

SECTION 63

**HOME BASED SUPPORTS AND SERVICES  
FOR OLDER AND DISABLED ADULTS  
ROUTINE TECHNICAL RULE/MAJOR SUBSTANTIVE RULE**

LAST UPDATED: 12/28/2024

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**63.01 INTRODUCTION**

Home Based Supports and Services (HBSS) for Older and Disabled Adults is a state funded program to provide long term care services to assist eligible Consumers to avoid or delay institutionalization. Provision of these services is based on the availability of funds. State funds furnished through 22 M.R.S. §§ 7301-06, 7321-23 and 34-B M.R.S. § 5439 may not be used to supplant the resources available from families, neighbors, agencies and/or the Consumer from other federal or state programs unless specifically provided for elsewhere in this Section. State HBSS funds shall be used to purchase only those covered services that are essential to assist the Consumer to avoid or delay institutionalization and which will foster independence, consistent with the Consumer's circumstances and the Authorized Plan of Care. This program supports Consumer choice, Consumer direction, flexibility, as well as Consumer responsibility in the provision of these services.

**All provisions of this rule are routine technical, except for the Consumer Payments provision (subsection 63.12) which is a major substantive rule provision pursuant to 34-B M.R.S. § 5439(9).**

**63.02 DEFINITIONS**

1. Activities of Daily Living: Basic activities of self-care performed by individuals on a daily or frequent basis necessary for independent living and may include activities such as:
  - A. Bed Mobility: How a person moves to and from lying position, turns side to side, and positions body while in bed;
  - B. Transfer: How a person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
  - C. Locomotion: How a person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
  - D. Eating: How a person eats and drinks (regardless of skill);

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- E. Toilet Use: How a person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
  - F. Bathing: How a person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and
  - G. Dressing: How a person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.
2. Acute/Emergency Episode: The unforeseen occurrence of an acute health episode that requires a change in the Consumer's Authorized Plan of Care, or the unforeseen circumstance where the availability of the Consumer's caregiver or informal support system is compromised.
  3. Assessing Services Agency: An Authorized Entity providing services to the Department for medical eligibility determinations, and Authorized Plan of Care development under this Section. The ASA conducts face-to-face assessments, using the Department's Medical Eligibility Determination (MED) Form. A Consumer's medical eligibility is based upon a Consumer's assessment outcome. If medical eligibility is determined for this Section, the ASA develops the Authorized Plan of Care with the Consumer and specifies all services to be provided under this Section, including type of services and number of hours for all Provider types.
  4. Assisted Living Services: The provision, either directly by the provider or indirectly through contracts with persons, entities or agencies, of assisted living services as defined in 10-144 C.M.R. ch. 113, Regulations Governing the Licensing and Functioning of Assisted Housing Programs.
  5. Attendant: An individual who meets the qualifications required in subsection 63.09-2(F). The Attendant provides Personal Care Services specified in the Authorized Plan of Care to a Consumer utilizing the Consumer-Directed Option.
  6. Authorized Entity: An organization authorized by the Department to perform functions under a valid contract or other approved, signed agreement. The Assessing Services Agency and any designated Service Coordination Agency are Authorized Entities under this Section.

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7. Authorized Plan of Care: A plan authorized by the Assessing Services Agency, or the Department, and which specifies all services to be delivered to a Consumer under this Section, including the number of hours for each covered service, and the Provider type to deliver each service. The Authorized Plan of Care is based upon the Consumer’s assessment outcome scores recorded in the Department’s Medical Eligibility Determination Form, utilizing the time frames contained therein, and the professional clinical judgment of the assessor.

The Authorized Plan of Care will reflect the needs identified by the assessment, with consideration of the Consumer’s goals, preferences, living arrangement, informal caregiving supports provided by family and friends, and services provided by other public and private funding sources.

8. Back Up Plan: A part of the service plan that addresses contingencies such as emergencies, including the failure of a worker to appear as scheduled, when the absence of the service presents a risk to the Consumer’s health and welfare. The Back Up Plan also identifies potential risks to Consumers and the development of strategies to mitigate such risks that are integral to enabling Consumers to live in the community while ensuring their health and welfare.
9. Cognitive Capacity: The mental function of knowing, including aspects of awareness, perception, reasoning, and judgment, assessed for purposes of determining a Consumer’s ability to self-direct their care.
10. Consumer: An individual who meets the eligibility requirements of this Section and is authorized to receive services. A Consumer may be represented by their “guardian” as defined in 18-C M.R.S. § 5-102, or “agent” or “surrogate” as these terms are defined in 18-C M.R.S. § 5-802, or by a Representative as defined in this Section.
11. Consumer-Directed Option: A choice offered to Consumers to manage their Attendant Services. Specifically, the member hires, discharges, trains, schedules and supervises the Attendant(s) providing services. A member who chooses to engage in the Participant-Directed Option is considered the employer of their Attendant(s).
12. Cueing: Any spoken instruction or physical guidance which serves as a signal to do an activity and typically used when supporting Consumers who are cognitively impaired.

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13. Department: The Maine Department of Health and Human Services.
14. Dependent Allowances: Dependent Allowances are defined and determined in agreement with the method used in the MaineCare program. The allowances are changed periodically and cited in the *MaineCare Benefits Manual* (“MBM”), 10-144 C.M.R. ch. 101, and the TANF Maximum Benefit and Standard of Need Chart appended to 10-144 C.M.R. ch. 331. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the Consumer or Consumer’s spouse.
15. Direct Care Provider: A Provider who has a contract with a Service Coordination Agency that directly provides personal care, home health or in-home respite services under this Section.
16. Disability-Related Expenses: Out-of-pocket costs incurred by the Consumer for their disability, which are not reimbursed by any third-party sources.
17. Fiscal Intermediary: A Provider of financial management services on behalf of Consumers utilizing Attendants through the Consumer-Directed Option. The Fiscal Intermediary’s responsibilities include, but are not limited to, preparing payroll and withholding taxes, making payments for Attendant services and ensuring compliance with state and federal tax and labor regulations, and the requirements under this Section.  
  
The Fiscal Intermediary acts as an entity of the employer (i.e., the Consumer or the Consumer’s Representative) in accordance with Federal Internal Revenue Service codes and procedures.
18. Health and Welfare Tool: An evaluation completed by the Service Coordination Agency to assess risks and unmet needs of Consumers as required by the Department.
19. Health Maintenance Activities: Activities designed to assist the Consumer with Activities of Daily Living and Instrumental Activities of Daily Living, and additional activities specified in this definition. These activities are performed by a designated caregiver for a Consumer who would otherwise perform the activities if they were physically or cognitively able to do so and enable the Consumer to live in their home and community. These additional activities include, but are not limited to catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of



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medications, care of skin with damaged integrity, and occupational and physical therapy activities such as assistance with prescribed exercise regimes.

20. Income:
  - A. Income includes:
    1. Wages from work, including payroll deductions, excluding state and federal taxes and employer mandated or court ordered withholdings;
    2. Benefits from Social Security, Supplemental Security Insurance, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;
    3. Adjusted gross income from property and/or business, based on the Consumer's most recent federal income tax;
    4. Interest and dividends;
    5. Payments made directly to an individual from an irrevocable trust.
  - B. Income does not include:
    1. Low Income Home Energy Assistance Program (LIHEAP);
    2. Supplemental Nutrition Assistance Program (SNAP);
    3. General Assistance; or
    4. Maine Property Tax Fairness Credit pursuant to 36 M.R.S. § 5219-II.
21. Instrumental Activities of Daily Living: Tasks necessary for maintaining a Consumer's immediate environment, such as preparing and serving meals, washing dishes, dusting, making bed, pick-up living space, sweeping, vacuuming and washing floors, cleaning toilet, tub and sink, appliance care, changing linens, refuse removal, shopping for groceries and prepared foods, storage of purchased groceries, and laundry, either within the residence or at an outside laundry facility.

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22. Irrevocable Trust: A trust which cannot in any way be revoked by the individual.
  
23. Licensed Assisted Living Agency: A state funded agency licensed with the Department as an assisted living program and holds a valid contract with the Department to provide services. These Providers employ Certified Residential Medication Aides (CRMAs) with the intention to serve Consumers who have daily Medication Administration needs as outlined in Subsection 63.03(2)(E) - Level V.
  
24. Limited Assistance: A term used to describe a Consumer's self-care performance in Activities of Daily Living, as defined by the Minimum Data Set (MDS) assessment process. Limited Assistance means the resident was highly involved in the activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance on three (3) or more times during the last seven (7) days.
  
25. Liquid Asset: Something of value available to the Consumer that can be converted to cash in three (3) months or less and includes:
  - A. Bank accounts;
  - B. Certificates of deposit;
  - C. Money market and mutual funds;
  - D. Life insurance policies;
  - E. Stocks and bonds;
  - F. Lump sum payments and inheritances;
  - G. Funds from a home equity conversion mortgage that are in the Consumer's possession whether they are cash or have been converted to another form;
  - H. Funds which are available to the Consumer but carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements, annuities, or other such assets named specifically to provide Income as a

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replacement for earned Income. The Income from these payments will be counted as Income;

- I. Revocable trusts; and.
  - J. For irrevocable trusts, only trust assets that are available to the individual according to the terms of the trust may be considered a “liquid asset” of the individual. Also, for funds that are left to trustee discretion, what is available as a liquid asset, are whatever funds made available to the individual by the trustee pursuant to the terms of the trust.
26. Medical Eligibility Determination Form: The form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms, and timeframes relating to this form, as defined in this Section, provide the basis for services and the care plan authorized by the Assessing Services Agency. The care plan summary, contained in the MED Form, documents the authorized care plan to be implemented by the Service Coordination Agency in the service order or, for Level V, by the Licensed Assisted Living Agency. The care plan summary also identifies other services the recipient is receiving, in addition to the authorized services provided under this Section.
27. Medication Administration: The daily administration of routine prescription medications by a Licensed Assisted Living Agency performed by a Certified Residential Medication Aide (CRMA) under the supervision of a registered nurse for Level V, as outlined in subsection 63.03(2)(E).
28. Multi-Disciplinary Team: The team involved in an individual’s care and may include the following:
- A. The Consumer;
  - B. Service Coordination Agency staff, as appropriate;
  - C. The registered nurse assessor, or a health professional; and
  - D. Other people who provide or have an interest in the Consumer’s services.

