications	☐	per invoice	202	1.00	3429.68	692795.36	
Home Delivered Meals S5170 Total:							1301324.56
Home Delivered Meals S5170	☐	per meal	566	251.00	9.16	1301324.56	
Home Health							656269.76

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Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Home Health Aide - 1 Member Served - Per Visit	☐	per visit	1	1.00	34.34	**34.34**	
Home Health Aide - 2 Members Served - Per Visit	☐	per visit	1	1.00	18.88	**18.88**	
Home Health Aide - 3 Members Served - Per Visit	☐	per visit	1	1.00	13.47	**13.47**	
Home Health Aide - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.61	**8.61**	
Home Health Aide - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.73	**4.73**	
Home Health Aide - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.44	**3.44**	
Skilled Nursing Visit (RN) - 1 Member Served - Per Visit	☐	per visit	1	1.00	64.30	**64.30**	
Skilled Nursing Visit (RN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	35.36	**35.36**	
Skilled Nursing Visit (RN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	25.71	**25.71**	
Skilled Nursing Visit (RN) - 1 Member Served - 1/4 HR	☐	1/4 hour	497	80.00	16.48	**655244.80**	
Skilled Nursing Visit (RN) - 2	☐	1/4 hour	1	1.00	9.06	**9.06**	

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Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Member Served - 1/4 HR							
Skilled Nursing Visit (RN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.60	**6.60**	
Other Nursing (LPN) - 1 Member Served - Per Visit	☐	per visit	1	1.00	46.84	**46.84**	
Other Nursing (LPN) - 2 Members Served - Per Visit	☐	per visit	1	1.00	25.77	**25.77**	
Other Nursing (LPN) - 3 Members Served - Per Visit	☐	per visit	1	1.00	18.73	**18.73**	
Nursing Visit (LPN) - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	11.69	**11.69**	
Nursing Visit (LPN) - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	6.43	**6.43**	
Nursing Visit (LPN) - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.68	**4.68**	
Physical Therapy Visit - Per Visit	☐	per visit	1	1.00	111.46	**111.46**	
Occupational Therapy Visit - Per Visit	☐	per visit	1	1.00	118.44	**118.44**	
Speech Therapy Visit - Per Visit	☐	per visit	1	1.00	116.75	**116.75**	
Certified Physical Therapy Assistant - Per Visit	☐	per visit	1	1.00	78.82	**78.82**	
Occupational Therapy Assistant - Per Visit	☐	per visit	1	1.00	83.75	**83.75**	

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Average Length of Stay on the Waiver: 251

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	14.83	**14.83**	
Occupational Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	15.43	**15.43**	
Speech Therapy Visit - 1/4 HR	☐	1/4 hour	1	1.00	15.43	**15.43**	
Certified Nurse Aid - 1 Member Served - 1/4 HR	☐	1/4 hour	1	1.00	8.61	**8.61**	
Certified Nurse Aid - 2 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	4.73	**4.73**	
Certified Nurse Aid - 3 Members Served - 1/4 HR	☐	1/4 hour	1	1.00	3.44	**3.44**	
Medical Social Services Visit - Per Visit	☐	per visit	1	1.00	100.86	**100.86**	
Medical Social Services Visit - 1/4 HR	☐	1/4 hour	1	1.00	13.77	**13.77**	
Living Well for Better Health (Chronic Disease Self-Management) Total:							**3934.08**
Living Well for Better Health (Chronic Disease Self-Management)	☐	30 Minutes	16	12.00	20.49	**3934.08**	
Matter of Balance (Falls Prevention) Total:							**3415.68**
Matter of Balance (Falls Prevention)	☐	30 Minutes	16	12.00	17.79	**3415.68**	
Non-Medical Transportation (NMT) Total:							**35365.28**
Non-Medical Transportation - PMPM	☒	PMPM	4330	8.25	0.99	**35365.28**	
Personal Emergency Response System (PERS) Total:							**750938.61**

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monthly Service Fee	☐	month	2090	8.25	41.99	**724012.58**	
Installation and Testing	☐	yearly	499	1.00	53.96	**26926.04**	

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