TABLE OF CONTENTS

PAGE

18.01 INTRODUCTION 1

18.02 DEFINITIONS 1

18.02-1 Abuse 1

18.02-2 Assessing Services Agency (ASA) 1

18.02-3 Authorized Entity 1

18.02-4 Blocking 1

18.02-5 Care Coordinator 1

18.02-6 Care Monitor 2

18.02-7 Care Plan 2

18.02-8 Contingent Reinforcement 2

18.02-9 Environmental Alteration 2

18.02-10 Exploitation 2

18.02-11 Extinction 2

18.02-12 Mayo Portland Adaptability Inventory 2

18.02-13 Medical Eligibility Determination Tool 2

18.02-14 Member 2

18.02-15 Natural Supports 3

18.02-16 Neglect 3

18.02-17 Non-exclusionary Timeout 3

18.02-18 Overcorrection 3

18.02-19 Positive Behavioral Supports 3

18.02-20 Prior Authorization 3

18.02-21 Redirection 3

18.02-22 Target Behavior 3

18.02-23 Token 3

18.02-24 Token Economy 4

18.02-25 Utilization Review 4

18.02-26 Verbal Reprimand 4

18.03 DETERMINATION OF ELIGIBILITY 4

18.03-1 Approved Opening 4

18.03-2 General Eligibility Criteria 4

18.03-3 Establishing Medical Eligibility 6

18.03-4 Priority 7

18.03-5 Redetermination of Eligibility 7

18.04 CARE PLAN DEVELOPMENT 8

18.04-1 Procedures for Developing the Care Plan 8

18.04-2 Content of the Care Plan 9

18.04-3 Review and Updating of the Care Plan 10

TABLE OF CONTENTS *(cont.)*

18.05 COVERED SERVICES 10

18.05-1 Assistive Technology Device and Services 10

18.05-2 Care Coordination Services 11

18.05-3 Career Planning 11

18.05-4 Community/Work Reintegration 12

18.05-5 Employment Specialist Services 12

18.05-6 Home Support Services 13

18.05-7 Non-Medical Transportation Services 16

18.05-8 Self Care/Home Management Reintegration 16

18.05-9 Work Ordered Day Club House 17

18.05-10 Work Support Services 17

18.06 NONCOVERED SERVICES 18

18.07 LIMITS 19

18.07-1 Assistive Technology Services 19

18.07-2 Care Coordination Services 19

18.07-3 Career Planning 19

18.07-4 Community/Work Reintegration 19

18.07-5 Home Support Services 19

18.07-6 Self Care/Home Management Reintegration 20

18.07-7 Work Ordered Day Club House 20

18.07-8 Work Support Services 20

18.07-9 Section 18, “Home and Community Based Services for Adults with

Brain Injury” 20

18.08 DURATION OF CARE 20

18.08-1 Voluntary Termination 20

18.08-2 Involuntary Termination 20

18.08-3 Suspension of Services 21

18.09 RECORDS 21

18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS 22

18.10-1 Assistive Technology Services 23

18.10-2 Care Coordination Services 23

18.10-3 Career Planning.. 23

18.10-4 Employment Specialist Services 23

TABLE OF CONTENTS *(cont.)*

18.10-5 Home Support Level I, Level II, and Level III and Remote Support.. 23

18.10-6 Self/Care/Home Management Reintegration and

Community/Work Reintegration 25

18.10-7 Work Ordered Day Club House 26

18.10-8 Work Support 27

18.10-9 Background Check Criteria 27

18.10-10 Informed Consent Policy 28

18.10-11 Reportable Events 29

18.10-12 Requirements for Residential Settings Owned or Controlled by a Provider 29

18.10-13 CARF Accreditation 29

18.10-14 General Requirements for Services requiring CBIS or equivalent 31

18.11 BEHAVIORAL INTERVENTIONS 32

18.11-01 Process for Review and Approval of Behavioral Interventions 32

18.11-02 Categories of Behavioral Interventions 34

18.11-03 Prohibitions 35

18.12 APPEALS 36

18.13 REIMBURSEMENT 37

18.14 BILLING INSTRUCTIONS 37

18.15 QUALITY REPORTING 37

18.16 APPENDIX I 38

**18.01 INTRODUCTION**

This benefit is a Home and Community-Based Waiver for Adults with Brain Injury who are 18 or older, meet criteria for care in an intermediate care facility or nursing facility and choose to live in the community with the support of this waiver. This Home and Community-Based Waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the member. Member choice in all services and components of services is a primary goal of this waiver. Additionally, the principles of conflict-free care coordination, services provided in the least restrictive modality and effective use of assistive technology for communication, environmental control and safety are inherent to this waiver.

This benefit has been designed and will be implemented in such a manner so as to ensure that every waiver service setting:

• Is integrated in and supports full access to the greater community;

• Is selected by the member from among setting options;

• Ensures members rights of privacy, dignity and respect, and freedom from coercion and restraint;

• Optimizes autonomy and independence in making life choices; and

• Facilitates choice regarding services and who provides them.

**18.02 DEFINITIONS**

**18.02-1** **Abuse** means the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; or the intentional, knowing or reckless deprivation of essential needs as defined in 22 MRSA §3472.

**18.02-2** **Assessing Services Agency (ASA)** is an Authorized Entity of the Department of Health and Human Services (DHHS) for Medical Eligibility Determinations that conducts face-to-face assessments, using the DHHS Medical Eligibility Determination form or other DHHS approved form.

**18.02-3** **Authorized Entity** is an organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

**18.02-4** **Blocking** is momentary deflection of an individual’s movement, when that movement would otherwise be destructive or harmful. Blocking is a moderately intrusive intervention.

**18.02-5 Care Coordinator** is a provider responsible for the development and ongoing support of the implementation of the Care Plan. This includes monitoring of the health, welfare and safety of the participant.

**18.02 DEFINITIONS** *(cont.)*

**18.02-6** **Care Monitor** is the Department of Health and Human Services (DHHS) professional who assists the member with the member’s enrollment in the waiver services and monitors the services received to assure they are meeting the health and safety needs of the member.

**18.02-7 Care Plan** is a comprehensive document that specifies the services a member will receive under this section and the manner in which those services will be provided.

**18.02-8** **Contingent Reinforcemen**t is using rewards based upon modification of inherent rights. Positive contingent reinforcement is a reward given contingent upon the occurrence of a target behavior. Negative contingent reinforcement is the removal of an unpleasant event contingent upon the occurrence of a target behavior. Both positive and negative contingent reinforcement result in a higher rate of the target behavior. A contingent reinforcement is a moderately intrusive intervention.

**18.02-9** **Environmental alteration** is the modification of a site, activity or schedule that appears to be triggering or contributing to a dangerous or maladaptive behavior.

**18.02-10** **Exploitation** means the illegal or improper use of an incapacitated or dependent member or that member’s resources for another’s profit or advantage as defined in 22 MRSA §3472.

**18.02-11** **Extinction** is withdrawal of attention or planned ignoring of the target behavior that is in response to behavior that is disruptive but not harmful or destructive. This is a mildly intrusive behavioral intervention.

**18.02-12 Mayo Portland Adaptability Inventory** **(MPAI)** is a clinical evaluation tool designed to assist in the clinical evaluation of people during the post-acute (post-hospital) period following acquired brain injury (ABI), and to assist in the evaluation of rehabilitation programs designed to serve these people. The MPAI is one of the tools used to establish eligibility and level of care for the waiver initially and on a yearly renewal basis. For more information see this website <http://www.tbims.org/combi/mpai/index.html>

**18.02-13 Medical Eligibility Determination (MED) Tool** means the form approved by DHHS to assess the medical service needs of the member. The information provided by the MED tool will be used in determining the eligibility for the waiver and authorizing services.

**18.02-14** **Member** is a person determined to be eligible for MaineCare benefits by the Office for Family Independence (OFI) in accordance with the eligibility standards published by the OFI in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

**18.02 DEFINITIONS** *(cont.)*

**18.02-15** **Natural Supports** include the relatives, friends, neighbors, and community resources that a member or family goes to for support. They may participate in the treatment team, but are not MaineCare reimbursable.

**18.02-16** **Neglect** means a threat to an member’s health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 MRSA §3472.

**18.02-17 Non-exclusionary Timeout** is the voluntary withdrawal of an individual from a reinforcing activity or setting while remaining in the reinforcing environment. Coercion may not be used. This is a mildly intrusive behavioral intervention.

**18.02-18 Overcorrection** is activity done in excess of what would reasonably be required simply to restore a setting or situation to its original state. There are two forms of overcorrection. The first involves activity in excess of what is necessary or desired, such as mopping the entire room when milk is spilled onto the floor, rather than simply cleaning the spill. The second, also called positive practice overcorrection, consists of practicing an alternative more desirable behavior, such as spending ten minutes putting glasses into the dishwasher. This is a moderately intrusive intervention.

**18.02-19 Positive behavioral supports** are supports that help people develop and engage in adaptive, socially desirable behaviors and overcome patterns of destructive and stigmatizing responding, but which do not entail any limitations upon the individual’s rights. Positive behavioral support incorporates a comprehensive set of procedures and support strategies that are selectively employed based on an individual’s needs, characteristics, and preferences.