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29. Nursing Services: Services provided to an individual by a licensed nurse as part of a Plan of Care. Services may consist of the following:
- A. Intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of unstable conditions requiring medical or nursing intervention other than daily insulin injections for a Consumer whose diabetes is under control;
  - B. Nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past thirty (30) days) or unstable condition;
  - C. Nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within past thirty (30) days) or unstable condition;
  - D. Treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, second or third degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);
  - E. Administration of oxygen on a regular and continuing basis when the recipient's medical condition warrants professional nursing observations, for a new or recent (within past thirty (30) days) condition;
  - F. Professional nursing assessment, observation and management of an Unstable Medical Condition (observation must, however, be needed at least once every eight hours throughout the twenty-four (24) hours);
  - G. Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the recipient's medical record;
  - H. Services to manage a comatose condition;

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- I. Care to manage conditions requiring a ventilator/respirator;
  - J. Direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (e.g. grand mal);
  - K. Physician-ordered occupational, physical, or speech/ language therapy or some combination of the three (time limited with patient-specific goals) which is provided by and requires the professional skills of a licensed or registered therapist. Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist. Maintenance or preventive services do not meet the requirements of this section;
  - L. Professional nursing assessment, observation and management of a medical condition;
  - M. Administration of treatments, (excluding nebulizers, CPAP or BIPAP systems and airway clearance system vest), procedures, or dressing changes which involve prescription medications for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring;
  - N. Professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis;
  - O. Professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability; and
  - P. Professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior.
30. Office of Aging and Disability Services: The designated office within the Maine Department of Health and Human Services that supports the needs of older and disabled adults.
31. One-Person Physical Assist: manual assistance that requires one person over the last seven (7) days or twenty-four (24) to forty-eight (48) hours if in a hospital setting, to

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provide either weight-bearing or non-weight bearing assistance for a Consumer who cannot perform the activity independently. This does not include Cueing.

32. **Person-Centered Planning:** A process used to ensure that the Consumer's assessment, service plan development, and services and supports are led by the Consumer. This process encourages the Consumer to maintain their independence; retain connections to their community, family, and friends; and to receive support in a manner that respects their goals, values, and preferences.
33. **Personal Care Agency:** A non-medical entity that provides Personal Care Services to individuals in their homes. Personal Care Agencies are subject to the licensing and regulatory authority of the Department and must adhere to applicable statutes and rules, including 22 M.R.S. § 1717.
34. **Personal Care Services:** Covered Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) services provided by a home health aide, certified nursing assistant, Personal Support Specialist, or Attendant which are required by an adult with long-term care needs to achieve greater physical independence, in accordance with the Authorized Plan of Care.
35. **Personal Support Specialist:** A person who provides Personal Care Services for ADL and IADL needs and has completed a Department approved training course of at least fifty (50) hours, unless otherwise exempt under this Section.
36. **Provider:** Any entity, agency, facility, or individual who offers or plans to offer any in-home or community support services.
37. **Representative:** An individual responsible for managing Attendant Services on behalf of a Consumer using the Consumer-Directed Option. The Representative must meet the qualifications and requirements described in subsection 63.09-2(H).
38. **Residential Care Facility:** A house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services. Residential Care Facilities provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. Residential Care Facilities do not include a licensed nursing home, or a supported living arrangement certified by the Department for behavioral and developmental services.

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39. Respite Care: Services provided at home or in a facility to temporarily relieve the family or other caregivers who usually provide such services to the Consumer.
40. Revocable Trust: A trust which can, under state law, be revoked by the individual or a court. It includes a trust which ends if some action is taken by the individual.
41. Service Coordination Agency: An organization that has the statewide capacity to provide care coordination and Skills Training to eligible Consumers under this Section. In addition to care coordination and Skills Training, the SCA is responsible for administrative functions, including but not limited to, maintaining Consumer records, billing, conducting internal utilization and quality assurance activities, and meeting the reporting requirements of the Department.
42. Service Order: The document provided by the SCA to the Direct Care Provider that includes information on the type, amount, and frequency of services to be provided to the Consumer. The Service Order specifies the tasks authorized by the ASA in the Authorized Plan of Care.
43. Signature: Effective with the implementation of the computerization of the Medical Eligibility Determination (MED) Form, signature of the registered nurse assessor or the Service Coordination Agency staff will equate with “login” onto the appropriate electronic system.
44. Significant Service Change: A major change in the Consumer’s status that is not self-limiting, impacts more than one area of their health status, and requires multidisciplinary review or revision of the Authorized Plan of Care
45. Skills Training: A service that provides Consumers and Representatives with the information and skills necessary to carry out their responsibilities when choosing to participate in the Consumer-Directed Option, who have attained authorization for Attendant services. This is a required service for Consumers utilizing the Consumer-Directed Option.
46. Unstable Medical Condition: A medical condition that is irregular and/or is deteriorating and affects the Consumer’s ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment, and management at least once every eight (8) hours is required. An Unstable Medical

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Condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and Authorized Plan of Care adjustments must be documented in the medical record. Not included in this definition is the loss of function resulting from a temporary disability from which full recovery is expected.

**63.03 ELIGIBILITY**

1. General and Specific Eligibility Requirements

To be eligible for services under this Section, a Consumer must:

- A. Be at least 18;
- B. Be a resident of Maine;
- C. Have Liquid Assets of no more than \$50,000, or for couples have assets of no more than \$75,000;

EXCEPTION: Consumers who received services under 14-197 C.M.R. ch. 11 (Consumer Directed Personal Assistance Services) on September 30, 2023, are not subject to the Liquid Assets eligibility requirement.

- D. Lack personal and/or financial resources for in-home services as determined by a Consumer's Eligibility in subsection 63.08-1 and Consumer Payment in subsection 63.12;
- E. Be ineligible for the following services:
  - (1) Private Duty Nursing and Personal Care Services, MBM ch. II, Sec. 96, except as otherwise provided in this Section;
  - (2) Day Health Services, MBM ch. II, Sec. 26;
  - (3) Consumer Directed Attendant Services, MBM ch. II, Sec. 12; and



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- (4) Home and Community Based Services Waivers, MBM ch. II, Sec. 18, 19, 20, 21, and 29.
  
  - F. Not be a participant of the following state-funded services:
    - (1) Adult Day Services, 10-149 C.M.R. ch. 5, Sec. 61;
    - (2) Congregate Housing Services Program, 10-149 C.M.R. ch.5, Sec. 62;
    - (3) Respite Care for People with Alzheimer’s or Related Disorders, 10-149 C.M.R. ch. 5, Sec. 68; and
    - (4) Homemaker Program, 10-149 C.M.R. ch. 5, Sec. 69.
  
  - G. Not be a resident of a licensed residential setting, excluding Consumers receiving services in a state funded Licensed Assisted Living Agency. The Consumer’s residence may be the Consumer’s home or a transitional living program. Personal Care services under this program cannot be delivered in an Adult Family Care Home (AFCH) setting or other Licensed Assisted Living Facility which is currently reimbursed by state and/or federal funds for providing Personal Care Services; and
  
  - H. Agree to pay the monthly calculated Consumer payment directly or through their Representative.
2. Medical and Functional Eligibility Requirements

Applicants for HBSS must meet the medical and functional eligibility requirements as set forth in this Section and documented on the Medical Eligibility Determination (MED) Form. Medical eligibility will be determined using the MED Form. A person meets the medical eligibility requirements for a particular level of care if they require a combination of assistance with the following services: Activities of Daily Living, Instrumental Activities of Daily Living, and Nursing Services; or for Level V, Medication Administration seven (7) days prior to assessment. The requirements for each level of care are defined below. The clinical judgment of the Department’s Assessing Services Agency shall be the basis of the scores entered on the MED Form.

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A. Level I

A person meets the medical eligibility requirements for Level I of Home-Based Supports and Services if they require at least one (1) of the following:

- (1) Cueing seven (7) days per week for eating, toilet use, bathing, and dressing;
- (2) Limited Assistance and a One-Person Physical Assist with at least two (2) ADLs plus physical assistance with at least one (1) IADL;
- (3) Limited Assistance and a One-Person Physical Assist with at least one (1) ADL plus physical assistance with at least two (2) IADLs;
- (4) Limited Assistance and a One-Person Physical Assist with at least three (3) ADLs;
- (5) One (1) of the nursing services listed in subsections 63.02-29(A) - (K), at least once per week, that are or otherwise would be performed by or under the supervision of a registered nurse and Limited Assistance plus a One-Person Physical Assist with at least two (2) ADLs;
- (6) Two (2) of the nursing services listed in subsections 63.02-29(A) - (K), at least once per week, that are or otherwise would be performed by or under the supervision of a registered nurse and Limited Assistance plus a One-Person Physical Assist with at least one (1) ADL; or
- (7) One (1) of the nursing services listed in subsections 63.02-29(A) - (K), at least once per week, that are or otherwise would be performed by or under the supervision of a registered nurse and Limited Assistance plus a One-Person Physical Assist with at least one (1) ADL plus physical assistance with at least one (1) IADL.

B. Level II

A person meets the medical eligibility requirements for Level II Home-Based Supports and Services if they require:

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- (1) At least one (1) of the nursing services listed in subsections 63.02-29(A)-(P), at least once per month, that are or otherwise would be performed by or under the supervision of a registered nurse; and
- (2) At least one (1) of the following:
  - (a) Cueing seven (7) days per week for eating, toilet use, bathing, and dressing; or
  - (b) Limited Assistance and a One-Person Physical Assist with at least two (2) IADLs.

C. Level III

A person meets the medical eligibility requirements for Level III of Home-Based Support and Services if they require:

- (1) At least Limited Assistance and One-Person Physical Assist in two (2) of the following five (5) ADLs: bed mobility, transfer, locomotion, eating or toileting; and
- (2) Limited Assistance and a One-Person Physical Assist with at least three (3) IADLs.

D. Level IV

A person meets the medical eligibility requirements for Level IV of Home-Based Support and Services if they meet the medical eligibility requirements for nursing facility level of care set forth in MBM ch. II, Sec. 67, § 67.02-3, Nursing Facility Services.

