Lifespan Concept Paper Update

The Concept Paper published on June 28, 2023 below, is not current, and does not include changes resulting from feedback received during the comment period.

Please review the FAQ document on the Lifespan website for updated content.

The next published summary of the waiver will be the CMS Waiver application, which will have a comment period. The announcement for this will be provided through DHHS' GovDelivery messaging. Sign up on the OADS' webpage.

The Lifespan Waiver

A Concept Paper
for Stakeholder Review and Input
June 28, 2023

The Maine Department of Health and Human Services (DHHS) is developing a new Lifespan Waiver program for individuals with Intellectual Disabilities (ID), including Autism Spectrum Disorder (ASD), and other related conditions. The primary goal is to better meet the needs of individuals across the lifespan, beginning at age 14, improving transitions as needs change.

This concept paper describes key aspects of the proposed program. This is one of several opportunities to provide feedback to the Department. The Offices of MaineCare Services (OMS), Aging and Disability Services (OADS) and Child and Family Services (OCFS) will jointly host two virtual public forums, July 6th from 12:30PM to 2PM and July 20th from 10:30AM to 12PM, to present the key ideas in this concept paper to stakeholders, and to gather input. Invitations and details about these meetings may be found at: https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs-lifespan-project.

Comments about this Concept Paper may also be submitted through July 28th by the following means:

- Preferred: Submit comments online at: https://forms.office.com/g/SV9ewiLjeg
  OR
- Through email to: **OADS.LifespanProject@maine.gov**
  OR
- Submit comments by mail to:
  Attn: Lifespan Project
  Office of Aging & Disability Services
  11 State House Station
  41 Anthony Avenue
  Augusta, ME 04333

OMS, OADS and OCFS will carefully consider feedback received on the concept paper as they develop the necessary application(s) to the federal Centers for Medicare and Medicaid Services (CMS) to implement a Lifespan Waiver. The application(s) to CMS will also be posted for public comment prior to submission.

The Lifespan Waiver:
A Concept Paper for Stakeholder Review and Input
June 28, 2023

Executive Summary

This paper describes a proposal for how the State of Maine can provide Medicaid Waiver Home and Community-Based Services (HCBS) to individuals with Intellectual Disabilities (ID), Autism Spectrum Disorder (ASD), and other related conditions[1] who need these services once the legislature has approved the rule for this waiver in 2025 for ID/ASD and in 2026 for ORC.

This concept paper is based on statewide input received from stakeholders through:

- The Developmental Services Lifelong Continuum of Care proposed by stakeholders brought together by the Maine Coalition for Housing and Quality Services[2]
- The Disability Services Reform Innovation Workgroup sponsored by the Department of Health and Human Services (DHHS) Office of Aging and Disability Services (OADS)[3]
- Three stakeholder engagement strategies focused specifically on the development of a Lifespan Waiver:
    - A series of six listening sessions held in the fall of 2022 that culminated in a statewide seventh session which summarized the findings of the prior sessions;
    - A stakeholder workgroup convened by OADS between January and June 2023, which met for ten (10) sessions on a range of topics for the waiver; and
    - A survey of individuals with ID and ASD on the Section 21 waiver waiting list for HCBS which was conducted in early spring of 2023.

Through the three Lifespan-specific strategies noted above, 417 individuals, family members, advocates, providers, and other stakeholders provided feedback that echoed previous input and reinforced the reasons for creating a Lifespan Waiver. Reflecting the breadth of stakeholder input to date, the proposed goals of the Lifespan HCBS Program are:

> **1. Flexibility across the lifespan.** Provide HCBS that can change over a member's lifespan as the member and the persons who support that member get older without

[1] "Other related conditions" exist when a participant meets the minimum eligibility criteria for an Intermediate Care Facility for individuals with an Intellectual Disability (ICF/ID).The specific criteria for services is individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to-- (1) Cerebral palsy or epilepsy; or (2) Any other condition, other than mental illness, found to be closely related to intellectual disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons. (b) It is manifested before the person reaches age 22. (c) It is likely to continue indefinitely. (d) It results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care. (2) Understanding and use of language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living.