**18.02-20 Prior Authorization** **(PA)** is the process of obtaining prior approval as to the medical necessity and eligibility for a service.

**18.02-21** **Redirection** is the distraction or diversion of the attention of an individual from a maladaptive or dangerous behavior to a positive or neutral behavior; a suggestion, by word or gesture, that an individual try an alternate activity. No threats or coercion are involved.

**18.02-22 Target Behavior** is a specific behavior of an individual that is operationally defined. This is the behavior identified in a behavioral intervention with the intention of purposefully increasing or decreasing the rate of the behavior.

**18.02-23** **Token** is an object used to positively reward target behavior with the understanding that multiple tokens or objects are exchanged for desired items.

**18.02 DEFINITIONS (cont.)**

**18.02-24** **Token Economy** is a system of positive reinforcement to reward target behavior whereas an individual earns a token for eliciting specific target behaviors. A token Economy is a moderately intrusive intervention.

**18.02-25 Utilization Review** is a formal assessment of the medical necessity, efficiency and appropriateness of services and Care Plans on a prospective, concurrent or retrospective basis. The provider is required to notify DHHS or its Authorized Entity upon initiation of all services provided under Section 18 in order for the Authorized Entity to begin utilization review.

**18.02-26** **Verbal reprimand** is a matter-of-fact message, delivered against a background of a generally positive and supportive environment, to express disapproval of an individual’s behavior. It must be conveyed without humiliating or threatening language. This is a mildly intrusive behavioral intervention.

**18.03 DETERMINATION OF ELIGIBILITY**

**18.03-1** **Approved Opening**

The number of MaineCare members who can receive services under this section is limited to the number of openings approved by the Centers for Medicare and Medicaid Services (CMS). Persons who would otherwise be eligible for services under this section are not eligible to receive services if all of the approved openings are filled.

**18.03-2** **General Eligibility Criteria**

Consistent with Subsection 18.03-1, a person is eligible for services under this section if the person:

A. Is age eighteen (18) or older; and

B. Has a diagnosis of acquired brain injury. Acquired Brain Injury means an insult to the brain resulting directly or indirectly from trauma, anoxia, or vascular lesions, or infection, which is not of a degenerative or congenital nature, can produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical functioning, can result in the disturbance of behavioral or emotional functioning, can be either temporary or permanent, and can cause partial or total functional disability or psychosocial maladjustment. (Title 22 §3086); and

**18.03 DETERMINATION OF ELIGIBILITY** *(cont.)*

C. The individual has received an assessment by a qualified neuropsychologist (as defined in the *MaineCare Benefits Manual*, Rehabilitative Services, Section 102.08-5 B) and/or a licensed physician who is Board certified or Board eligible in Physical Medicine and Rehabilitation, which:

1. positively indicates the individual: is not in a persistent vegetative state; is able to demonstrate potential for physical and/or behavioral and/or cognitive rehabilitation; shows evidence of moderate to severe behavioral and/or cognitive and/or functional disabilities; and
2. results in specific rehabilitation goals, based upon the findings of the assessment, describing types and frequencies of therapies and expected outcomes and timeframes; and

D. Has a completed Department-approved Health and Safety Assessment administered by the Department with an overall score of 0.1 or higher. The Department approved Health and Safety Assessment evaluates cognitive, physical, and behavioral needs related to a person’s brain injury. It assesses whether a person needs support for the three areas. Additionally, it assesses if the person needs cueing, direct support, or a behavioral support. Scores range from 0-1.The assessment can be found at the Department’s Brain Injury Services website: <http://www.maine.gov/dhhs/oads/disability/bi/index.shtml> The assessment was last revised: 02/25/14. The Department will only accept assessments conducted no more than three months prior to application; and

E. Has completed Mayo-Portland Adaptability Inventory – 4 (or current Department approved version of the MPAI) with an item score of 3 or higher for two of the following items:

a. Novel Problem Solving

b. Impaired Self-Awareness

c. Irritability, Anger, Aggression

d. Inappropriate Social Interaction

e. Fund of Information or Attention/Concentration or Memory

The Department will only accept assessments conducted no more than three months prior to application; and

F. Does not receive services under any other federally-approved MaineCare home and community-based waiver program; and

**18.03 DETERMINATION OF ELIGIBILITY** *(cont.)*

G. Meets all MaineCare eligibility requirements as set forth in the *MaineCare Eligibility Manual*; and

H. The estimated annual cost of the member’s services under the waiver is equal to or less than one hundred percent (100%) of a blended rate of the statewide average annual cost of care for individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and Nursing Facility Brain Injury units, as determined by DHHS (the blended rate being the sum of 20% of the statewide average annual cost of care in an ICF/IID and 80% of the statewide average annual cost of care in a Nursing Facility Brain Injury unit); and

I. Can have his or her health and welfare needs assured in the community setting as stated in § 18.04-2(D).

**18.03-3** **Establishing Medical Eligibility**

Determination of the member’s medical eligibility for services under this Section requires the following:

A. Completion of a Medical Eligibility Determination (MED) assessment by the Assessing Services Agency (ASA);

B. Completion of the Mayo Portland Adaptability Inventory (MPAI) or current functional assessment, as approved by DHHS, by DHHS or its Authorized Entity;

C. Completion of the Department approved Health and Safety Assessment (HSA); and

D. Documentation from a qualified neuropsychologist (as defined in the *MaineCare Benefits Manual*, Rehabilitative Services, Chapter II, Section 102.08-5 (B)) and/or a licensed physician who is Board certified or Board eligible in Physical Medicine and Rehabilitation that the waiver services are medically necessary as described in Section 18.03-2(C) .

The member and Care Monitor are responsible for working with DHHS to ensure that each of these items is completed. DHHS shall notify each member or the member’s guardian in writing of any decision regarding the member’s medical eligibility, and the availability of benefit openings under this section. The notice will include information about the member’s right to appeal any of these decisions. Rights for notice and appeal are further described in Chapter I of the *MaineCare Benefits Manual*.

**18.03 DETERMINATION OF ELIGIBILITY** *(cont.)*

**18.03-4 Priority**

When a member is found to meet MaineCare financial eligibility and medical eligibility for these services, the priority for an approved opening shall be established in accordance with the following:

A. **Priority 1:** A member shall be identified as Priority 1 if the member is currently residing in a facility of more than 8 beds that is engaged in providing diagnosis, treatment or care, which typically includes: medical attention; nursing care and related services; 24-hour supervision; and coordination and integration of health or rehabilitative services; and the member continues to meet the financial and medical eligibility criteria at the time that an approved opening becomes available. Order of enrollment will be based on date of application; an application will be considered complete on the date upon which items (A) through (D) from Section 18.04-1,

Procedures for Developing the Care Plan, have been completed to DHHS satisfaction and DHHS has received all documents. If there are two applications received on the same day, the applicant with the longest continuous stay in institutional care will be prioritized first.

B. **Priority 2:** A member shall be identified as Priority 2 if the member has been determined to be residing in the community. A higher priority will be given to those members who are at imminent risk of abuse, neglect or exploitation followed by those at anticipated risk of abuse, neglect or exploitation or homelessness and institutionalization with the next year.

If applications exceed approved openings in any given year, a waiting list will be established. The list will be prioritized, as specified above, such that when there is a funded opening an individual will be selected from priority one first and then immediately from priority two if there are not any completed and approved applicants from priority one.

**18.03-5** **Redetermination of Eligibility**

Eligibility for services under this section must be redetermined annually. When determining continuing eligibility, the Care Coordinator will initiate an updated MED assessment, updated Mayo Portland Adaptability Inventory or current functional assessment, as approved by DHHS, and an updated Department approved Health and Safety Assessment. The MED Assessment and Mayo Portland Adaptability Inventory or current functional assessment will be conducted by DHHS or its Authorized Entity. The Department approved Health and Safety Assessment will be completed by the Department or its Authorized Entity. Updated assessments must be completed

**18.03 DETERMINATION OF ELIGIBILITY (cont.)**

twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. Once the assessment has been updated, the Care Plan will be updated annually. If the updated Assessment Referral is received after the due date, reimbursement for services will resume upon completion of the assessment. Whenever there is a significant change in the member condition that requires an alteration in the level of care, the Care Coordinator will provide notice to DHHS or its Authorized Entity and request an updated assessment. See 18.04-3 regarding updating of the Care Plan.

**18.04 CARE PLAN DEVELOPMENT**

**18.04-1 Procedures for Developing the Care Plan**

A member’s Care Plan will be developed as part of the process of applying to receive services under the waiver. The process for applying is as follows:

1. Choice Letter: The process begins by the member signing and submitting a “choice letter” to the Office of Aging and Disability Services (OADS) requesting services under the waiver. The choice letter is a form that DHHS sends to individuals who may be eligible for services under this section requesting that the individual indicate their preference between receiving services in an institutional setting (such as a nursing facility) or receiving services in a community setting under this section.
2. Application: After receiving the choice letter, the DHHS Care Monitor will meet with the member and guardian or power of attorney (where applicable) and complete the initial application

**C. Functional and Medical Assessments:** The Care Monitor will request the MED assessment to be completed by the ASA. The Care Monitor will complete the Mayo Portland Adaptability Inventory (or current functional assessment, as approved by the DHHS) and the Department approved Health and Safety Assessment. The Health and Safety Assessment must have been completed within the past 90 days from the date of application.