E. Level V

A person meets the medical eligibility requirements for Level V if at least one (1) of the following criteria is met:

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- (1) The person requires daily assistance with medication administration for routine prescription medications delivered by a Certified Residential Medication Aid and physical assistance with at least two (2) IADLs;
- (2) The person requires daily assistance with medication administration for routine prescription medications delivered by a Certified Residential Medication Aid and physical assistance with at least one (1) ADL; or
- (3) The persons meets eligibility for Level I, II or III under this Section and resides in a facility that meets the requirements of being a state funded Licensed Assisted Living Agency.

3. Continued Eligibility

- A. If the assessment for continued eligibility indicates medical eligibility for a MaineCare program and potential financial eligibility for MaineCare, Consumers will be given written notice that the Consumer has up to thirty (30) days to file a MaineCare application.
- B. If HBSS is currently being received, services shall be discontinued if the Department's Office of Family Independence notice is not received within thirty (30) days of the assessment date indicating that a financial application has been filed.
- C. Services shall also be discontinued if, after filing the application within thirty (30) days, the application requirements have not been completed in the time required by MaineCare policy.
- D. No further notice of termination is required in order for the termination to be effective as soon as MaineCare eligibility is established. Services under this section will not be terminated if MaineCare eligibility is denied, unless otherwise indicated in subsection 63.03-3(C).

4. Additional Requirements for Consumer-Directed Option

For a Consumer to direct their own services under the Consumer-Directed Option without the use of a Representative, the Consumer must have Cognitive Capacity, as assessed on

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the MED Form, to be able to self-direct their Attendant(s). The ASA will assess Cognitive Capacity as part of each Consumer's eligibility determination using the MED findings. Minimum MED Form scores are:

- A. Decision making skills: a score of 0 or 1;
- B. Making self-understood: score of 0, 1 or 2;
- C. Ability to understand others: score of 0, 1 or 2;
- D. Self-performance of managing finances: a score of 0, 1, or 2; and
- E. Support for managing finances: a score of 0, 1, 2 or 3.

A Consumer not meeting the specific scores detailed above during their eligibility determination will be presumed not able to self-direct without the use of a Representative under this Section.

**63.04 DURATION OF SERVICES**

Each Consumer may receive as many HBSS covered services as are required within the limitations and exceptions as described below. All HBSS under this Section require prior authorization from the Department or its Assessing Services Agency. Beginning and end dates of a Consumer's medical eligibility determination period correspond to the beginning and end dates for Home Based Supports and Services coverage of the plan of care authorized by the Assessing Services Agency or the Department. The services provided must be reflected in the service plan and based upon the authorized covered services documented in the care plan summary of the MED Form.

1. Suspension

Services may be suspended for up to sixty (60) days. If the circumstances requiring suspension extend beyond sixty (60) days, the Consumer's eligibility in the program will be terminated.

After services are terminated, a Consumer will need to be reassessed to determine medical eligibility for services and be subject to the requirements of the waiting list,

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provided in subsection 63.07-2. If the SCA does not become aware until after sixty (60) days of the circumstances requiring suspension, the Consumer will be terminated as of the date the SCA verifies the change in status.

Upon discharge from a hospital or institutional care facility, the Consumer's previous level of service will resume until a reassessment is conducted. The reassessment will be conducted within two (2) weeks following the Consumer's discharge from the hospital or institutional care facility.

2. Service Reduction, Denial or Termination

- A. HBSS may be reduced, denied, suspended or terminated under the following circumstances; only the Department may terminate HBSS.
- (1) The individual does not meet or declines eligibility requirements;
  - (2) The individual declines services;
  - (3) The Department determines it is likely that the individual would, if they applied, be eligible to receive services under a MaineCare program, including any MaineCare Home or Community Based waiver program or a State funded long term services and supports program;
  - (4) The health or safety of the individual providing services is endangered by the Consumer or Representative;
  - (5) Services have been suspended for more than sixty (60) days;
  - (6) The Consumer refuses personal care or nursing services;
  - (7) The Consumer has failed to make their calculated monthly co-payment within thirty (30) days of receipt of the co-pay bill;
  - (8) The Consumer or Representative gives fraudulent information to the Department or Authorized Agency, including, but not limited to assessment information and reporting, payroll records, and all other record keeping documents;

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- (9) The Consumer is eligible to receive home health services for some or all of the services authorized under this Section from Medicare or another third-party payer;
  - (10) The availability of informal and formal supports, including public and private sources, duplicate the services provided under this Section;
  - (11) The Consumer is using program funds to pay the Attendant to complete tasks outside the covered services described in subsection 63.05;
  - (12) The Consumer or Representative fails to demonstrate the skills necessary to successfully manage their personal health maintenance, including management of the Attendant in compliance with this Section;
  - (13) The Consumer endorses or attempts to endorse a check that is made payable to the Attendant;
  - (14) The Consumer fails to carry out their responsibilities for FICA withholding, unemployment insurance or worker's compensation insurance;
  - (15) The Consumer's Authorized Plan of Care is reduced to match the Consumer's needs as identified in the Consumer's most recent MED Assessment, subject to the limitations of the program; or
  - (16) HBSS funding has been reduced.
- B. Notice of any denial, termination, or reductions of services must be provided in accordance with 10-149 C.M.R. ch. 5, Sec. 40.
3. Violation of Requirements
- A. In the event that a Consumer is found to have used program funds in violation of the requirements of this subsection, the Consumer must reimburse the Authorized Entity for all such funds before being subsequently considered for services under this Section.

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- B. In the event that services have been denied by the Authorized Entity or terminated by the Authorized Entity or the Department for fraud, waste and abuse reasons included in this subsection, such actions will be a factor in determining eligibility in any subsequent application for services under this Section.

4. Denial of Consumer-Direction

The ASA, SCA or Department, as appropriate, may deny or terminate the Consumer from receiving consumer-directed services for the following reasons:

- A. The Consumer or Representative provides fraudulent or repeatedly inaccurate information to the Department, ASA, SCA or Fiscal Intermediary in connection with obtaining or receiving services, including the submission of time sheets that are not accurate of the services provided;
- B. The Department, the SCA or the ASA documents that Representative harasses, threatens or endangers the safety of the Consumer or individuals delivering services; or
- C. The SCA documents that the Consumer or the Representative fails to hire or manage an Attendant consistent with the requirements of this Section, including directing an Attendant to provide services that are inconsistent or not covered by the Authorized Plan of Care or hiring an Attendant who does not have the ability provide Attendant Services as defined by the Authorized Plan of Care.

Prior to and as part of denying or terminating services specific to the Consumer-Directed Option, the SCA will work to transition the Consumer to another Representative or to agency services, as appropriate.

Notice of any denial or termination services must be provided in accordance with 10-149 C.M.R. ch. 5, Sec. 40.

5. Out of State Services

Personal care or Attendant Services provided to a Consumer while the Consumer is out of state must be approved by the SCA and may not exceed fourteen (14) consecutive days.



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The SCA will review the Authorized Plan of Care and determine if all ADL and IADL services are needed by the Consumer while out of state. The Consumer is allowed thirty (30) days total of out of state services per fiscal year. This section applies only when the service is being provided by an agency licensed or registered in Maine or provided by an Attendant under the Consumer-Directed Option. The Consumer must continue to meet all other program requirements.

**63.05 COVERED SERVICES**

Covered services are available for Consumers meeting the eligibility requirements set forth in subsection 63.03. All covered services require prior authorization by the Department, or its Assessing Services Agency, consistent with this Section, and are subject to limitations. The Authorized Plan of Care shall be based upon the Consumer's assessment outcome scores recorded on the Department's MED Form, according to its definitions, and the timeframes therein and the task time allowances defined in the appendix to this section.

Services provided must be required to meet the identified needs of the Consumer, based upon the outcome scores on the MED Form, and as authorized in the plan of care. Coverage will be denied if the services provided are not consistent with the Consumer's Authorized Plan of Care. The Department may also recoup payment from the Service Coordination Agency or Licensed Assisted Living Agency for inappropriate services provision, as determined through post payment review. The Assessing Services Agency has the authority to determine the plan of care, which shall specify all services to be provided, including the number of hours for each covered service.

The Assessing Services Agency will use Task Time Allowances set forth in the appendix to this section to determine the time needed to complete authorized ADL tasks for the plan of care not to exceed the program limits specified in subsection 63.07.

Covered services are as follows:

1. Care Coordination Services

Care Coordination services are provided by the SCA (through the care coordinator) to help the Consumer access services in the Authorized Plan of Care. Care Coordination Services require the SCA to engage in Person-Centered Planning. Care Coordination Services assist Consumers in receiving appropriate, effective, and efficient services, which allows the Consumer to retain or achieve the maximum amount of independence

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possible and desired. Care Coordination Services are designed to assist the Consumer with identifying immediate and long-term needs so that the Consumer is offered choices in service delivery based on their needs, preferences, and goals.