[2] See: DD Continuum of Care - Maine Coalition for Housing & Quality Services (maineparentcoalition.org)

[3] See: Disability Services Reform Innovation Work Group | Department of Health and Human Services (maine.gov)

needing to move from one waiver program to another.

2. Seamless transitions. Provide different types and levels of support within a single HCBS program to adapt to a member's changing needs across the lifespan and create a seamless experience for the member and those that support them to eliminate confusion and the need to change waivers when needs change.

3. Expanded access. Expand upon the department's current childhood-to-adulthood transition initiatives by reducing the minimum age for enrollment from 18 to 14 and implementing a five-year plan to eliminate waiting lists for individuals with ID, ASD, or other related conditions.

4. Early planning for independence and inclusion. Emphasize in-home supports, independent living skills, and community and employment supports for youth and young adults to prepare them for as much independence as possible throughout adulthood. This includes building on the strengths and capacities of members, their families, other natural supports and their communities.

5. More comprehensive coordination of supports and services. Increase the span of coordination to include services available from other public programs, including but not limited to education, behavioral health, vocational rehabilitation, housing, transportation programs and other natural supports in the community.

6. Innovation. Include service innovations currently under development, such as tiered shared living, standardized assessment of need, enhanced medical and behavioral health supports, self-direction, innovative employment supports, independent living options, and remote support technology. This includes models of support that can be successfully implemented with reliance on a smaller workforce; and

7. Simplified and effective payment methods for service providers. Include alternative payment methods for services to promote quality and efficiency and reduce the administrative burden for service providers and the department.

Maine DHHS has operated three, separate HCBS waivers for individuals with ID, ASD and other related conditions. As of April 2023:

- The Section 21 Waiver is a comprehensive waiver for individuals with ID and ASD, ages 18 and older. It currently has 3,553 participants enrolled and a waiting list of 282 individuals with no other known waiver coverage, and 1,703 individuals who have other coverage, such as Section 29.
- The Section 29 Waiver is a supports waiver for individuals with ID and ASD, ages 18 and older. It currently has 2,804 participants enrolled and a waiting list of 186 individuals.
- The Section 20 Waiver is a comprehensive waiver for individuals with other related conditions, ages 21 and older. It currently has 44 participants enrolled and a waiting list of 21 individuals.

The state currently manages separate waiting lists for each of these waivers. Individuals may place themselves on multiple waiting lists if anticipated to be eligible. Individuals may receive services under one waiver and may also be on a waiting list for a different waiver. For example, in state fiscal year 2022, 73.5% of individuals on the Section 21 waitlist were already receiving other waiver services. This creates confusion for individuals and their families. The proposed Lifespan Waiver design is anticipated to address this by creating one door to HCBS waiver services.

Additionally, DHHS seeks to eliminate waiting lists for individuals with ID, ASD and other related conditions through the creation of the Lifespan Waiver which will enroll individuals into a single HCBS waiver program that can serve them for life. By eliminating the waiting list, eligible individuals can be enrolled as soon as they apply, better ensuring that crises can be prevented and transitions throughout the lifespan can be more effectively supported.

Members already enrolled in Section 20, 21 or 29 waivers will be able to remain on those waivers when the Lifespan Waiver opens. **If members already enrolled in Section 20, 21 or 29 waiver services are happy with their services, they will not be required to transition to the Lifespan Waiver**. However, members already enrolled in Section 21 or 29 when the Lifespan Waiver opens for individuals with ID or ASD in 2025, and members already enrolled in Section 20 when the Lifespan Waiver opens for individuals with other related conditions in 2026 who wish to transfer to the Lifespan Waiver voluntarily will have the opportunity to do this after receiving counseling to ensure informed choice. It was originally proposed that these voluntary transitions would start two years after the Lifespan Waiver opened to the target population. However, based on stakeholder input, these voluntary transitions are now proposed to start one year after the Lifespan Waiver is opened to the target population, which allows the Lifespan Waiver some time to be sufficiently established to effectively support these transitions.