**D**. **Preliminary Care Plan:** The Care Monitor will work with the member and guardian or power of attorney (where applicable) to create a preliminary Care Plan to address all safety/risks needs identified by the Health and Safety Assessment, the MED assessment, and the Mayo Portland Adaptability Inventory (or current functional assessment approved by DHHS). Each safety/risk need identified will require a plan to safely support the member in the community with two forms of back-up support. The member will also select the member’s service package and preliminary budget.

**18.04 CARE PLAN DEVELOPMENT** *(cont.)*

**E**. **Selection of Home Support Option and Development of Final Care Plan:** The final Care Plan must be developed by the member, the Care Monitor, guardian or power of attorney (where applicable) and the Home Support Services provider. The member will work with the Care Monitor, guardian or power of attorney (where applicable) to select an approved Home Support provider as outlined in 18.05-6. Once the Home Support Services provider is selected, the Home Support provider will assist the member in developing the final Care Plan including the budget and selection of services.

**F**. **Signatures:** In order for the final Care Plan to be approved, the Care Plan must include signatures of (1) the member, or guardian, where applicable, and (2) the Care Coordinator.

**G.** **Department Review and Approval:** All services must be Prior Authorized by OADS. Prior to implementation or start of Section 18 Services, the Care Plan must be reviewed and approved by OADS, and OADS must determine that the member is eligible for services as outlined in Section 18.03-1, 2 and 3.

**H**. **Utilization Review:** All Care Plans must be reviewed and approved by OADS. DHHS and its Authorized Entity reserve the right to conduct Utilization Review of any service authorized under this Section, applying the service-specific eligibility standards set forth in this Section. DHHS and its Authorized Entity may terminate or revise a service authorization upon finding that the member no longer satisfies the eligibility standards for the service or level of service authorized.

**18.04-2 Content of the Care Plan**

At a minimum the Care Plan must describe:

A. All MaineCare Benefit services determined medically necessary by DHHS;

B. The frequency of provision of the services;

C. How services contribute to the member’s health and well-being and the member’s ability to reside safely in a community setting;

D. A safety/risk plan, which shall describe the potential risks to the member’s health and welfare while living in the community and the reasonable steps to alleviate those risks. Each identified safety need must be addressed by two back-up strategies for meeting the member’s safety needs;

E. The member’s goals for strengthening and cultivating personal, community, family, and professional relationships as identified in the member’s most

**18.04 CARE PLAN DEVELOPMENT** *(cont.)*

recent Mayo Portland Adaptability Inventory (or current functional assessment, as approved by the DHHS) ;

F. The role and responsibility of the member’s providers in supporting the member’s goals, including goals for strengthening natural and supportive personal, family, community and professional relationships; and

G. A budget for the services to be provided under this section.

The Care Plan may include other services not covered under this section that the member may choose to pursue.

**18.04-3 Review and Updating of the Care Plan**

The Care Plan must be reviewed and updated at a minimum annually, or when there are significant changes in the member’s condition sufficient to warrant a review whether the services in place are adequate.

**18.05 COVERED SERVICES**

**18.05-1** **Assistive Technology Device and Services**- 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 the functional capabilities of members.

**Assistive Technology Service** means a service that directly assists a member in the selection, acquisition, or use of an Assistive Technology device. Assistive Technology Services include:

A. the evaluation of the Assistive Technology needs of a member, including a functional evaluation of the impact of the provision of appropriate Assistive Technology Devices and appropriate Assistive Technology Services to the member in the customary environment of the member;

B.) services consisting of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology Devices for members;

C. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing Assistive Technology Devices;

D. coordination and use of necessary therapies, interventions, or services with Assistive Technology Devices, such as therapies, interventions, or services associated with other services in the Care Plan;

**18.05 COVERED SERVICES** *(cont.)*

E. training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member;

F. training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of members; and

G. transmission of data required for use of the Assistive Technology Device via internet or cable utility.

Assistive Technology Services excludes duplicate services available under the State Plan subject to §18.06-7. The components above are subject to the following limits:

* + - The Assistive Technology Device and services described above in paragraphs (B) and (C) are subject to a combined limit of $6,000.00 annually.
    - The services described above in paragraphs (A), (D), (E) and (F) are subject to a combined limit of 32 units (8 hours) annually.
    - The data transmission utility costs described above in paragraph (G) are limited to $50.00 per month.

**18.05-2 Care Coordination Service**- consists of a conflict-free service that assist members in gaining access to needed waiver and State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is sought. Care Coordination Services also include responsibility for assisting the member to access and coordinate natural supports, and monitoring and assurance of the implementation of the Care Plan. This includes monitoring of the health, welfare and safety of the member. This service requires face-to-face contact between the Care Coordinator and the member, at a minimum, every thirty days. A member who has this service may not receive duplicative care coordination services including, but not limited to, Section 13, “Targeted Case Management Services”; Section 91, “Health Home Services”; Section 92, “Behavioral Health Home Services”; or similar such services under the State Plan.

**18.05-3** **Career Planning**-Career planning is a person-centered, comprehensive employment planning and direct support service that provides assistance for a waiver program participant to obtain, maintain or advance in competitive employment or self-employment at or above the State’s minimum wage. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the State’s minimum wage. The outcome of this service is documentation of the participant’s stated career

**18.05 COVERED SERVICES** *(cont.)*

objective and a career plan used to guide individual employment support. This service assists in identifying skills, priorities, and capabilities determined through an individualized discovery process. This may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, development of experiential learning opportunities and career options consistent with the participant’s skills and interests. Career Planning may be used in preparation to gather information to be used as part of a referral to Vocational Rehabilitation.

Career planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. §1401(16 and 17).

Career Planning is limited to 60 hours annually, to be delivered in a six-month period. No two six-month periods may be provided consecutively. Career Planning services must have the long-term goal of individual, competitive, integrated employment for which the member is compensated at or above the minimum wage. In order to receive Career Planning services, the member’s Care Plan must identify specific career goals and describe how the Career Planning services will be used to achieve those goals.

Career Planning services can be provided within a variety of community settings such as a Career Center, the community and local business and must be documented in the Care Plan with related goals.

**18.05-4 Community/Work Reintegration** is an integrated clinical service to improve the member’s ability to successfully integrate into his or her current or desired community and/or work setting. The service includes compensatory interventions and treatment focused on functional improvement and reinforcement of community and work reintegration for the member. Specifically, the treatment is based on the clinical needs of the member as defined by their current Mayo Portland Adaptability Inventory. Individual functional goals are defined based on these identified needs. These treatments are provided on a 1:1 and group basis. Group services are coded with HQ and may be provided in groups up to 6 participants.

**18.05-5 Employment Specialist Services**- consists of services necessary to support a member in maintaining employment. Services include:

A. periodic interventions on the job site to identify a member’s opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion;

**18.05 COVERED SERVICES (cont.)**

B. assistance in transitioning between employers when a member’s goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job. The need for continued Employment Services must be documented in the Care Plan as necessary to maintain employment over time; and

C. For Job Development, if Vocational Rehabilitation denies services under the Rehabilitation Act and the member is unable to benefit from Vocational Rehabilitation then the member may receive Employment Specialist Services for job development. If Employment Specialist Services are used for job development, current documentation of ineligibility from Vocational Rehabilitation is required.

Employment Specialist Services are provided by an Employment Specialist who may work either independently or under the auspices of a Supported Employment agency.

Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. Employment

Specialist Services may be utilized to assist a member to establish and or sustain a business venture that is income-producing. MaineCare funds may not be used to defray the expenses associated with the start-up or operating a business.

A member may not receive Employment Specialist Services while enrolled in high school.

The cost of transportation related to the provision of Employment Specialist Services is a component of the rate paid for the service and is not separately billable.

A member cannot receive these services while working under a Special Minimum Wage Certificate issued by the Department of Labor under the *Fair Labor Standards Act*.

Employment Specialist Services cannot be provided at the same time as Work Support Services.

**18.05-6 Home Support Services-** There are four types of Home Support Services:

**A.** **Home Support Services** **(1/4 hour) Level I**- consist of services for a member who does not require 24/7 care; the services may be provided in the member’s home. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development,

**18.05 COVERED SERVICES (cont.)**

assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs.

These supports also include personal care and protective oversight and supervision.

**B. Home Support Services (Per Diem) Level II**-consist of services for a member who requires 24/7 care typically provided in a provider- owned facility with not more than 8 members. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community as defined in the Care Plan. The Care Plan will specify the minimum number of 1:1 direct support hours a member needs on a daily basis. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs.

These supports also include personal care and protective oversight and supervision.