The SCAs must provide the following Care Coordination Services to Consumers:

- A. Initial contact with the Consumer or the responsible party, by telephone or other appropriate method, within two (2) business days of notification of authorization by the ASA of Care Coordination Services to discuss the Authorized Plan of Care, service delivery options, choice of Provider(s), preferred frequency of service delivery based on the Consumer's needs consistent with the timeframe of the service authorization (i.e. weekly/monthly), clarify issues, and answer questions;
- B. For Consumer's receiving Personal Care Services through an agency, face-to-face monitoring with the Consumer at least annually to monitor the Consumer's overall health status by completing the Health and Welfare Tool and following up on identified needs and issues;
- C. For Consumers authorized to receive Attendant Services through the Consumer-Directed Option, face-to-face monitoring with the Consumer at least every six (6) months to monitor the Consumer's overall health status by completing the Health and Welfare Tool and following up on identified needs and issues;
- D. Skills training prior to the start of consumer-directed services. Initial skills training must occur within thirty (30) calendar days from when the Consumer requests to direct their own services. The SCA may extend the thirty (30) day time frame for good cause (e.g. hospitalization of the Consumer or Representative). A competency-based assessment may be performed in lieu of skills training for Consumers who have previously completed such training;
- E. Advocating on behalf of the Consumer for access to appropriate community resources and services by providing information, making referrals and otherwise facilitating access to these supports, including employment and support;
- F. Implementing the Authorized Plan of Care and coordinating of service Providers who are responsible for delivery of services pursuant to the Consumer's

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- Authorized Plan of Care and identified needs; Maintaining contacts, on behalf of the Consumer, with family members, designated representative, guardian, Providers of services or supports and the Assessing Services Agency to ensure the continuity of care and coordination of services;
- G. Monitoring the Consumer's receipt of services and reviewing the Authorized Plan of Care by contacting the Consumer at least once per month, or more frequently upon request by the Consumer. Monitoring calls may be reduced to a lesser frequency but not less than quarterly if the Consumer requests less frequent calls and there is documentation in the record to support this choice. Monitoring may be done by telephone unless an in-person visit is needed to be effective as determined by the SCA or the Department;
- H. Assessing the Consumer/Provider relationship, including whether agency or Attendant duties are being performed satisfactorily; in addition assessing if the Attendant is trained adequately or if additional training is needed;
- I. Calculating the Consumer's co-payment based on the estimated copayment determined by the Assessing Services Agency and receipt and review of the documented dependent allowances and Disability Related Expenses. Consumers receiving services under this Section may be selected for verification of Income and assets;
- J. Making referrals for reassessments at least twenty-one (21) days prior to the end of the eligibility period and based upon a Significant Service Change in the Consumer's condition;
- K. Beginning discharge planning on the first day of services. A discharge plan will enable the Consumer to transition to other services, as appropriate;
- L. In the event a Consumer experiences an unexpected need, the Service Coordination Agency has the authority to adjust the frequency of services under the Authorized Plan of Care, in order to meet the needs, as long as the total Authorized Plan of Care hours for the eligibility period are not exceeded;
- M. Modifying the Authorized Plan of Care in the event a Consumer experiences an Acute/Emergency Episode as defined in this section. The Care Coordinator may

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adjust the Authorized Plan of Care up to (15) percent of the monthly authorized amount, not to exceed the monthly program cap. Services added or change due to the Acute/Emergency Episode may not continue beyond fourteen (14) days;

- N. Issuing notice to reduce, deny or terminate HBSS; and
- O. Other administrative tasks including, but not limited to:
  - (1) Processing assessment packets;
  - (2) Maintaining Consumer records;
  - (3) Tracking and reporting services;
  - (4) Preparing the Service Coordination Agency budget and processing of claims to the Department;
  - (5) Contracting with service Providers including Fiscal Intermediaries and requiring compliance by any and all sub-contractors with policy requirements; and conducting required utilization review activities.
  - (6) Reimbursing subcontracted home care Providers;
  - (7) Preparing information as required by the Department; and
  - (8) Following mandated reporting requirements in accordance with 22 M.R.S. § 3477.

2. Homemaking Services

Homemaking services means services to assist a Consumer with their general housework, meal preparation, grocery shopping, laundry, and incidental personal hygiene and dressing. If the Consumer is receiving care at Level I, IADL tasks may constitute up to, but shall not exceed, two (2) hours per week of authorized services.

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3. Personal Care Services

Personal Care Services consist of services to aid Consumers with ADLs and IADLs and Level V Medication Administration. Personal Care Services may be delivered by a Personal Care Agency or an Attendant through the Consumer-Directed Option.

The Consumer-Directed Option is a choice offered to Consumers to manage their Attendant services. Specifically, the Consumer hires, discharges, trains, schedules, and supervises the Attendant(s) providing services. A Consumer who chooses to engage in the Consumer-Directed Option is considered the employer of their Attendant(s).

- A. ADL services include bed mobility, transfer, locomotion, eating, toilet use, bathing and personal hygiene, dressing, and Health Maintenance Activities. When authorizing a plan of care that includes Personal Care Services the Assessing Services Agency will use the task time allowances specified in the appendix attached to this Section not to exceed limits specified elsewhere in this Section. ADL services may be provided in the Consumer's residence or at an adult day services program.
- B. IADL services include meal preparation, grocery shopping, routine housework and laundry, which are directly related to the Consumer's Authorized Plan of Care.
  - (1) These tasks must be performed in conjunction with personal support ADL services or Level V Medication Administration services delivered by a Certified Residential Medication Assistant.
  - (2) These IADL tasks would otherwise be normally performed by the Consumer if they were physically or cognitively able to do so, and it must be established by the Assessing Services Agency that there is no family member or other person available and willing to assist with these tasks.
  - (3) If the Consumer is receiving care at Level I, IADL tasks may constitute up to, but shall not exceed, two (2) hours per week of authorized Personal Care Services.

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- (4) If the Consumer is receiving care at Level II, IADL tasks may constitute up to, but shall not exceed, three (3) hours per week of authorized Personal Care Services.
  - (5) If the Consumer is receiving care at Level III, IADL tasks may constitute up to, but shall not exceed, four (4) hours per week of authorized Personal Care Services.
  - (6) If the Consumer is receiving care at Level IV, there are no limitations on IADLs, the total monthly cost of services authorized may not exceed the lesser of the cost of the monthly plan of care authorized by the Assessing Services Agency or 80% of the average cost of MaineCare nursing facility level of care established by the Department.
  - (7) If the Consumer is receiving care at Level V, IADL tasks may constitute up to, but shall not exceed, four (4) hours per week of authorized Personal Care Services.
  - (8) If the Consumer is receiving care at Level V, Medication Administration may constitute up to, but shall not exceed six (6) medication pass visits per day for a total of forty-two (42) passes weekly, based on the availability of contractual funds
- C. All Personal Care Services may be used for ADLs if necessary.
  - D. No individual providing this service may be reimbursed for more than forty (40) hours of care per week for an individual Consumer or for a household in which there is more than one Consumer.
  - E. When authorizing a Consumer's Authorized Plan of Care, Personal Care Services for ADLs must be authorized in accordance with the Task Time Allowances not to exceed program caps or limits specified elsewhere in this section (see appendix to this Section). If these times are not sufficient when considered in the light of a consumer's unique circumstances as identified by the Authorized Entity, the Authorized Entity may make an appropriate adjustment as long as the authorized hours do not exceed limits established for Consumer's level of care. Task time allowances will consider the possibility for concurrent performances of

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activities and tasks listed. Services listed in the Task Time Allowances that are not covered services under this Section may not be authorized.

- F. Except for Level V, a “one Hour” PSS visit is a one-hour visit to deliver Personal Care Services and Health Maintenance Activities to a Consumer, no more than once per day. This service may be authorized up to seven (7) days per week. If a person requires more than one (1) hour of personal care service on a given day, then the PSS services must be billed using the quarter-hour units.

4. Home Health Services

Home health services assist a Consumer with health and medical and ADL needs as identified on the MED Form and authorized by the Assessing Services Agency. These include nursing; home health aide and certified nursing assistant services; physical, occupational, and speech therapy; and medical social services, when no other method of third-party payment is available. Home Health services may only be purchased from licensed agencies and shall be reimbursed at an hourly rate. When authorizing personal care services provided by a HHA or CNA, the Assessing Services Agency must use the task time allowances set forth in the appendix attached to this Section to authorize the time covered to complete authorized ADL and IADL tasks for the Authorized Plan of Care not to exceed the program caps or limits specified in subsection 63.07.

5. Respite

Respite Services are provided to Consumers, furnished on a short-term basis because of the absence of or need for relief of the caregiver. This service may be provided at home, in a licensed Adult Day Program, or in an institutional setting. The annual cost of respite services may not exceed the equivalent of 15 days at the nursing facility daily rate as established by the Department and is included in the Consumer’s annual care plan cost limit. A Consumer receiving MaineCare Private Duty Nursing and Personal Care Services pursuant to MBM, ch. II, Sec. 96, may receive respite services, to the extent that budgeted resources permit and to the extent that there is no waiting list under this Section.

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6. Transportation

Personal Support Specialists, certified nursing assistants, home health aides and homemakers may escort or transport a Consumer only to carry out the Authorized Plan of Care. Any individual providing transportation must hold a valid State of Maine driver's license for the type of vehicle being operated. All Providers of transportation services shall maintain adequate liability insurance coverage for the type of vehicle being operated. Escort services may be provided only when a Consumer is unable to be transported alone, there are no other resources (family or friends) available for assistance, and the transportation agency can document that the agency is unable to meet the request for service. Reimbursement shall only be made for mileage in excess of ten (10) miles per single trip on a one-way trip for transportation provided by personal care assistants, homemakers, or other home health Providers in the course of delivering a covered service under this section.

7. Adult Day Services

Adult day services are furnished by Providers who are licensed and certified by the Department.

8. Home Modification

Home modifications are permitted to promote independent living and carry out the Authorized Plan of Care up to a lifetime cost of \$3,000, and when there is no alternative source of funding.

9. Personal Emergency Response System (PERS)

A Personal Emergency Response System is an electronic device which enables certain high-risk individuals to secure help in the event of an emergency. PERS services may be provided to those individuals who live alone, or who are alone for significant parts of the day, who are capable of using the system, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The use of the PERS will result in a reduction of authorized hours that are equal to the cost of the service.



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10. Skills Training

Skills training is a service that provides Consumers and Representatives with the information and skills necessary to carry out their responsibilities when choosing to participate in the Consumer-Directed Option. This is a required service for Consumers utilizing the Consumer-Directed Option.

Skills Training services instruct the Consumer in the management of Attendant Services under the Consumer-Directed Option. Instruction in management of Attendant Services includes instruction in recruiting, interviewing, selecting, training, scheduling, discharging, and directing a competent Attendant in the activities in the Authorized Plan of Care and requirements under this Section. Skills Training must include information on how to report suspected abuse, neglect, and exploitation to Adult Protective Services.

11. Home Delivered Meals

For consumers eligible for Level IV, meals that are either hot, cold, shelf stable, or frozen, and are delivered to the member's home, up to one meal per member per day, and up to seven days per week.