The Lifespan Waiver is proposed to initially serve 540 individuals with ID and ASD in its first year of operation (2025) using newly appropriated funding. Those targeted for enrollment will include newly eligible youth, ages 14-17, and eligible adults. Based on stakeholder feedback, youth ages 14-17 (not on the waiting list due to age) and adults on the waiting list who are not receiving any waiver services will be prioritized for enrollment in the first year of the Lifespan Waiver.

With recommendations from stakeholders, best practices resulting from a diverse range of pilots currently funded by DHHS American Rescue Plan Act (ARPA) funding and best practices from other states, we can serve individuals with ID, ASD and other related conditions timelier, more effectively and in ways that address the direct service workforce shortage the state currently faces. As proposed in this concept paper, the Lifespan Waiver is designed to achieve these outcomes.

Please read on to learn more about the proposed Lifespan Waiver and how it will work for Mainers with ID, ASD and other related conditions, and their families. The proposed Lifespan Waiver is also anticipated to offer case managers and provider agencies an opportunity to move beyond some of the long-standing challenges they have faced.

Introduction

The State of Maine currently operates three separate Medicaid Home and Community-Based Services (HCBS) waivers for individuals with Intellectual Disabilities (ID), including Autism Spectrum Disorder (ASD), and other related conditions:

- The Section 21 Waiver is a comprehensive waiver for individuals with ID and ASD, ages 18 and older.
- The Section 29 Waiver is a supports waiver for individuals with ID and ASD, ages 18 and older.
- The Section 20 Waiver is a comprehensive waiver for individuals with other related conditions, ages 21 and older.[4]

Ensuring the continuity of services and the stability of the existing service delivery system is an important priority. Accordingly, the state intends to continue these waivers for those already enrolled to ensure continuity of services for these existing waiver participants.

In addition, the Department of Health and Human Services (DHHS) Offices of MaineCare Services (OMS), Aging and Disability Services (OADS) and Child and Family Services (OCFS) are collaborating to develop a new "Lifespan" Waiver for individuals with ID, ASD and other related conditions to achieve the following goals:

1. Flexibility across the lifespan. Provide HCBS that can change over a member's lifespan as the member and the persons who provide support to that member get older, without needing to move from one waiver program to another.

2. Seamless transitions. Provide different types and levels of support within a single HCBS program to adapt to a member's changing needs across the lifespan and create a seamless experience for members and those that support them to eliminate confusion and the need to change waivers when needs change.

3. Expanded access. Expand upon the department's current childhood-to-adulthood transition initiatives by reducing the minimum age for enrollment from 18 to 14 and implementing a five-year plan to eliminate waiting lists for individuals with ID, ASD or other related conditions.

4. Early planning for independence and inclusion. Emphasize in-home supports, independent living skills, community and employment supports for youth and young adults to prepare them for as much independence as possible throughout adulthood. This includes building on the strengths and capacities of members, their families, other natural supports, and their communities.

[4] "Other related conditions" exist when a participant meets the minimum eligibility criteria for a ICF/ID. The specific criteria for services is individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to-- (1) Cerebral palsy or epilepsy; or (2) Any other condition, other than mental illness, found to be closely related to intellectual disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons. (b) It is manifested before the person reaches age 22. (c) It is likely to continue indefinitely. (d) It results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care. (2) Understanding and use of language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living.

5. More comprehensive coordination of supports and services. Increase the span of coordination to include services available from other public programs, including but not limited to education, behavioral health, vocational rehabilitation, housing, transportation programs, and other natural supports in the community.

6. Innovation. Include service innovations currently under development, such as tiered shared living, standardized assessment of need, enhanced medical and behavioral health supports, self-direction, innovative employment supports, independent living options, and remote support technology. This includes models of support that can be successfully implemented with reliance on a smaller workforce; and

7. Simplified and effective payment methods for service providers. Include alternative payment methods for services to promote quality and efficiency and reduce the administrative burden for service providers and the department.

These goals have been identified and defined based on consistent input from existing system stakeholders over time and more recent targeted stakeholder engagement conducted by OADS since September 2022.