**C. Home Support Services (Per Diem) Level III**- Home Support (Residential Habilitation) Level III- Increased Neurobehavioral- consist of services for a member who requires 24/7 care typically provided in a provider-owned facility with not more than 8 members. This service is for members who have an increased clinical need relating to their behaviors associated with their brain injury. To qualify for Home Support Services Level III, a member must have at least a score of 0.5 on the Department Approved Health and Safety Assessment. The service is intended for members who are not typically successful without structured services in an individually tailored setting, and who typically are not successful in group settings. The service includes neurobehavioral treatment specific to the individual’s needs, as well as personal care and protective oversight and supervision. The Care Plan will specify the minimum number of 1:1 direct support hours a member needs on a daily basis. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs.

**18.05 COVERED SERVICES** *(cont.)*

Home Support (Residential Habilitation) Level III is an intensive neurobehavioral level of treatment. The rate for this service is all inclusive and therefore, includes the treatment of cognitive and behavioral clinical needs for the Member as part of the rate. A member who has this service may not receive Self/Home Reintegration, Work/Community Reintegration, or Work Ordered Day Club House as separate services.

**D. Home Support Services (Remote Support)** - consist of services for a member who does not require face-to-face care but would benefit from electronic communication to ensure health and safety. The service is designed to work in concert with Home Support Services (1/4 hour) to provide habilitation support and to assist the member in achieving the most integrated setting possible and increase the member’s independence through assistive technology. Whereas members served under this waiver have limitations that inhibit their ability to communicate, control their environment, and maintain their personal safety, this service provides real- time remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, door, temperature, smoke, carbon monoxide, etc.), video cameras, microphones and speakers, as well as health monitoring equipment. This assistive technology links each member’s residence to the residential service provider. The residential service provider must have staff available 24 hours per day 7 days per weeks to deliver direct 1:1 care when needed. Two levels of emergency back-up are required for any Care Plan that includes Home Support Services (Remote Support).

The use of this service is based upon the member’s assessed needs and the resulting Care Plan. The Care Plan must reflect the member’s and, where applicable, his or her guardian’s informed consent and commitment to the Care Plan elements including all assistive communication, environmental control and safety components. A thorough evaluation of all Assistive Technology must be completed prior to the finalization of the Care Plan with the assistance of the Care Coordinator and use of appropriate Assistive Technology consultants. The member must be provided educational support in order to fully understand the risks and benefits of all elements of the Care Plan and this must be documented and acknowledged by the member served. All assistive devices and systems must allow the member served to “opt out.” The member must be informed as to the methods for ending a service, either on a short-term basis or permanently. These options must be delineated in the member’s Care Plan. If a member served experiences a change in support needs or status, the provider must immediately adjust the direct support services to meet those needs.

**18.05 COVERED SERVICES (cont.)**

All Remote Support Services must be provided in real time. All electronic systems must have back-up power connections to insure functionality in case of loss of electric power. Providers must comply with all federal, state and local regulations that apply to its business including but not limited to the “Electronic Communications Privacy Act of 1986”.

Any services that use networked services must comply with HIPAA requirements.

Remote Support has two components, Monitor only and Interactive Support. Monitor only means that the member is being electronically monitored for over sight and supervision purposes. Interactive Support means that the member and the staff person monitoring the member electronically are interacting back and forth with the use of cameras or other approved devices.

Payment is not made under this section for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

A provider may provide Home Support to more than one member at a time.

The cost of transportation related to the provision of Home Support is a component of the rate paid for the serviceand is not separately billable.

**18.05-7** **Non-Medical Transportation Services** consists of services to enable members to gain access to certain Section 18 Covered Services, as specified by the Care Plan. Transportation services for Section 18 services are provided under the *MaineCare Benefits Manual*, Section 113, “Non-Emergency Transportation Services”. Whenever possible, family, friends or community agencies, which can provide this service without charge, must be utilized.

A provider may only be reimbursed for providing transportation when the cost of transportation is not a component of a rate paid for another service.

**18.05-8 Self Care/Home Management Reintegration** is an integrated clinical service to improve the member’s ability to care for him/herself successfully and/or manage his/her home setting successfully. The service that includes compensatory interventions and treatment focused on functional improvement and reinforcement of self-care and home management reintegration for the member. Specifically, the treatment is based on the clinical needs of the member as defined by their current Mayo Portland Adaptability Inventory. Individual functional goals are defined based on these identified needs. Group services are coded with HQ and may be provided in groups of up to 6 participants.

**18.05 COVERED SERVICES** *(cont.)*

**18.05-9 Work Ordered Day Club House** is a set of services provided at a community-based facility, referred to as a “Club House,” that assist members with community reentry, the rebuilding of social relationships and the training of skills required to return to productive activity. The Work Ordered Day Club House is designed to help individuals build skills specific to a work environment.

This Service specializes in treatment techniques for members with acquired brain injuries. Providers of Services develop and provide staff training, which focuses on the needs of individuals with an acquired brain injury identified in the Care Plan, and the specific manner in which this service will meet the member’s individual needs. The program focuses on adaptive skills and is distinct from work production objectives. These services are provided during the day through programs that are

offered at facilities within the community. At the end of each day, the member returns to his/her home.

**18.05-10** **Work Support Services-**consist of intensive, ongoing supports that enable members, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting, to work in a regular work setting. Work Support Services may include assisting the member to locate a job or developing a job on behalf of the member. Work Support Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Work Support Services includes activities needed to sustain paid work by members, including supervision and training. When Work Support Services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving waiver services as a result of their disabilities and not for the supervisory activities rendered as a normal part of the business setting.

This service is only available in the absence of a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. §§1401 *et seq*.). Members cannot receive these services while working under a Special Minimum Wage Certificate issued by the Department of Labor under the Fair Labor Standards Act.

Documentation must be maintained in the file of each member receiving this service that the service is not available under such a program.

Work Support Services may not be used for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

A. Incentive payments made to an employer to encourage or subsidize the employer's participation in Work Support Services; or

**18.05 COVERED SERVICES** *(cont.)*

B. Payments that are passed through to users of Work Support Services; or

C. Payments for training that is not directly related to an individual's Work Support Services.

Work Support Services must be delivered on an individualized basis and not in a group format.

The cost of transportation related to the provision of Work Support Services is a component of the rate paid for the service and is not separately billable.

**18.06 NONCOVERED SERVICES**

Services for which reimbursement is not allowed under this Section include, but are not limited to, the following:

**18.06-1** Services not authorized by the Care Plan.

**18.06-2** Services to any member who is hospitalized, a nursing facility resident, or ICF/IID resident.

**18.06-3** Any service otherwise reimbursable under the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act*, including but not limited to job development and vocational assessment or evaluations.

**18.06-4** Room and board. The term “room” means shelter-type expenses, including all property-related costs, such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day or any other full nutritional regimen.

**18.06-5** Services provided directly or indirectly by the legal guardian, spouse, or a relative of the member.

**18.06-6** Work Support when the member is not engaged in employment.

**18.06-7** Assistive Technology unless the service has been determined non-reimbursable under Section 60, “Medical Supplies and Durable Equipment”, the State Plan and/or other sections of the *MaineCare Benefits Manual*.

**18.06-8 Non-Duplication of Services**

Services as defined under this section if the member is receiving comparable or duplicative services under this or another section of the *MaineCare Benefits Manual*. A member may not receive services under this section, if the member is

**18.06 NONCOVERED SERVICES** *(cont.)*

in a residential treatment facility or if the member is receiving services in an institution, including, but not limited to Section 2, “Adult Family Care Services”; Section 13, “Targeted Case Management Services”; Section 45, “Hospital Services”; Section 46, “Psychiatric Hospital Services”; Section 50, “ICF/IID Services”; Section 67, “Nursing Facility Services” and Section 97, “Private Non-Medical Institution Services”. A member may not receive services if they are in another Home and Community Based Waiver such as Section 19, “Home and Community-Based Benefits for the Elderly and for Adults with Disabilities”, Section 20, “Home and Community Based Services for Adults with Other Related Conditions”, Section 21, “Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder”, Section 22, “Home and Community Benefits for the Physically Disabled”, Section 29, “Support Services for Adults with Intellectual Disabilities or Autistic Disorder” and Section 32, “Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders”.

**18.07 LIMITS**

The following service limits apply to each member:

**18.07-1 Assistive Technology Services**- Assistive Technology Services are limited to as described in the covered service 18-05-1. Each system or device will be revised based on medical necessity, efficiency and meets compatibility with safety needs.

**18.07-2 Care Coordination Services**- Care Coordination Services are limited to 400 units for the first year in which the member receives services under this Section and 200 units every year after the initial year. The Care Coordination provider may not offer any other services to the member under this Section.

**18.07-3 Career Planning-**The maximum annual allowance is 60 hours to be delivered within a six month period. No two six month periods may be provided concurrently. Career Planning may not be provided at the same time as Home Support, Employment Specialist Services or Work Support.