**63.06 NON-COVERED SERVICES**

The following services are non-covered services:

1. Room and board (except when allowed as part of Home Delivered Meals or as part of Respite Services delivered in a nursing facility);
2. Home Delivered Meals for Consumers receiving Level I, II, III, or V .
3. Services for which the cost exceeds the limits described in subsections 63.05 and 63.07, except as described in subsection 63.07-1;
4. Personal Care Services delivered in a Residential Care Facility, a supported living arrangement certified by the Department for behavioral and developmental services or a licensed or unlicensed assisted living program except for those that meet the definition of a Licensed Assisted Living Agency;

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5. Services provided by anyone prohibited from employment under the following:
  - A. A Personal Support Specialist or homemaker who is prohibited from employment pursuant to 22 M.R.S. §§ 1717(3), 2149-A(2), 7851(4), or 8606; or
  - B. A certified nursing assistant who is prohibited from employment pursuant to 22 M.R.S. § 1812-G(6);
6. Homemaker and handyman/chore services not directly related to medical need pursuant to subsections 63.05-2 and -4;
7. Those services which can be reasonably obtained by the Consumer by going outside their place of residence;
8. Travel time and mileage by the Authorized Entity, Authorized Entity's staff, and/or the assistant to and from the Consumer's residence;
9. Mileage for Personal Assistants;
10. Supervisory visits made for the purpose of supervising home health aides, certified nursing assistants, or personal care assistants;
11. Custodial or supervisory care;
12. Respite services when delivered by the Consumer's spouse;
13. Personal Care Services when delivered by the Consumer's guardian, conservator, attorney-in-fact acting under a power of attorney, or other legally responsible individual;
14. Services provided not in the presence of the Consumer unless in the provision of covered; IADLs, such as grocery shopping or laundry while the Consumer remains at home;
15. Venipuncture, as a stand-alone service.
16. Any reimbursement for hours of services in excess of the maximum authorized service amount;

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17. Services in excess of forty (40) hours per week provided by a paid individual to any individual Consumer or household;
18. Services provided out of state except as otherwise allowed in subsection 63.04-5;
19. Personal Care or Attendant Services provided to a Consumer receiving respite in an institutional setting; and
20. Reimbursement for HBSS provided by a Consumer who receives personal care services under this Section or any other MaineCare or state-funded program.

**63.07 LIMITS**

The total monthly cost of Home-Based Supports and Services may be capped by the Department. The limits are as follows:

1. For Consumers accessing Adult Day Services reimbursed by HBSS funds, the monthly caps may be exceeded by up to 20 hours per week of Adult Day Services.
2. For Consumers classified for Level I level of care, the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level I" cap, established by the Department.
3. For Consumers classified for Level II level of care, the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level II" cap established by the Department.
4. For Consumers classified for Level III level of care, the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level III" cap established by the Department.
5. For Consumers classified for Level IV level of care, the total monthly cost of services may not exceed the lesser of the cost of the monthly plan of care authorized by the Assessing Services Agency or 80% of the average cost of MaineCare nursing facility level of care established by the Department.

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6. For Consumers classified for Level V level of care, the total monthly cost of services may not exceed the lesser of the cost of the monthly plan of care authorized by the Assessing Services Agency or the "Level V" cap established by the Department.
7. For Consumers eligible for Level IV, Home Delivered Meals has a limit of one meal per member, per day up to seven days per week. The cost of this service shall be included in the monthly program cap for the member.
8. For Consumers accessing Respite Services, the total cost of an individual Consumer's Respite Services per year may not exceed the equivalent of 15 days at the nursing facility daily rate as established by the Department.

**63.08 POLICIES AND PROCEDURES**

1. Eligibility Determination

An eligibility assessment, using the Department's approved MED Form, shall be conducted by the Department or the Assessing Services Agency. All other Home-Based Supports and Services require eligibility determination and authorization by the Assessing Services Agency to determine eligibility pursuant to subsection 63.03.

- A. The Assessing Services Agency will accept verbal or written referral information on each prospective new Consumer, to determine appropriateness for an assessment. When funds are available to conduct assessments, appropriate Consumers will receive a face-to-face medical eligibility determination assessment at their current residence within the time requirement specified by OADS in the contract, of the date of referral to the Assessing Services Agency. All requests for assessments shall be documented indicating the date and time the assessment was requested and all required information provided to complete the request. The Assessor, as outlined in subsection 63.09-2(A), shall be a registered nurse (RN) and will be trained in conducting assessments and developing an Authorized Plan of Care with the Department's approved MED Form. The Assessor shall, as appropriate within the exercise of professional judgment, consider documentation, perform observations and conduct interviews with the long-term care Consumer, family of Consumers, direct care staff, the Consumer's physicians and other individuals and document in the record of the assessment all information considered relevant in their professional judgment. The Assessor's

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findings and scores recorded in the MED Form shall be the basis for establishing eligibility for services and the Authorized Plan of Care. The anticipated costs of covered services to be provided under the Authorized Plan of Care must conform to the limits set forth in subsections 63.05 and 63.07.

- B. The Assessing Services Agency shall inform the Consumer of available community resources and authorize a plan of care that reflects the identified needs documented by scores and task time allowances on the MED Form, giving consideration to the Consumer's living arrangement, informal supports, and services provided by other public and private funding sources. HBSS provided to two (2) or more Consumers residing in the same household shall be authorized by the Assessing Services Agency with consideration to the economies of scale provided by the group living situation, according to limits in subsections 63.05 and 63.07. The Assessing Services Agency shall assign the appropriate level of care for which the Consumer is eligible (see subsection 63.03-2) and authorize a plan of care based upon the scores and findings recorded in the MED assessment.

The covered services to be provided in accordance with Level I, II, III, IV or V and the Authorized Plan of Care shall:

- (1) Not exceed the lesser of the cost of the monthly plan of care authorized by the Assessing Services Agency or the financial cap established by OADS for the corresponding level of care; and
- (2) Be prior authorized by the Department or its Assessing Services Agency.

The Assessor shall approve an eligibility period for the Consumer, based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment. An initial eligibility period for Level IV shall not exceed three (3) months.

- C. The Assessor will provide a copy of the Authorized Plan of Care, in a format understandable by the average reader, a copy of the applicable eligibility notice, a release of information form, and the appeal hearing rights notice, to the Consumer at the completion of the assessment. The Assessor will inform the Consumer of the estimated co-payment and the cost of services authorized.

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- D. Except for those Consumers eligible to receive services under Level V of this Section, the assessor shall forward the completed assessment packet to the Department's authorized Service Coordination Agency within seventy-two (72) hours of the medical eligibility determination and authorization of the plan of care. For those Consumers eligible to receive services under Level V of this Section, the assessor shall forward the completed assessment and plan of care to the appropriate Licensed Assisted Living Agency.
  
- E. For Levels I-IV, the Service Coordination Agency shall contact the Consumer within the time required under their contract with OADS of transmission of the MED assessment and Authorized Plan of Care. The Service Coordination Agency shall assist the Consumer with locating Providers and obtaining access to services authorized on the care plan summary by the Assessing Services Agency or the Department. The Service Coordination Agency shall implement and coordinate services with the Provider agency or independent contractor using service orders, as well as, monitor service utilization and assure compliance with this Section.
  
- F. For Levels I-IV, the Provider or independent contractor shall request through the Service Coordination Agency any change in the Authorized Plan of Care. The Service Coordination Agency shall be responsible to assure that the authorized service plan shall not exceed the lesser of the Authorized Plan of Care authorized by the Assessing Services Agency or the financial cap established by the Department for the level of Home-Based Supports and Services authorized.
  
- G. For Levels I-IV, the Direct Care Provider or independent contractor contracted by the Service Coordination Agency to provide skilled nursing services shall develop a nursing plan of care, which shall be reviewed and signed by the recipient's physician. It shall include the personal care and nursing services authorized by the Assessing Services Agency or the Department, and the medical treatment plan signed by the recipient's physician. A copy must be forwarded to the Service Coordination Agency at no additional charge.
  
- H. For Levels I-IV, the Service Coordination Agency will complete standardized referral requests for reassessment and submit the requests to the Department or the Assessing Services Agency at least twenty-one (21) days prior to the reassessment due date. The most up to date status of the Consumer as reported by

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the care coordinator, care monitor and any MDT findings must be included in the reassessment request.

- I. For Level V, the Licensed Assisted Living Agency will complete standardized referral requests for reassessment and submit the requests to the Department or the Assessing Services Agency at least five (5) days prior to the reassessment due date. The most up to date status of the Consumer must be included in the reassessment request.
  
2. Waiting List
  - A. When availability of services exceeds six (6) months the Assessing Services Agency will establish a statewide interest list for assessments. As funds become available, Consumers will be assessed on a first come, first served basis.
  - B. For Consumers found ineligible for HBSS, the Assessing Services Agency will inform each Consumer of alternative services or resources and offer to refer the person to those other services.
  - C. When funds are not available to serve new Consumers who have been assessed for eligibility or to increase services for current Consumers, a waiting list will be established for Levels I-IV by the Department. For Consumers on the waiting list, eligibility will be advisory only. As funds become available Consumers will be taken off the list and served on a first come, first served basis, and eligibility will be determined, and a plan of care authorized.
  - D. When there is a waiting list, the Assessing Agency will inform each Consumer who is placed on the waiting list of alternative services or resources and offer to refer the person to those other services.
  - E. Consumer names may be removed from the waiting list at the request of the Consumer or if the Department determines that another funding source is available to the Consumer, or the Consumer has entered a hospital, Residential Care Facility or nursing facility for longer than thirty (30) days or upon the death of the Consumer.

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3. Reassessment and Continued Services
  - A. For all Consumers under this Section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and authorization of services is required and must be conducted within the timeframe of twenty-one (21) days prior to and no later than the reassessment due date. HBSS payment ends with the reassessment date, also known as the end date.