Stakeholder Input Used to Inform this Lifespan Waiver Proposal

This concept paper is based on statewide input received from stakeholders through:

- The Developmental Services Lifelong Continuum of Care proposed by stakeholders brought together by the Maine Coalition for Housing and Quality Services[5]
- The Disability Services Reform Innovation Workgroup sponsored by the Department of Health and Human Services (DHHS) Office of Aging and Disability Services (OADS)[6]
- Three stakeholder engagement strategies focused specifically on the development of a Lifespan Waiver:
    - A series of six listening sessions held in the fall of 2022 that culminated in a statewide seventh session which summarized the findings of the prior sessions;
    - A stakeholder workgroup convened by OADS between January and June 2023, which met for ten sessions on a range of topics for the waiver; and
    - A survey of individuals with ID and ASD on the Section 21 waiver waiting list for HCBS which was conducted in early spring of 2023.

Through the three Lifespan-specific strategies noted above, 417 individuals, family members, advocates, providers, and other stakeholders gave input through these opportunities. This stakeholder input echoed prior input and validated the proposed reasons for creating a Lifespan Waiver to better meet the needs of individuals with ID, ASD and other related conditions, as discussed in the previous section. Additionally, the targeted stakeholder consultation efforts since

[5] See: DD Continuum of Care - Maine Coalition for Housing & Quality Services (maineparentcoalition.org)
[6] See: Disability Services Reform Innovation Work Group | Department of Health and Human Services (maine.gov)

the fall of 2022 have focused on building out the concept for the Lifespan Waiver detailed in this paper. Notes from each stakeholder input opportunity can be found at: https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs-lifespan-project

Key Consensus Input from Stakeholders

Stakeholder input gathered through the listening sessions, stakeholder workgroup, and waiting list survey all indicated support for the following:

- Establishing age 14 as the minimum age for Lifespan Waiver enrollment to support the transition more effectively to adulthood, including the transition to employment and community involvement after exiting high school.
- Implementing the Lifespan Waiver to provide a viable pathway to ending the waiting list for the target population, particularly ensuring that youth in transition must not wait until adulthood to access enrollment and that adults on the waiting list who receive no services are prioritized for enrollment.
- Designing a Lifespan Waiver that:
    - Reduces confusion currently experienced by individuals and families;
    - Serves people before they are in crisis to actively avoid crises across the lifespan – particularly at key life transitions when crises are more likely;
    - Increases meaningful and effective coordination of services and supports across systems and ensures waiver participants have access to services and supports available from other systems, in addition to natural, community and waiver-funded supports;
    - Increases quality and effectiveness of case management and defines the role more broadly in terms of broad-based resource coordination;
    - Focuses on the goal of authentic community inclusion, where people are included and engaged in their communities and inclusion is achieved and facilitated by everyone in the community.
    - Provides formal supports that complement and supplement natural support provided by family and community.
    - Increases service options to support employment, skill development, use of technology and community engagement; and
    - Increases the range of services that can be self-directed and the robustness of support for people to choose self-direction.
- Establishing the Lifespan Waiver in a way that does not disrupt services for or force change upon members enrolled in the existing Section 20, 21 and 29 waivers, but also provides an opportunity for these members to transition to the Lifespan Waiver as soon as possible after the Lifespan Waiver opens to each target population.

Services and Supports Individuals and Their Families Need Most

The services that individuals with ID, ASD and other related conditions and their families reported they need most included:

- Transportation;
- Services to support community involvement and participation based on interests and preferences, including volunteering opportunities.
- Employment services, including benefits and work incentives, counseling, and assistance with career advancement.
- Services that support finding and keeping positive relationships and opportunities to socialize to combat isolation and build natural sources of support.
- Behavioral health support services, including crisis intervention (in-home and in-community).
- In-home services focused on skills training and promoting maximal independence, including financial literacy skills.
- Services to support education and learning opportunities after high school.
- Services to support increased communication skills, including access to technology and training.
- Health and medical-related supports, including access to medical care and managing medications.
- Services that provide primary supporters a break while providing the person with quality experiences that align with their goals and needs.
- Peer-to-peer support for individuals with ID, ASD and other related conditions and peer-to-peer support for families and other natural supporters of these individuals.
- Support to assist individuals with ID, ASD and other related conditions, and their families/natural supports to navigate available community and system resources; and
- Supported living services that can enable an individual to have a home they can share with others, if they choose, that is not owned or controlled by a waiver service provider. **(**Provider stakeholders also identified these as services that individuals with ID and their families need most.) "Home" could mean an apartment, condominium, duplex, single-family home, manufactured home or mobile home.