**18.07-4** **Community/Work Reintegration-**A member may have up to 72 units per week of either Community/Work Reintegration, Self Care/Home Management Reintegration

or any combination of both. A member may not also access the state plan service in the *MaineCare Benefits Manual*, Section 102, “Rehabilitative Services”.

* + 1. Home Support Services - are limited as follows:

A. Home Support Services (1/4 hour) Level I- are limited to 64 units per day.

B. Home Support Services (Remote Support) - are limited to 64 units per day.

**18.07 LIMITS (cont.)**

C. Home Support Services (Increased Neurobehavioral) Level III per diem - Members receiving this service are not authorized to have Self/Home Management Reintegration, Work/Community Reintegration, or Work Ordered Day Club House as separate services.

**18.07-6 Self Care/Home Management Reintegration-** A member may have up to 72 units per week of either Community/Work Reintegration, Self Care/Home Management Reintegration or any combination of both. A member may not also access the state plan service in the *MaineCare Benefits Manual*, Section 102, “Rehabilitative Services”.

**18.07-7 Work Ordered Day Club House-** Members may attend Work Ordered Day Club House 3 days a week, per diem (3-5 hours a day).

**18.07-8 Work Support** **Services**-Work Support Services are limited to 64 units per week, not to exceed 3328 units per service year.

**18.07-9** **Section 18, “Home and Community Based Services for Adults with Brain Injury”,** may not be provided in a residence where other Home and Community Based Waiver services are provided. Exceptions to this limit will be considered on a case-by-case basis by the Department. Consideration of this exception will be contingent on the member’s Care Plan ensuring that all identified services will be delivered without compromising the quality of care, and on all aspects of the costs of services being clearly delineated in order to demonstrate that there is not blending of financial benefits between the members served.

**18.08 DURATION OF CARE**

**18.08-1 Voluntary Termination**- A member who currently receives the benefit, but no longer wants to receive the benefit, will be terminated from waiver services, after DHHS receives written notice from the member that he or she no longer wants the benefit.

**18.08-2 Involuntary Termination**- DHHS will give written notice of termination from waiver services to a member at least thirty (30) days prior to the effective date of the termination, providing the reason for the termination, and the member’s right to appeal such decision. A member may be terminated from this benefit for any of the reasons listed below:

A. The member has been determined to be financially or medically ineligible for this benefit;

B. The member has been determined to be a nursing facility resident or ICF/IID resident without an approved Care Plan to return to his or her home;

**18.08 DURATION OF CARE (cont.)**

C. The member has been determined to be receiving MaineCare services from another Home and Community Based Waiver benefit;

D. The member is no longer a resident of the State of Maine;

E. The health and welfare of the member can no longer be assured because:

1. The member or immediate family, guardian or caregiver refuses to participate in Care Planning or abide by the Care Plan or other benefit policies;

2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of harm or injury to the member or to individuals providing covered services to the member; or

3. There is no approved Care Plan.

F. The member has not received at least one service in a consecutive thirty (30) day period;

G. The estimated annual cost of the member’s services under the waiver is equal to or less than one hundred percent (100%) of a blended rate of the statewide average annual cost of care for individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and Nursing Facility Brain Injury units, as determined by DHHS (the blended rate being the sum of 20% of the statewide average annual cost of care in an ICF/IID and 80% of the statewide average annual cost of care in a Nursing Facility Brain Injury unit).

**18.08-3 Suspension of Services**- Services may be suspended for up to thirty (30) days if requested by the member and approved by DHHS. If such circumstances extend beyond 60 day**s**, the member’s service coverage under this section will be terminated and the member will need to be reassessed to determine medical eligibility for these services.

**18.09 RECORDS**

Each provider serving the member must maintain records for each member it serves in accordance with the requirements of Chapter I of the *MaineCare Benefits Manual*. The member’s records are subject to DHHS’s review.

**18.09 RECORDS** *(cont.)*

The member’s records must contain:

A. The member's name, address, birth date, and MaineCare identification number;

B. The member's social and medical history, and diagnoses;

C. The member’s Care Plan;

D. The member’s most recent Mayo Portland Adaptability Index;

E.A summary of authorized services; and

F. Written progress notes that identify any progress toward the achievement of the goals, identify activities and identify needs established by the member’s Care Plan. Written progress notes must be signed and dated by the staff performing the service.

The provider must document each service provided including: the date of each service, the type of service, the activity, the need or goal to which the service relates, the length of time of the service, and the signature of the individual performing the service.

DHHS will conduct a review of provider records that may include, but is not limited to, staff schedules, payroll records and member records to substantiate service delivery and units of authorization.

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS**

To provide services under this section a provider must be a qualified vendor as approved by DHHS and enrolled by the MaineCare program. Once a provider has been authorized to provide services, the provider cannot terminate the member’s services without written authorization from DHHS. Written documentation of all certifications, and licensure requirements and date of hire must be contained in a personnel file.

In order for services to be reimbursable, a Provider must meet the following standards:

**18.10-1** **Assistive Technology Services**-In order to provide Assistive Technology Services, a provider must be an OADS-approved agency and the individual providing the services must meet one of the following training requirements:

A. A Licensed Occupational Therapist licensed under MRSA title 32, ch. 32; or

B. A Licensed Speech Pathologist licensed under MRSA title 32, ch. 137; or

C. A certified Direct Support Professional (DSP) as detailed in 18.10-5 who is also certified as a Rehabilitation Engineering Technologist (RET) or an Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

**18.10-2** **Care Coordination Services**- In order to provide Care Coordination Services, a provider must be an OADS-approved, CARF-accredited agency consistent with the requirements of Section 18.10-13 and employ staff who are Certified Brain Injury Specialist (CBIS) certified consistent with the requirements of Section 18.10-14 or other Department approved curriculum within the first 12 months of employment and be a:

1. A Registered Nurse; or

B. A Licensed Occupational Therapist; or

C. A Licensed Social Service or health professional with four years of education in health or social services field and one year of community experience in providing direct behavioral health service.

**18.10-3** **Career Planning** – In order to provide Career Planning Services, a provider must be an OADS-approved Provider Agency and the individual providing the service must meet one of the following training requirements and must have completed an additional 6 hours of Career Planning and Discovery training provided through Maine’s Workforce Development System:

1. Certificate of completion Maine’s Direct Support Professional Curriculum as detailed in 18.10-5; or

1. Employment Specialist National Certification approved by the Association of Community Rehabilitation Educators (ACRE).

**18.10-4 Employment Specialist Services** - In order to provide Employment Specialist **Services**, a provider must be an OADS-approved Provider Agency and the individual providing the services must be nationally certified by the Association of Community Rehabilitation Educators (ACRE) and maintain that certification through meeting ongoing continuing education requirements.

**18.10-5** **Home Support Level I, Level II, and Level III and Remote Support-** In order to provide Home Support Services, a provider must be an OADS-approved Provider Agency and must have Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation (or provisional certification), consistent with the requirements of Section 18.10-13, in the Home and Community Services, Residential Services and Brain Injury Modules. All staff providing Home Support Services must:

1. Meet one of the following training requirements:

1. **Direct Support Professional (DSP)**

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

To qualify as a Direct Support Professional, an individual must successfully complete the Direct Support Professional curriculum as adopted by DHHS**,** or demonstrated proficiency through DHHS’s approved Assessment of Prior Learning, or successfully complete the curriculum from the Maine College of Direct Support (CDS) within six (6) months of date of hire. The Maine College of Direct Support is accessed on the internet at: <http://www.maine.gov/dhhs/oads/disability/ds/cds/index.shtml>;

Or

2. **Personal Support Specialist (PSS)**

To qualify as a Personal Support Specialist an individual must meet one of the training and examination requirements below. An individual without the required training may be hired and reimbursed for delivering personal care services as long as the individual enrolls in a certified training program within sixty (60) days of hire and completes training and examination requirements within nine months of employment and meets all other requirements. If the individual fails to pass the examination within nine months, reimbursement for his or her services must stop until such time as the training and examination requirements are met. A PSS must 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-base examination of didactic and demonstrated skills. The training course must include at least 50 hours of formal classroom instruction, demonstration, return demonstration, and examination. Tasks covered under this Section must be covered in the training;

**AND**

1. Be a Certified Brain Injury Specialist or have completed equivalent training, as set forth in Section 18.10-14, within the first 12 months of employment; and
2. Be at least 18 years of age; and
3. Have graduated from high school or acquired a GED; and
4. Have completed Reportable Events Training; and
5. Have completed a Department approved Behavior Regulations Training ; and

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

1. Have an adult protective and child protective record check; and
2. Have a background check consistent with 18.10-9.

Documentation of completion must be retained in the personnel record.