If the reassessment date for a Consumer occurs within the sixty-day suspension period, that reassessment date will be extended for as long as services are suspended, but no later than the last day of the sixty (60) day suspension period. If services are suspended beyond sixty-days, the Consumer's eligibility in the program will be terminated. After services are terminated, a Consumer will need to be reassessed to determine medical eligibility for services and will be placed on the waiting list and will be subject to the waiting list requirements.
  - B. An individual's specific needs for Home Based Supports and Services must be reassessed at least every twelve (12) months, or earlier if indicated by the clinical judgment of the nurse assessor;
  - C. Unscheduled reassessments due to financial changes that may potentially result in a change in program funding source must be requested by the Service Coordination Agency or the Licensed Assisted Living Agency.
  - D. Unscheduled financial reassessments may be completed by the Service Coordination Agency or Licensed Assisted Living Agency when a spouse or significant other household member passes away or there has been a documented change of 20% or greater in the asset or Income level of the household;
  - E. Unscheduled reassessments due to eligibility or service needs must be justified with consideration given to any MDT findings and requested by the Service Coordination Agency.
  - F. Significant Change reassessments will be requested by the Service Coordination Agency or the Licensed Assisted Living Agency). The Assessing Services Agency will review the request and the most recent assessment to determine



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whether a reassessment is warranted and has the potential to change the level of care or alter the Authorized Plan of Care.

- G. For Consumers currently under the appeal process pursuant to 10-149 C.M.R. ch. 5, Section 40, reassessments will not be conducted unless the Consumer experiences a Significant Change or has an Acute/Emergency Episode.

4. Rates

The Department contracts with the Services Coordination Agency vendors and established rates are outlined within the contract.

5. Appeals

A Consumer may appeal the Department adverse actions through the Department's appeals process pursuant to 10-149 C.M.R. Chapter 5, Section 40 (General Administrative Requirements for all Parties), within sixty (60) days of the date of the notice of adverse action.

**63.09 PROFESSIONAL AND OTHER QUALIFIED STAFF**

1. Professional Staff

The following professional staff must be fully licensed, by the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure and approval to practice conditions. Professional staff also must have appropriate education, training, certification, and experience, as verified by the employing agency.

- A. Registered Professional Nurse
- B. Practical Nurse
- C. Social Worker: A social worker must hold a Master's Degree from a school of social work accredited by the Council on Social Work Education.

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- D. Physical Therapist: A physical therapist who meets the requirements and the qualifications set forth in 10-144 C.M.R. ch. 101, ch. II, Section 85 may provide physical therapy services.
- E. Occupational Therapist: A registered occupational therapist who meets the requirements and the qualifications set forth in 10-144 C.M.R. ch. 101, ch. II, Sec. 68 may provide occupational therapy services.
- F. Speech-Language Pathologist: A speech-language pathologist meeting the requirements and qualifications set forth in 10-144 C.M.R. ch. 101, ch. II, Sec. 109 may provide speech and language therapy services.

2. Other Qualified Staff

Other qualified staff members, other than professional staff defined above, must have appropriate education, training, certification, and experience, as verified by the employing agency.

A. Assessor

In order to determine medical eligibility for services under this subsection the assessor must:

- (1) Hold a valid registered nurse (RN) license in the State of Maine; and
- (2) Must be employed with the contracted Assessing Services Agency.

B. Care Coordinator

In order to provide Care Coordination Services under this Section, a care coordinator must be employed by an enrolled Service Coordination Agency and attend annual mandated reporter and fraud, waste, and abuse trainings.

Prior to employment, the care coordinator must provide written evidence of one (1) of the following:

- (1) Status as a licensed social service or health professional;

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- (2) Four years of education in the health or social services field and one year of community experience;
- (3) Status as a registered occupational therapist who is licensed to practice as an occupational therapy in Maine; or
- (4) Status as a certified occupational therapy assistant who is licensed to practice occupational therapy in Maine under the documented supervision of a licensed occupational therapist.

C. Home Health Aide

A home health aide must be listed on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and must not be prohibited from employment pursuant to 22 M.R.S. §1812-G. Home health aides employed by a home health agency must comply with the Regulations Governing the Licensing and Functioning of Home Health Care Services, 10-144 C.M.R. ch. 119. A home health aide shall work under the direct supervision of a registered nurse.

D. Certified Nursing Assistant (CNA)

A CNA must be listed on the Maine Registry of Certified Nursing Assistants or Direct Care Workers and must not be prohibited from employment under 22 M.R.S. § 1812-G. A CNA shall work under the direct supervision of a registered nurse.

E. Personal Support Specialist (PSS)

A PSS must be employed by, or acting under a contractual relationship with, a licensed home health agency or by a registered personal care agency. A family member who meets the requirements of this Section may be a PSS and receive reimbursement for delivering personal care services. A Consumer's guardian, conservator or power of attorney may not be a PSS and receive reimbursement for delivering personal care services.

- (1) All individuals employed as a PSS must:

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- a. Undergo criminal background checks and checks on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and Maine APS Substantiation Registry. A PSS may not be employed by the Provider agency if they are prohibited from employment pursuant to 22 M.R.S. § 1717.
  
- b. An individual without the required training may be hired and reimbursed for delivering Personal Support 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 (9) months of employment and meets all other requirements. If the individual fails to pass the examination within nine (9) months, reimbursement for his or her services must stop until such time as the training and examination requirements are met. A PSS must meet one (1) of the following:
  - i. Hold a valid certificate of training for Certified Nursing Assistants and be listed on the Maine Registry of Certified Nursing Assistants;
  
  - ii. Hold a valid certificate of training, issued within the past three (3) years, for nurse's aide or home health aide training that meets the standards of the Maine State Board of Nursing assistant training program;
  
  - iii. If a CNA's status on the Maine Registry of Certified Nursing Assistants has become inactive, or an individual holds a valid certificate of training meeting the standards of the Maine State Board of Nursing assistant program issued more than three (3) years ago, the individual must pass the competency-based examination of didactic and demonstrated skills from the Department's approved Personal Support Specialist curriculum. A certificate of training as a personal care assistant/Personal Support Specialist will be awarded upon passing this examination;

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- iv. Hold a valid certificate of training as a Personal Support Specialist issued as a result of completing the Department approved Personal Support Specialist training curriculum and passing the competency-based examination of didactic and demonstrated skills. The training course must include at least fifty (50) hours of formal classroom instruction, demonstration, return demonstration, and examination. Tasks covered under this Section must be covered in the training; or
  - v. Be a Personal Support Specialist who successfully completed a Department-approved curriculum prior to September 1, 2003. Such individuals will be grandfathered as a qualified PSS.
- (2) A newly hired PSS must participate in a new employee orientation as described below.
- a. A PSS, newly hired to an agency, who meets the Department's PSS training requirements, must receive an agency orientation. The training and certification documents must be on file in the PSS's personnel file.
  - b. A newly hired PSS who does not yet meet the Department's training and examination requirements must undergo an eight (8) hour orientation that reviews the role, responsibilities, and tasks of the PSS. To meet the required eight (8) hours for orientation an agency may choose to use job shadowing for a maximum of two (2) hours of the eight (8) hour time requirement. The orientation must be completed by the PSS prior to the start of delivering services. The PSS must demonstrate competency to the employing agency in all required tasks prior to being assigned to a Consumer's home, with the exception of Health Maintenance Activities, whereby a PSS can demonstrate competency via on-the-job training once being assigned to a Consumer's home.

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- (3) Provider agency responsibilities include, but are not limited to, the following:
- a. Assuring that a PSS meets the training, competency, and other requirements of this Section; and
  - b. Maintaining documentation of how each requirement is met in the PSS's personnel file, including: evidence of orientation when applicable; check of the CNA and Direct Care Worker Registry; criminal background check; and the verification of credentials including the certificate of training and/or verification of competency.
  - c. Supervisory visits
    - i. Initial visit. A Provider agency supervisor must make an initial visit to a Consumer's home prior to the start of PSS services to develop and review with the Consumer the Authorized Plan of Care as authorized by the ASA and as ordered by the care coordinator.
    - ii. Scheduled supervisory visits. An agency employer will provide a PSS on-site supervision at least every six (6) months in a Consumer's residence to observe and verify PSS competency in the delivery of service. The documentation of supervisory visits shall be maintained in the PSS's employee file. More frequent or additional on-site supervision visits of the PSS occur at the discretion of the Provider agency as governed by its personnel policies and procedures.
    - iii. A Provider agency must develop and implement written policies and procedures that ensure a smoke-free environment. PSSs are not allowed to smoke, consume alcohol, or use controlled substances in the Consumer's home or vehicle during work hours.

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- iv. A Provider agency must develop and implement written policies and procedures that address abuse, neglect or misappropriation of a Consumer's property and that includes information on mandated reporting requirements.
  
- (4) Recoup funds for services provided if the sub-contracted agency or Fiscal Intermediary did not provide required documentation to support qualifications of the agency, staff, Attendants or services billed.
  
- (5) Ensure the quality of services and has the authority to determine whether a PSS agency or Consumer or Representative has the capacity to comply with all service requirements. Failure to meet standards must result in no-approval or termination of sub-contracts or memorandums of agreement for PSS services. Termination of a sub-contract cannot be appealed in accordance with 10-149 C.M.R. ch. 5, Section 40.
  
- (6) An agency must provide documentation demonstrating compliance with these requirements upon request by the Service Coordination Agency, or Department, including OADS.
  
- F. Attendant
  - (1) The following requirements apply to Attendants employed under the Consumer-Directed Option:
    - a. Attendants must be at least seventeen (17) years old;
    - b. Attendants must demonstrate competency to the Consumer or Representative in all required tasks;
    - c. Attendants will not be reimbursed for more than forty (40) hours of service per week; and
    - d. Attendants must be paid through a qualified Fiscal Intermediary.

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- (2) The following individuals may not be reimbursed as Attendants under this Section:
  - a. A Consumer's guardian, conservator, or power of attorney;
  - b. A Consumer's Representative as defined in 63.02-35;
  - c. An individual who has an annotation of abuse, neglect, or misappropriation of property on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and the Maine APS Substantiation Registry;
  - d. An individual prohibited from being hired by an agency pursuant to 22 M.R.S. § 1717; or
  - e. An individual who receives Attendant or Personal Care Services as a Consumer under this Section or other MaineCare or state funded program.
  
3. After the completion of Skills Training instruction, the Consumer or Representative shall train the Attendant on the job. Within a twenty-one (21) day probation period, the Consumer or Representative will determine the competency of the Attendant on the job. At a minimum, based upon the Attendant's job performance, the Consumer or Representative will certify competence in the following areas:
  - a. Ability to follow verbal and written instructions and carry out tasks as directed by the Consumer or Representative;
  - b. Disability awareness;
  - c. Use of adaptive and mobility equipment;
  - d. Transfers and mobility; and
  - e. Ability to assist with Health Maintenance Activities.