As discussed above, a broad range of stakeholders consistently voiced support for a Lifespan Waiver as the appropriate "next step" for the State of Maine to provide HCBS more effectively to Mainers with ID, ASD and other related conditions, and to eliminate the waiting lists for these services.

Lifespan Waiver Eligibility

To be eligible for enrollment in the Lifespan Waiver an individual must:

- Be age 14 or older.
- Meet the same diagnostic requirements as Section 20, 21 and 29 waivers which include:
    - **For Section 20 (Other Related Conditions),** eligibility exists when a participant meets the minimum eligibility criteria for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50. The specific criterion for services is a severe, chronic disability that meets all of the following conditions:
      (a) It is attributable to —(1) Cerebral palsy or epilepsy; or 2) Any other condition, other than mental illness, found to be closely related to intellectual disabilities because this

condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons.
(b) It is manifested before the person reaches age 22.
(c) It is likely to continue indefinitely.
(d) It results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care. (2) Understanding and use of language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living.

- **For Section 21 and Section 29 (Intellectual Disabilities or Autism Spectrum Disorder)** eligibility exist when an individual meets the minimum eligibility criteria for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50. The specific criterion for services is a severe, chronic disability that meets all of the following conditions:
  (a) It is attributable to an Intellectual Disability (ID) as defined in 34-B M.R.S. §5001, or attributable to Autism Spectrum Disorder (ASD), which may include Rett's Syndrome. ID and ASD, including Rett's Syndrome, must be diagnosed following Diagnostic Criteria outlined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, (American Psychiatric Association).
  (b) It is manifested before the person reaches age 22.
  (c) It is likely to continue indefinitely.
  (d) It results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care. (2) Understanding and use of language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living.

- Be financially eligible according to MaineCare's Eligibility Manual[7]. Lifespan will utilize the same income/asset requirements as apply to Section 20, 21 and 29 waivers except that, based on stakeholder input, DHHS proposes disregarding 100% of earned income to encourage competitive integrated employment and economic self-sufficiency.

Proposed Policy on Prioritization for Enrollment

The state proposes to create 540 enrollment slots in the Lifespan Waiver initially. The state proposes to reserve a specific number of these enrollment slots each year for people in certain circumstances:

a. Individuals who choose to leave an ICF/IID or long-term nursing home placement or state psychiatric hospital setting;
b. Individuals under 21 in out-of-state residential placements;
c. Incapacitated or dependent adults who require adult protective services to alleviate the risk of serious harm from abuse, neglect and/or exploitation; and
d. Individuals determined to be at imminent risk of harm to self and/or others.

The number of enrollment slots reserved for each of the four listed categories above would be updated whenever the waiver is renewed or amended, based on the overall number of waiver slots and recent trends in need for each category of reserve slot.

[7] MaineCare Eligibility Manual 10-144 Chapter 322 (Effective November 6, 2022)

Beyond reserving slots for the above categories, the state proposes allocating 56% of available slots to adults (ages 18+) and 44% to youth (ages 14-17). These slots will be offered based on the following prioritization policy:

1. Adults on the waiting list that are receiving no HCBS (i.e., those not already enrolled in another HCBS waiver);
2. Youth as they apply and are found eligible. Once all slots allocated to youth are filled, youth will be enrolled as slots become available, with those who have waited for the longest being enrolled first; and
3. Adults on the waiting list, with those who have waited the longest being enrolled first.

All new enrollees to the Lifespan Waiver, ages 15 ½ and above, are required to have Supports Intensity Scale (SIS-A ®) needs assessment completed before enrollment to inform the larger comprehensive assessment and person-centered planning process and to ensure access to funding and services aligned with the level of need.