**18.10-6 Self Care/ Home Management Reintegration and Community/ Work Reintegration-** In order to provide Self Care/Home Management Reintegration or Community Work Reintegration Services, a provider must be an OADS-approved Agency and must have Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation (or provisional certification), consistent with the requirements

of Section 18.10-13, in the Outpatient Medical Rehabilitation, section 2-Medical Rehabilitation, Home and Community Based Services and Brain Injury modules. All staff providing Self Care / Home Management Reintegration or Community / Work Reintegration Services must:

1. Meet one of the following training requirements:
   * + 1. Licensed Social Worker (LSW) as licensed under MRSA title 32, ch. 83; or
       2. Licensed Clinical Social Worker (LCSW) as licensed under MRSA title 32, ch. 83; or
       3. Licensed Clinical Professional Counselor (LCPC) as licensed under MRSA title 32, ch. 119; or
       4. Licensed Occupational Therapist as licensed under MRSA title 32, ch. 32; or
       5. Certified Occupational Therapy Assistant (COTA) as certified under MRSA title 32, ch. 32; or
       6. Mental Health Rehabilitation Technician-Certified (MHRT-C); or
       7. Health Professional with a 4 year degree; or
       8. Licensed Neuropsychologist as licensed under MRSA title 32, ch. 56; or
       9. Certified Therapeutic Recreation Specialist (CTRS); AND

B. Be a Certified Brain Injury Specialist or have completed equivalent training, as set forth in Section 18.10-14, within the first 12 months of employment; and

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

C. Be at least 18 years of age; and

D.Have a background check consistent with 18.10-9.

**18.10-7 Work Ordered Day Club House** - In order to provide Work Ordered Day Club House Services, a provider must be an OADS-approved Provider Agency and must have Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation (or provisional certification), consistent with the requirements of Section 18.10-13, in the Home and Community Services and Brain Injury Modules. All staff providing Work Ordered Day Club House Services must:

A. Meet one of the following training requirements:

* 1. Licensed Social Worker as licensed under MRSA title 32, ch. 83; or
  2. Licensed Clinical Social Worker as licensed under MRSA title 32, ch. 83; or
  3. Licensed Clinical Professional Counselor as licensed under MRSA title 32, ch. 119; or
  4. Licensed Occupational Therapist as licensed under MRSA title 32, ch. 32; or
  5. Certified Occupational Therapy Assistant (COTA) supervised by a Licensed Occupational Therapist; or
  6. Certified Therapeutic Recreation Specialist (CTRS); or
  7. Mental Health Rehabilitation Technician-Certified (MHRT-C); or
  8. Health Professional with a 4 year degree; or

9. Licensed Neuropsychologist as licensed under MRSA title 32, ch. 56; or

10. Certified Therapeutic Recreation Specialist (CTRS); AND

B. Be a Certified Brain Injury Specialist or have completed equivalent training, as set forth in Section 18.10-14, within the first 12 months of employment; and

C. Be at least 18 years of age; and

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

D. Have a background check consistent with 18.10-9.

**18.10-8 Work Support-** In order to provide Work Support, a provider must be an OADS Approved Provider Agency and must have Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation (or provisional certification), consistent with the requirements of Section 18.10-13, in the Outpatient Medical Rehabilitation, Section 2 - Medical Rehabilitation, Home and Community Based Services and Brain Injury modules. All staff providing Work Support Services must:

1. Meet one of the following training requirements:

1. Certificate of completion of Maine’s Direct Support Professional (DSP) Curriculum as detailed in 18.10-5(A)(1); or

2. Personal Support Specialist (PSS) as detailed in 18.10-5(A)(2); and

A DSP who also provides Work Support must have completed the additional employment modules in the Maine College of Direct Support (CDS) in order to provide services.

Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification.

AND:

B. Be a Certified Brain Injury Specialist or have completed equivalent training, as set forth in Section 18.10-14, within the first 12 months of employment; and

C. Be at least 18 years of age; and

D. Have a background check consistent with 18.10-9; and

E. Completed Reportable Events Training; and

F. Completed a Department approved Behavior Regulations Training.

**18.10-9** **Background Check** **Criteria**- Providers must conduct criminal and child and adult protective services background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Section. Background checks on persons professionally licensed by the State of Maine must include a confirmation that the licensee is in good standing with the appropriate licensing board or entity.

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this section if that person has a record of:

A. any criminal conviction that involves abuse, neglect or exploitation;

B. any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;

C. any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection with any victim; or

D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any criminal conviction based upon reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two (2) years; or

E. any criminal conviction within Title 29-A, chapter 23, subchapter 2, article 1, or Title 29-A, chapter 23, subchapter 5.

Employment of individuals with records of such convictions more than five (5) years prior to the time of the background check is a matter within the provider's discretion after consideration of the individual's criminal record in relation to the nature of the position. The member receiving services must be prior notified and approve the receipt of services from such staff in writing if the provider decides to hire a staff person with a conviction.

The provider shall contact child and adult protective services (including the Office of Aging and Disability Services) units within DHHS, within the parameters of current applicable state and federal law, 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 child or adult protective services investigation substantiating abuse, neglect or exploitation by a prospective employee of the provider, it is the provider’s responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards.

**18.10-10** **Informed Consent Policy**

Providers must put in place and implement an informed consent policy approved by the Department. For the purposes of this requirement, informed consent means consent obtained in writing from a member or the member's legally authorized representative for a specific treatment, intervention or service, following disclosure of information adequate to assist the person in making the consent. Such information

may include the diagnosis, the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and consequences of the procedure(s)

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

or service(s), an assessment of the likelihood that the procedure(s) or service(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided.

At a minimum, a provider’s informed consent policy must ensure that members served by the provider (and their guardians, where applicable) are informed of the risks and benefits of services and the right to refuse or change services or providers.

**18.10-11 Reportable Events**

Providers shall comply with all terms and conditions of the Department’s Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings**.** All staff must receive training in mandatory reporting/reportable events before they provide any services under this waiver.

**18.10-12 Requirements for Residential Settings Owned or Controlled by a Provider**

Where the member receives Home Support Services in a residential setting owned or controlled by the provider, the provider must ensure that the following requirements are met:

1. The member must occupy the residence pursuant to a lease or other written, legally enforceable agreement providing comparable protections, including eviction and appeal processes required under Maine law;
2. The member must have privacy in his or her unit, including doors lockable by the member, with only appropriate staff having keys to such doors;
3. Where members share a unit, each member must have choice of roommates;
4. The member must have the freedom to furnish or decorate the unit;
5. The member must control his or her own schedule and activities;
6. The member must have access to food at any time;
7. The member must be allowed to receive visitors of his or her choosing at any time; and
8. The setting must be physically accessible.

These requirements may only be modified where necessary to respond to a specific assessed need. Modifications require clinical documentation supporting the need, and must be identified and justified in the Care Plan.

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

**18.10-13** **CARF Accreditation**

A. **Accreditation**

Where CARF accreditation is required, the provider must either be accredited by the Rehabilitation Accreditation Commission (CARF) to provide brain injury rehabilitation services (other than vocational services, which are not covered by MaineCare,) or otherwise have an eighteen (18)-month provisional certification from the Maine Department of Health and Human Services to cover the period the provider is working to secure CARF accreditation. The Department is responsible for determining compliance with the provisional certification standards in Appendix I of this Section. A copy of the Department-issued provisional certification, or evidence of current CARF accreditation, must be on file with the MaineCare Services. Additionally, the provider must also supply the Department with a copy of the current CARF accreditation survey and if applicable, any plans of corrections.

1. Accreditation Maintenance

Providers must maintain CARF accreditation to receive MaineCare reimbursement. CARF accreditation is for a specified period of time and requires periodic review and approval. To maintain accreditation beyond the expiration date, a provider must be resurveyed by CARF by the expiration date or be in the process of a resurvey by the expiration date. Evidence that the resurvey visit has been scheduled can indicate that the resurvey process is underway, as long as the visit was scheduled prior to the expiration date. MaineCare reimbursement will be subject to recoupment, back to the day on which accreditation expired, if CARF accreditation is denied. The facility must provide to the office listed below written evidence of the scheduled CARF survey visit. Evidence of current CARF accreditation, upon receipt, must also be submitted to this office:

Provider File Unit

MaineCare Services

11 State House Station

Augusta, ME 04333-0011

AND

Office of Aging and Disability Services-Brain Injury Services

11 State House Station

Augusta, ME 04333-0011

C. **Clinical Director**

Each provider requiring CARF accreditation must have a written agreement for services with a clinical director, or shall employ a physician, a neuropsychologist, and other professional personnel to assure appropriate

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

supervision, medical review, and approval of services provided. The clinical director must have responsibility for the overall management of the service and have two (2) years’ experience in the rehabilitation of individuals with brain injury, as well as have management and specific training that will enable the director to understand and respond to the unique needs of individuals with brain injuries. The clinical director must be actively involved in the service and provide oversight for day-to-day operations.

D. **Adding Services**

If a Provider plans to add a new Brain Injury service component that will require additional CARF accreditation (CARF requires new services to be delivered for at least six (6) months prior to a survey visit), the provider may receive MaineCare reimbursement for these new services while working toward CARF survey and certification, so long as the Department is notified in writing at least two (2) months in advance of the intent to seek CARF certification and the date services will start. Additionally, the CARF survey visit must be scheduled prior to the end of the six (6) month period, i.e. a survey visit must be scheduled, not necessarily completed, and the Department notified in writing of the CARF survey appointment date. Reimbursement for the new service component will be subject to recoupment, back to start date of the new services, if CARF accreditation is denied.