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4. Satisfactory performance in the areas above will result in a statement of Attendant competency for each Attendant. This statement must be completed on a Department-approved form signed by the Consumer, submitted to the SCA, with a copy kept in the Consumer's record. The SCA may require that the Consumer or the Representative provide additional information or verification regarding the competency of an Attendant before or after hiring.

G. Skills Trainer

A Skills Trainer must:

- (1) Have a high school degree or equivalent;
- (2) Be an employee of the SCA; and
- (3) Have the ability to teach the skills required for a Consumer to successfully utilize the Consumer-Directed Option including information on recruiting, interviewing, selecting, training, scheduling and supervising a competent Attendant.

Requisite skills which must be documented by the SCA include the ability to effectively communicate with Consumers or Representatives, their families and other support staff; knowledge of program regulations and the principles of Consumer direction; and knowledge of community resources.

H. Representative

A Representative may manage Attendant Services for a Consumer under the Consumer-Directed Option and shall not be compensated for the services provided under this Section. The Representative must be able to manage and direct program Attendant Services for the Consumer in accordance with the Consumer's preferences and meet all program requirements. The Representative may not actively manage the care for more than two Consumers participating in the Consumer-Directed Option under this Section or another MaineCare or state funded long-term care program. Specifically, the Representative must:

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- (1) Be at least eighteen (18) years of age;
- (2) Have the ability to understand and perform tasks required to manage an Attendant as determined by the SCA;
- (3) Have the ability to communicate effectively with the SCA, FI and Attendant(s) in performing the tasks required to employ an Attendant;
- (4) Agree to visit the Consumer in person at least once a month and contact the Consumer in person, by phone or other means at least weekly;
- (5) Not be an Attendant reimbursed for providing care to the Consumer; and
- (6) Undergo criminal background checks and checks on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and the Maine APS Substantiation Registry.

**63.10 RESPONSIBILITIES OF THE ASSESSING SERVICES AGENCY (ASA) AND THE SERVICE COORDINATION AGENCY (SCA)**

1. ASA and the SCA Requirements

The ASAs and SCAs shall meet the following requirements:

- A. Employ staff qualified by training and/or experience to perform assigned tasks and meet the applicable licensure requirements;
- B. Comply with requirements of the Adult Protective Services Act, 22 M.R.S. §§ 3470-and 22 M.R.S. §§ 4011-17 to report any suspicion of abuse, neglect or exploitation;
- C. Pursue other sources of reimbursement for services prior to the authorization of Home-Based Supports and Services;
- D. Operate and manage the program in accordance with all requirements established by rule or contract;

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- E. Have sufficient financial resources, other than federal or state funds, available to cover any Home-Based Supports and Services expenditures that are disallowed as part of the Office of Aging and Disability Services utilization review process;
  - F. Inform in writing any Consumer or any designated Representative of a Consumer with an unresolved complaint regarding their services about how to contact the Long-Term Care Ombudsman;
  - G. Assure that costs to HBSS funds for services provided to a Consumer in a twelve (12) month period do not exceed the applicable annual authorized care plan cost limit, per level of care for which the Consumer is determined eligible, established by the Office of Aging and Disability Services; and
  - H. Assure when hiring or contracting for delivery of services that conflict of interest has been disclosed and measures taken to avoid the issue in provision of services. If conflict of interest is identified, document that specific measures have been taken to comply.
2. The SCA Requirements for Levels I-IV

The SCAs shall, for Levels I-IV:

- A. Assure that service Providers employed by agencies and independent contractors meet applicable licensure and/or certification and/or training requirements and maintain records which show entrance and exit times of visits, total hours spent in the home, and tasks completed. Travel time to and from the location of the Consumer is excluded;
- B. Maintain annual written agreements with service Providers employed by agencies and independent contractors, and communicate current policy or service rate changes to all Providers;
- C. Implement an internal system to assure the quality and appropriateness of services delivered including, but not limited to the following:
  - (1) Consumer satisfaction surveys;

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- (2) Documentation of all complaints, by any party including resolution action taken; or
  - (3) Measures taken by the Authorized Entity to improve services as identified in (1) and (2);
- D. Include a provision in service Provider agreements for reimbursing the Service Coordination Agency if services paid for by HBSS are subsequently reimbursed by another payor;
- E. Establish MDTs who will review plans of care, as needed, to identify overlaps of service, over utilization of services or deficits in plans of care. Consider, as appropriate, any findings of the MDT when implementing the Authorized Plan of Care and issuing service authorizations. The registered nurse assessor is considered a member of the MDT;
- F. Assure contact with each Consumer as required under the contract with The Department to verify receipt of authorized services, discuss Consumer's status, review any unmet needs and provide appropriate follow-up and referral to community resources;
- G. Employ either directly, or through contract, care coordinators who meet the qualifications listed in subsection 63.09-2(B).
- H. Assure that all contracts for Personal Care Services and homemaker services require checks of the CNA registry and any required criminal background checks for all employees prior to the provision of services by the employees of the agency under contract;
- I. Reimburse Providers in accordance with these rules and the SCA contract with the Department based on the unit of service ad rates established by the Department;
- J. Contract with a Fiscal Intermediary who agrees to perform employer-related tasks and administrative tasks specified in subsection 63.02-18;

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- K. Contract with a Home Delivered Meals vendor who meets the following qualifications:
- (1) Be a qualified vendor as approved by DHHS and enrolled by the MaineCare program;
  - (2) Be a licensed eating establishment by the State of Maine and meet the requirements of Maine DHHS-Centers for Disease Control, Environmental Health Division and local municipalities;
  - (3) Have a Maine-licensed dietician on staff or available on a consultant basis;
  - (4) Be able to provide meals to meet participating members' special dietary needs;
  - (5) Be able to produce and deliver meals to members' homes; and
  - (6) Be able to provide up to one meal per day, seven (7) days per week to eligible members. This includes meals that are either hot, cold, shelf stable or frozen.
- L. Establish and maintain a record for each Consumer that includes at least:
- (1) The Consumer's name, address, mailing address if different, and telephone number;
  - (2) The name, address, and telephone number of someone to contact in an emergency;
  - (3) Complete MED Form and financial assessments and reassessments that include the date they were done and the signature of the person who did them;
  - (4) A care plan summary that promotes the Consumer's independence, matches needs identified by the scores and timeframes on the MED Form and authorized by the Assessing Services Agency, gives consideration of

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other formal and informal services provided and which is reviewed no less frequently than semiannually. The service plan includes:

- a. Evidence of the Consumer's participation;
  - b. Identification of needs;
  - c. The desired outcome;
  - d. A Back Up Plan;
  - e. Who will provide what service, when and how often, reimbursed by what funding source, the reason for the service and when it will begin and end; and
  - f. The signature the nurse assessor who determined eligibility and the Authorized Plan of Care and the SCA staff who authorized the service plan.
- (5) A dated release of information signed by the Consumer that conforms with applicable state and federal law is renewed annually and that:
- a. Is in a language the Consumer can understand;
  - b. Names the agency or person authorized to disclose information;
  - c. Describes the information that may be disclosed;
  - d. Names the person or agency to whom information may be disclosed;
  - e. Describes the purpose for which information may be disclosed; and
  - f. Shows the date the release will expire.

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- (6) Documentation that Consumers eligible to apply for a waiver for Consumer payments, were notified that a waiver may be available;
- (7) Monthly service orders to Providers that specify the tasks to be completed; and
- (8) Written progress notes that summarize any contacts made with or about the Consumer and:
  - a. The date the contact was made;
  - b. The name and affiliation of the person(s) contacted or discussed;
  - c. Any changes needed and the reasons for the changes in the Authorized Plan of Care;
  - d. The results of any findings of MDT contacts or meetings; and
  - e. The signature and title of the person making the note and the date the entry was made.

3. Written Progress Notes

Written progress notes for services delivered by a Direct Care Provider (includes SCA sub-contracted agencies) shall contain:

The service provided, date, and by whom;

- A. Visit entrance and exit times of nurses, home health aides, certified nursing assistants and Personal Support Specialists and total hours spent in the home for each visit. Exclude travel time (unless provided as a service as described in this Section);
- B. A written service plan that shows specific tasks to be completed and the schedule for completion of those tasks;

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- C. Progress toward the achievement of long- and short-range goals. Include explanation when goals are not achieved as expected;
  - D. Signature of the service Provider; and
  - E. Full account of any unusual condition or unexpected event, dated and documented.
4. Program Reports

Each SCA shall keep records and submit reports to the Department as specified in the contracts between the Department and the SCAs.

**63.11 RESPONSIBILITIES OF THE OFFICE OF AGING AND DISABILITY SERVICES**

1. Selection of Authorized Entity

To select the Assessing Services Agency and the Service Coordination Agency, the Office of Aging and Disability Services will request proposals by publishing a notice in Maine's major daily newspapers and posting on the Office of Aging and Disability Services' website. The notice will summarize the detailed information available in a request for proposals (RFP) packet and will include the name, address, and telephone number of the person from whom a packet and additional information may be obtained. The packet will describe the specifications for the work to be done. Criteria used in selection of the successful bidder or bidders will include but are not necessarily limited to:

- A. Cost;
- B. Organizational capability;
- C. Response to a sample case study;
- D. Qualifications of staff;
- E. References;
- F. Quality assurance plan;



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- G. Ability to comply with applicable program policies; and
  - H. Demonstrated experience.
2. Other Responsibilities of OADS
- The Office of Aging and Disability Services is responsible for:
- A. Setting the annual Consumer care plan cost limit for each level of care;
  - B. Establishing performance standards for contracts with authorized agencies including but not limited to the numbers of Consumers to be assessed and served and allowable costs for administration and direct service;
  - C. Conducting or arranging for quality assurance reviews that will include record reviews and home visits with HBSS Consumers;
  - D. Providing training and technical assistance;
  - E. Providing written notification to the administering agencies regarding strengths, problems, violations, deficiencies or disallowed costs in the program and requiring action plans for corrections;
  - F. Assuring the continuation of services if the Office of Aging and Disability Services determines that an Authorized Entity's contract must be terminated;
  - G. Administering the program directly in the absence of a suitable Authorized Entity;
  - H. Conducting a request for proposals for authorized entities at least every five (5) years thereafter;
  - I. At least annually, review randomly selected requests for waivers of Consumer payment;

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- J. Recouping HBSS funds from administering agencies when Office of Aging and Disability Services determines that funds have been used in a manner inconsistent with these rules or the Authorized Entity's contract; and
- K. Implementing a waiting list for Consumers until resources are available.