**18.10-14 General Requirements for Services Requiring CBIS or equivalent**

A. **Staff Requirements**

All staff will have expertise in brain injury rehabilitation as demonstrated by achieving the Certified Brain Injury Specialist (CBIS) designation from the Academy of Certified Brain Injury Specialists (ACBIS) or demonstrating competency through an approved equivalent training program supervised by the provider. New staff will achieve CBIS or demonstrate equivalent competency within twelve (12) months from date of hire.

B. **Equivalent Training Option**

If an equivalent training program is used, the provider must submit documentation and receive approval from the Department (Brain Injury Services) for this program. The provider must demonstrate the equivalency of its alternate training and evaluation methods used to determine the staff member’s competence in brain injury rehabilitation.

**18.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** *(cont.)*

The provider will submit a detailed curriculum, training and evaluation plan to the Department for review and approval prior to implementation of an equivalent training program. The provider must seek reevaluation of equivalent training programs from the Department on an annual basis. Documentation of plan approval and results of all training and evaluation of staff will be maintained by the provider for Department inspection. Equivalent training programs will be evaluated and approved by the Department based on the following:

1. **Curriculum** - must cover all of the content areas of the CBIS course; and

2. **Evaluation** - assessment methods used to determine the staff member’s competence in brain injury rehabilitation including some form of written test; and

3. **Continuing Education Requirements** – must have at least 10 hours of continuing education credits for staff each year.

C**. Maintenance of Records**

A roster of provider staff, their CBIS (or equivalent) status, date of hire, and professional license status (type, number & standing) if applicable, will be submitted to the Department (Brain Injury Services) annually.

**18.11 BEHAVIORAL INTERVENTIONS**

A provider of services under this Section must comply with the following provisions in planning for and carrying out any intervention to correct or modify a member’s behaviors.

**18.11-01 Process for Review and Approval of Behavioral Interventions**

Use of a particular intervention to change or eliminate a specific behavior of a member requires a written plan, incorporated within the member’s Care Plan, that is developed, reviewed, and approved as follows.

1. Functional Behavior Assessment: The use of an intervention must always be preceded by a Functional Analysis of Behavior and documented efforts to address the dangerous or maladaptive behavior by the use of positive techniques or less intrusive approaches, which have been tried systematically and determined to be ineffective.
2. Clinician Input: An intervention that is mildly or moderately intrusive as defined in section 18.11-02, must be developed and approved by a licensed

**18.11 BEHAVIORAL INTERVENTIONS** *(cont.)*

clinician who has direct experience working with individuals with a brain injury and is approved by the DHHS Program Manager for Brain Injury.

1. Planning Team Review: A planning team must meet to review proposed interventions and approve their use. The planning team must include: (1) the individual and guardian, where one has been appointed; (2) the Care Coordinator, who will be responsible for coordinating the inclusion of any other relevant individuals; and (3) representatives from every site at which the behavioral treatment procedure is to be implemented. Prior to approval, the team must evaluate factors that may be contributing to the occurrence of the behavior, which may include:

1. Illness, Disease, Medication Interaction;

2. Impact of brain injury on behavior;

3. Psychiatric conditions; and

4. Significant life events.

In the event that factors such as those listed above exist, the planning team may still determine that a behavioral plan is indicated, but the planning team shall include, as part of the plan, its rationale for so deciding.

1. Documentation in Care Plan: The behavioral intervention procedure must be documented in the Care Plan, and must include all of the following elements:

1. A concise and accurate identification and description of the specific behavior(s) to be addressed and the behavioral goal;

2. A Functional Analysis of Behavior including the history of the behavior and what positive methods have been utilized in the past;

3. A description of the baseline measurements of the frequency, duration, intensity and/or severity of the behavior(s);

4. A concise and precise description of the methodology for consistently implementing the plan;

5. A description of the means of recording and measuring of the frequency, duration, intensity and/or severity of episodes of the specific behavior(s) and the use of interventions;

6. A schedule for periodic review by the planning team of the plan which shall be at least semiannually;

**18.11 BEHAVIORAL INTERVENTIONS** *(cont.)*

7. Criteria for the discontinuation of the plan, whether because it has been successful, its continued implementation is unlikely to be successful, or it is causing the individual more harm than benefit. There may be behavioral plans which show slow progress. These plans may require implementation and monitoring over an extended period of time.

1. Department Oversight Committee Review: All Plans involving mildly or moderately intrusive interventions require review and approval by a Department oversight committee consisting of the Program Manager of Brain Injury Services and at least two other Department staff with expertise in the behavioral health field. Review shall be conducted both initially and on a semi-annual basis.
2. Written Consent: The intervention must be approved, in writing, by the individual or by the guardian, when one has been appointed. Such written consent must be incorporated within the Care Plan. Withdrawal of approval requires immediate termination of the intervention.

**18.11-02 Categories of Behavioral Interventions**

1. Positive Behavioral Supports
2. Positive behavioral supports are those which are directed toward reducing an individual’s maladaptive behavior, but which do not entail

any limitations upon the individual’s rights. Examples of such interventions include but are not limited to:

1. Rewarding positive behavior;
2. Rewarding the absence of dangerous behavior;
3. Modeling of appropriate behavior;
4. Environmental alteration;
5. Teaching of skills;
6. Teaching of Coping Skills, self-management, self-calming skills; and
7. Redirection.
8. Positive or neutral interventions may be used on an informal basis for individual safety or to promote a harmonious, supportive environment. The planning team must approve systematic use of an intervention.

**18.11 BEHAVIORAL INTERVENTIONS** *(cont.)*

1. Mildly Intrusive Interventions

1. Mildly intrusive interventions are characterized as those in which some form of limitation is imposed upon the individual, but the individual voluntarily complies with this imposition. Examples of mildly intrusive interventions include but are not limited to:

1. Non-exclusionary timeout;
2. Verbal reprimand; and
3. Extinction (withdrawal of attention or planned ignoring of the target behavior that is in response to the behavior that is disruptive but not harmful or destructive. This is a mildly intrusive intervention.)

2. An individual’s voluntary compliance in a mildly intrusive plan is essential. Coercion is not permitted. Even in cases where a guardian has approved a plan, implementation is predicated upon the individual’s voluntary compliance.

1. Moderately Intrusive Interventions

1. Moderately intrusive interventions are characterized by a greater degree of limitation being imposed upon the individual, but the individual voluntarily complies with this imposition. Examples of moderately intrusive interventions include, but are not limited to:

1. Overcorrection;
2. Token Economy;
3. Contingent Reinforcement using rewards based upon normal rights of access; and
4. Blocking.

2. An individual’s voluntary compliance in a moderately intrusive plan is essential. Coercion is not permitted, but planning teams must be mindful of the possibility of more extreme behavior if compliance is not achieved. Even in cases where a guardian has suggested a procedure, implementation is predicated upon the individual’s voluntary compliance.

**18.11-03 Prohibitions**

1. Prohibited Practices: The following procedures and interventions are expressly forbidden in all circumstances:
2. Intentional infliction of pain or injury;

**18.11 BEHAVIORAL INTERVENTIONS** *(cont.)*

1. The intentional instilling of fear, of pain or injury;
2. Actions or language intended to humiliate, dehumanize or degrade an individual;
3. Denial of basic rights including, but not limited to meals, sleep, adequate clothing, medications, medical treatment, and therapy; and
4. The use of experimental interventions or those without scientific basis or merit.
5. Violations: A service provider’s use of any of the above procedures will be cause for investigation and action by the Department, including, when appropriate, referral to a law enforcement agency, licensing authority or other similar oversight bodies.
6. Rights Limitations: Any limitation, whether actual or implied, upon an individual’s freedom of movement or exercise of a right is expressly forbidden unless there is a formal and approved portion of an individual’s Care Plan authorizing the rights limitations.
7. Unusual or Noxious Interventions: In unusual circumstances, a planning team may propose an unusual or noxious intervention in an attempt to assure the health and safety of an individual who is engaging in extremely dangerous behaviors. Unusual or noxious interventions must be denied unless the designer of the intervention shows to the Department Oversight Committee, by a preponderance of the evidence, why that program should be allowed. In order to be considered, the benefits of the intervention need to clearly outweigh the harm to the member.

**18.12 APPEALS**

In accordance with Chapter I of the *MaineCare Benefits Manual*, members have the right to appeal in writing or orally any decision made by DHHS to reduce, deny or terminate services provided under this benefit.

The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling Local: 207-287-6598, Toll Free: 1-800-606-0215 or TTY: 711.

Office of Aging and Disability Services

Department of Health and Human Services

11 State House Station

Augusta, ME 04333-0011

**18.13 REIMBURSEMENT**

Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 18, “Allowances for Home and Community Based Services for Adults with Brain Injury” or the provider’s usual and customary charge, whichever is lower.

In accordance with Chapter I, it is the responsibility of the provider to seek payment from any other insurance, including Medicare that is available for payment of the rendered service prior to billing MaineCare.