**63.12 CONSUMER PAYMENTS**

**THE FOLLOWING SUBSECTION OF THIS RULE IS MAJOR SUBSTANTIVE PURSUANT TO 34-B M.R.S. §5439(9).**

The administering agency will use an Office of Aging and Disability Services approved form to determine the individual's Income and Liquid Assets and calculate the monthly payment to be made by the Consumer. The agency may require the Consumer and their spouse to produce documentation of Income and Liquid Assets. A Consumer need not complete a financial assessment if they pay the full cost of services received. Their payments, as determined by an annual financial assessment may not exceed the total cost of services provided. For Level I-IV, the final Consumer payment will be determined by the SCA. For Level V, the final Consumer payment will be determined by the Licensed Assisted Living Agency.

1. Consumer Payment Formula

The Provider agency will use the following formula to determine the amount of each Consumer's payment, excluding Consumers who received services pursuant to 14-197 C.M.R. ch. 11 on September 30, 2023. Consumers who received services pursuant to 14-197 C.M.R. ch. 11 on September 30, 2023, are subject to the consumer payment formula in subsection 63.12-2.

**Step 1:** Calculate the Monthly Contribution from Income.

- A. Total the monthly Income of the Consumer and spouse.
- B. Deduct monthly allowable Disability Related Expenses.
- C. Deduct monthly allowable dependent allowances.
- D. Multiply the net Income by 4%.

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**Step 2:** Calculate the Monthly Contribution from Liquid Assets.

- A. Total the Liquid Assets of the Household Members.
- B. Deduct annual interest and annual dividends counted towards Income for the Household Members.
- C. Subtract \$15,000 from the amount of Liquid Assets calculated in Step 2(A & B). If the result is less than zero, use zero.
- D. Multiply the sum calculated in Step 2(C) by 3%. The result is the Monthly Contribution from Liquid Assets

**Step 3:** Add the result of the calculation in Step 1(D) to the result of the calculation in Step 2(D).

**Step 4:** The Consumer's monthly payment is the lesser of the sum calculated in Step 3 or the actual cost of services provided during the month.

**Step 5:** When two (2) persons in a household are both receiving Home Based Supports and Services pursuant to this Section, collect the required information for each person. Calculate the co-pay for each Consumer and combine the total. Divide the amount by two to determine the household monthly co-payment.

2. Consumer Payment Formula for Former Chapter 11 Consumers

The following Consumer payment formula applies only to Consumers who received 14-197 C.M.R. ch. 11, services on September 30, 2023. The Provider agency will use the following formula to determine the amount of each Consumer's payment.

**Step 1:** Calculate the Monthly Contribution from Income.

- A. Total the monthly Income of the Consumer and spouse.
- B. Deduct monthly allowable Disability Related Expenses.
- C. Deduct monthly allowable dependent allowances.

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- D. Multiply the net Income by 4%.

**Step 2:** Calculate the Monthly Contribution from Liquid Assets.

- A. Total the Liquid Assets of the Household Members.
- B. Deduct annual interest and annual dividends counted towards Income for the Household Members.
- C. Subtract \$30,000 from the amount of Liquid Assets calculated in Step 2(A & B). If the result is less than zero, use zero.
- D. Multiply the sum calculated in Step 2(C) by 3%. The result is the Monthly Contribution from Liquid Assets

**Step 3:** Add the result of the calculation in Step 1(D) to the result of the calculation in Step 2(D).

**Step 4:** The Consumer's monthly payment is the lesser of the sum calculated in Step 3 or the actual cost of services provided during the month.

**Step 5:** When two (2) persons in a household are both receiving home based care services pursuant to Chapter 11, collect the required information for each person. Calculate the co-pay for each Consumer and combine the total. Divide the amount by two to determine the household monthly co-payment.

3. Waiver of Consumer Payment

- A. Consumers may request a waiver from the Service Coordination Agency or the Licensed Assisted Living Agency for all or part of the assessed payment when:
  - (2) Monthly Income of Household Members is no more than 200% of the Federal Poverty Level as defined by the Federal Poverty Guidelines from <https://aspe.hhs.gov/poverty-guidelines>; and
  - (3) Household Assets are no more than:

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- a. \$ 30,000 for Consumers who received 14-197 C.M.R. ch. 11, services on September 30, 2023; or
  - b. \$ 15,000 for all other Consumers.
  
- B. Consumers requesting waivers may be asked to provide verification of any Income, Liquid Assets and expenses for housing, transportation, unreimbursed medical expenses, food, clothing, laundry and insurance.
  
- C. The request must be submitted in writing, on a Department approved form, to the SCA or the Licensed Assisted Living Agency within ten (10) business days of the date of:
  - (1) Notification of the assessed Consumer payment;
  - (2) The Consumer's last functional reassessment; or
  - (3) The start of the Consumer's services after being on the waiting list.
  
- D. The SCA or Licensed Assisted Living Agency must inform the Consumer of its decision in writing within twenty (20) days of receipt of the request. If denied, the SCA or Licensed Assisted Living must include information on appeal rights.
  
- E. If the SCA or Licensed Assisted Living Agency needs additional information, in order to determine whether the waiver can be granted, they will promptly notify the Consumer. The Consumer must submit the additional information within ten (10) business days. In such cases, the SCA or Assisted Living Agency must issue its decision within ten (10) business days of receipt of the additional information.
  
- F. A Consumer who is otherwise eligible may receive services while awaiting the decision on the request for waiver. The SCA or Licensed Assisted Living Agency will hold the Consumer payment in abeyance pending a decision on the request, or the completion of the appeals process, whichever is later.
  
- G. If the waiver is denied, the Consumer payment, including payments held in abeyance, is due within thirty (30) business days of the date of the decision, or services will be terminated.

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- H. Consumers who have applied for a full or partial waiver of the assessed payment and been denied may reapply only if one (1) of the following conditions exists and is expected to continue until the next regularly scheduled financial assessment:
- (1) The Consumer has at least a 20% decrease in monthly Income or Liquid Assets; or
  - (2) The Consumer has an increase in expenses which results in the sum of the allowable expenses plus the Consumer payment exceeding monthly Income plus the monthly contribution From Liquid Assets.
- I. When allowable expenses plus the Consumer payment exceed the sum of monthly Income plus the monthly contribution from Liquid Assets, the agency will waive the portion of the payment that causes expenses to exceed Income.

4. Expenses

Expenses will be reduced by the value of any benefit received from any source that pays some or all of the expense. Examples include but are not limited to: Medicare; MaineCare; Food Stamps; and Property Tax and Rent Refund. Business expenses that exceed business Income are not allowable. Allowable expenses include actual monthly costs of all household members for:

- A. Housing expenses which include and are limited to rent, mortgage payments, property taxes, home insurance, heating, water and sewer, snow and trash removal, lawn mowing, utilities and necessary repairs;
- B. Food, clothing and laundry not to exceed the amounts provided in the following chart;

<b>Number in Household</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5 &amp; up</b>
<b>Amount</b>	\$262	\$412	\$553	\$695	\$837

- C. Transportation expenses which include and are limited to ferry or boat fees, car payments, car insurance, gas, repairs, bus, car and taxi fare;

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- D. Unreimbursed medical expenses including but not necessarily limited to health insurance; prescription or physician ordered drugs, equipment and supplies; and doctor, dentist and hospital bills;
- E. Life insurance; and
- F. Limited discretionary expenses not to exceed the amounts provided in the following chart. Amounts in excess of the monthly allowance may not be claimed.

<b>Number in Household</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5 &amp; up</b>
<b>Amount</b>	\$76	\$120	\$161	\$203	\$244

**STATUTORY AUTHORITY:**

22 M.R.S. § 42(1), 22 M.R.S. § 7303, 34-B M.R.S. § 5439(4)

**ESTABLISHED:**

October 1, 2023 – filing 2023-096

**AMENDED:**

December 28, 2024 – filing 2024-275

10-149 Chapter 5  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AGING AND DISABILITY SERVICES POLICY MANUAL

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**APPENDIX A: TASK TIME ALLOWANCES FOR ACTIVITIES OF DAILY LIVING**

Activity	Definitions	Time Estimates		Considerations
Bed Mobility	How person moves to and from lying position, turns side to side and positions body while in bed.	5 – 10 minutes		Positioning supports, cognition, pain, disability level.
Transfer	How person moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet).	5 – 10 minutes  <b>up to 15 minutes for mechanical lift transfer</b>		Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition <b>mechanical lift transfer</b>
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair.	5 - 15 minutes (Document time and number of times done)		Disability level, Type of aids used or Pain
Dressing & Undressing	How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis.	20 - 45 minutes		Supervision, disability, pain, cognition, type of clothing, type of prosthesis.
Eating	How person eats and drinks (regardless of skill)	5 minutes		Set up, cut food and place utensils.
		30 minutes		Individual is fed
		30 minutes		Supervision of activity due to swallowing, chewing,
Toilet Use	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes.	5 - 15 minutes/use		Bowel, bladder program Ostomy regimen Catheter regimen cognition
Personal Hygiene	How person maintains personal hygiene. (EXCLUDE baths and showers)	Washing face, hands, perineum, combing hair, shaving and brushing teeth	20 min/day	Disability level, pain, cognition, adaptive equipment.
		Shampoo (only if done separately)	15 min up to 3 times/ week	
		Nail Care	20 min/week	
Walking	a. How person walks for exercise only b. How person walks around own room c. How person walks within home d. How person walks outside	Document time and number of times in POC, and level of assist is needed.		Disability Cognition Pain Mode of ambulation (cane) Prosthesis needed for walking
Bathing	How person takes full-body bath/shower, sponge bath (EXCLUDE washing of back, hair), and transfers in/out of tub/shower	15 - 30 minutes		If shower used and shampoo done then consider as part of activity, cognition