**18.14 BILLING INSTRUCTIONS**

Providers must bill in accordance with DHHS's Billing Instructions.

**18.15 QUALITY REPORTING**

In order to assure quality of care within the waiver services, DHHS requires providers to comply with all quality reporting requests. DHHS will develop and release a standard reporting form, which providers will be asked to complete and submit at regular intervals. At a minimum, the report will include the following information and supporting documentation:

A. **The Care Plan**: The provider must track and report data and documentation sufficient to establish that:

1. The provider’s services are meeting each member’s personal goals;

2. The provider’s services are meeting health and safety needs;

3. Each member is receiving all services outlined in the Care Plan;

4. Freedom of choice is offered both for services and provider selection; and

5. The Care Plan is reviewed and approved on an annual basis.

B. Copies of an annual Experience/Satisfaction Survey, on a form provided by the Department, completed on an annual basis by each member served by the provider.

C. Data and documentation sufficient to confirm that reportable events are reported by providers within the required timeframe.

**Appendix I**

**PROVISIONAL ACCREDITATION PROCESS**

The purpose of this Appendix is to describe the initial eighteen (18) month approval process for providers who are not ready to undergo the Rehabilitation Accreditation Commission (CARF) survey and certification and are requesting MaineCare reimbursement under this Section. The initial approval process is intended to assure the Maine Department of Health and Human Services that the applicant agency has a thorough understanding of the requirements of this Section, has sufficient clinical and administrative capability to carry out the intent of this Section, and has taken steps to assure the safety, quality, and accessibility of the service.

The Department will administer the initial approval process.

**Step #1 - Identification of Provider and Verification of the Provider's Intent to Undergo the Provisional Accreditation Process**

A. The director or administrator of the applicant agency must contact the Department to request the initiation of the process. The applicant agency's request must be accompanied by the following information:

1. Name of the agency (and the legal entity sponsoring the facility if different);

2. Address of the agency;

3. Name of agency contact person;

4. Telephone number of agency contact person; and

5. Estimated number of individuals to be served (service capacity).

B. The Department will start the review process. A representative of the Department will contact the agency within ten (10) working days of receipt of the identification information in order to:

1. Identify the Department’s representative assigned to carry out the review process;

2. Provide clarification regarding the process; and

3. Request written information to use in the document review phase of the process.

**Step #2 - Document Review**

This part of the process must be initiated at least thirty (30) days prior to the date when the agency proposes to provide services for MaineCare reimbursement under this Section. If the agency satisfies the requirements of this review, the Department will provisionally certify the agency for ninety (90) days from the first date of service for which MaineCare reimbursement is requested. In order to continue certification beyond this period, the agency must (during the ninety (90) day period) have undergone the on-site survey described in Step #3 of this Appendix and been granted continued approved status as a result of that review.

The following requirements must be satisfied to gain ninety (90) day provisional certification. Additionally, the provider must show it will be in compliance with the *MaineCare Benefits Manual* requirements.

A. Compliance with applicable legal requirements and regulations of all governmental and legally authorized agencies under whose authority the agency operates. These include, but are not limited to, those regulations regarding equal employment opportunity, state and federal wage hour regulations, health and safety codes, and affirmative action. The applicant must submit documents demonstrating compliance with such regulations.

B. Provision of documents providing the legal basis for the organization and identifying the members of the governing body or, in the case of a proprietary organization, the designated authority. The documents must identify the chief executive of the organization.

C. Provision of by-laws, or other applicable documentation, describing and governing the purpose, scope and activities of the organization.

D. A narrative history of the organization, which provides a brief history of the agency's activities.

E. A description of the agency's services, with particular attention to those governed by Section 18 of the *MaineCare Benefits Manual*. Service descriptions must include the purpose of each service and be written so as to govern the direction and character of each service.

F. The agency's criteria for admission/entrance to the service being reviewed.

G. Policies and procedures that address activities associated with member intake, assessment, individual planning, case coordination, and record keeping.

H. The agency's actual or projected staffing plan. This plan must identify staff providing covered services. There must be clear indication of which staff are actually employed by the agency at the time of Document Review.

I. Qualifications of all staff, consultants, independent contractors, trainees/interns, and volunteers.

J. Policies that address member rights and preserve confidentiality. These policies must meet the requirements of Chapter I of the *MaineCare Benefits Manual*.

K. Policies and procedures regarding quality assurance.

L. Proof of liability insurance covering the services reimbursed under this Section.

Within thirty (30) days of receipt of all information required by Step #2, the Department will issue a decision regarding the findings of the Document Review to the agency and to the Office of MaineCare Services. The finding will document all areas found to be non-compliant with the requirements of Step #2 and will stipulate corrective action, which must be accomplished to obtain 90-day provisional certification.

The agency must request an application for MaineCare enrollment from Provider File at the Office of MaineCare Services. Provider File will then process the agency application in order to begin MaineCare reimbursement after receiving the ninety (90) day provisional certification.

**Step #3 - On-Site Review**

Within ninety (90) days of the first date of service provided under this Section, the agency must have undergone an On-Site Review.

It will be the responsibility of the applicant agency to contact the Department’s representative who conducted the Document Review to arrange for the On-Site Review. The agency must request the On-Site Review at least thirty (30) days prior to the requested date of the Review.

The On-Site Review Team will consist of at least two (2) representatives of the Department of Health and Human Services. The team may also include a licensed practitioner of the medical profession with expertise in the area of brain injury rehabilitation. In the event the Department requires such a clinician as a member of the review team the costs of the clinician's services must be reimbursed by the agency being reviewed.

The On-Site Review will be scheduled for up to four (4) days. The reviewers will, through the inspection of the agency documents, interviews and observation, determine the extent to which the agency is in compliance with the policies and procedures previously submitted by the agency as well as the agency's compliance with all requirements of this Section of the *MaineCare Benefits Manual*. Particular attention will be given to items identified as requiring correction in the Document Review report.

The following represents the On-Site Review Team activities:

A. Orientation Session. The On-Site Review Team meets with agency staff and representatives of the governing body to clarify the purpose of the survey and explain each team member's role in the review. This is an opportunity for agency staff and representatives to ask questions about the process and provide files and records necessary to carry out the review. At this time the review team must be assigned a secure work space (where confidential material can be safely stored) and a separate area where interviews can be held. Staff interviews shall be arranged at this time.

B. A tour of the physical plant.

C. Record reviews, interviews with staff, board members, members, family members, representatives, or others, and program observation. The agency must post signs on a readily viewed area that the review is being performed and reviewers are available to meet with members in private, if requested.

D. On-Site Review Team meeting to coordinate findings and clarify questions requiring more attention.

E. Information gathering.

F. Exit interview with representatives of administration, the governing body, and staff. This is the agency's opportunity to question interpretations or findings of the Review Team. Any member or legal guardian who requests to attend the exit interview shall be allowed to do so.

The On-Site Review Team will write a report of its findings, including strengths and areas requiring improvement. The report will make recommendations regarding the continuation of provisional certification as well as listing corrective action the Team deems necessary. The report will be submitted to the Director of the Office of MaineCare Services and to Provider File at the Office of MaineCare Services within twenty (20) days of the completion of the On-Site Review. A copy of the report will be sent to the contact person at the applicant agency.

The Department will notify the agency of the decision regarding continuation or revocation of the agency's provisional certification status within ten (10) days of the receipt of the On-Site Review Team report. Agencies that fail to substantially meet the requirements outlined in Step #3 will have their provisional certification revoked. In the event of revocation, the Office of MaineCare Services will stop MaineCare reimbursement as of the date of revocation. Any agency that is denied the continuation of provisional certification may appeal this decision. The appeal process is defined in Chapter I of the *MaineCare Benefits Manual*.

All three (3) steps defined in this Appendix must be completed in order for the agency to receive the eighteen (18) month provisional certification.

The provisional certification will be awarded one time only, for a total of eighteen (18) months from the first date of service, including the ninety (90) day certification defined in Step #2 of this Appendix.

Complaints made to the Department regarding an agency that has a provisional certification or is in the process of receiving a provisional certification will be investigated. The Department must determine the validity of the complaint and must withdraw the provisional certification or discontinue the process of reviewing the agency for provisional certification; whichever is appropriate, if the Department determines that the health or safety of a member receiving services is in jeopardy.

In the event that the Department determines the applicant is out of compliance with the requirements of any applicable policy, or when non-compliant items represent a threat to the health, safety, or rights of members to be served under this policy, the Department must refuse or withdraw provisional certification to the applicant. In the event the provisional certification is refused or withdrawn, the Department’s decision may be appealed. Requests for hearings must be made, in writing, within ten (10) days of agency notification of an adverse decision. The appeal process is defined in Chapter I of the *MaineCare Benefits Manual*.

Each eligible program is allowed one eighteen (18) month provisional certification only. CARF accreditation must be obtained by the end of the eighteen (18) month provisional certification, or MaineCare will stop reimbursement until CARF accreditation is obtained.

If the application for CARF accreditation has been submitted and a review is scheduled, one three (3) month extension of the provisional certification will be granted by the Department.