A Single Waiver that Can Serve People Across the Lifespan

The state must currently operate three waivers to serve the population of individuals proposed to be served through the Lifespan Waiver. This creates confusion for individuals and families, administrative complexity and costs for the state, inconsistent experiences, and challenging transitions across the lifespan for members served. To address these issues, the state proposes a single Lifespan Waiver that can serve individuals with ID, ASD and other related conditions. Additionally, rather than establishing separate transition-age youth and adult waivers, the Lifespan Waiver is proposed to serve individuals from high school transition through the end of life. To do this effectively, the Lifespan Waiver design proposed will include four (4) distinct enrollment groups:

For individuals of any age who can live with natural family supports, and for adults 18+ who can live independently, in a supported living arrangement, or with paid family supports (Shared Living-Related), three (3) enrollment groups are proposed:

- Transition-Age Youth & Young Adults: For individuals ages 14 through 21.
- Working-Age Adults: For individuals ages 22 to 64.
- Older Adults: For individuals ages 65 and older.

Movement from one of these groups to another as a person ages will occur automatically in Lifespan without the burden on individuals and families of requiring disenrollment from one program and enrollment into a new program.

For adults (18+) who are not able to live independently, with natural family supports, in a supported living arrangement or with paid family supports (Shared Living-Related), a fourth enrollment group is proposed, which will provide residential options in provider-owned or controlled settings (e.g., Shared Living-Unrelated services and Agency Group Home services).

When an individual enrolls in the Lifespan Waiver, the appropriate enrollment group will be determined and the individual will be enrolled accordingly. Each group will have access to a set of supports and services designed for the needs of that group, as well as annual funding allocations

related to those needs. (Note: The proposed services/supports and annual funding allocation for each enrollment group are discussed in more detail in subsequent sections of this paper.) By creating a single waiver that includes multiple enrollment groups to meet the varied needs of individuals in the target populations, the Lifespan Waiver can provide a program that will meet people's needs throughout their lifetimes, avoiding the challenges and confusion associated with otherwise having to transition between waivers as needs change. Instead of moving to a new waiver, an individual whose needs change can move to a different enrollment group within the same waiver.

Criteria for Each Lifespan Enrollment Group

Individuals meeting eligibility criteria to be enrolled in the Lifespan Waiver, as described above, will be enrolled in the specific enrollment group for which they meet the following criteria:

Enrollment Group	Age Criteria	Living Situations Able to Meet Individual's Assessed Needs
Group #1	Ages 14-21	All aged 14-17 will be enrolled in Group #1, as well as those aged 18-21 who, with Lifespan Group #1 services, are able to live: • Live independently (ages 18-21 only) • Live with natural family • Live in supported living arrangement (ages 18-21 only); and/or • Live in a Shared Living-Related setting with paid family supports (ages 18-21 only).
Group #2	Ages 22-64	With Lifespan Waiver services available in this enrollment group, the person is able to: • Live independently • Live with natural family • Live in a Supported Living arrangement; and/or • Live in a Shared Living-Related setting with paid family supports.
Group #3	Ages 65+	With Lifespan Waiver services available in this enrollment group, the person is able to: • Live independently • Live with natural family • Live in a Supported Living arrangement; and/or; • Live in a Shared Living-Related setting with paid family supports.
Group #4	Ages 18+	With Lifespan Waiver services available in the enrollment group otherwise appropriate to age, the person is **not** able to: • Live independently • Live with natural family • Live in a Supported Living arrangement; and/or • Live in a Shared Living-Related setting with paid family supports

		and therefore needs placement in a provider owned or controlled residential setting (i.e., Shared Living-Unrelated setting or Agency Group Home setting.)

It is proposed that Lifespan Waiver participants will be able to transition between enrollment groups based on a change in age and/or needs that results in an updated determination of the least restrictive, most integrated living situation able to meet the participant's assessed needs.

Determination of Least Restrictive, Most Integrated Living Situation Able to Meet a Member's Needs

The determination of the least restrictive, most integrated living situation where a member's assessed needs can be appropriately met will be made using an objective assessment process that evaluates the member's needs and the various available living situations that can be supported using Lifespan Waiver services and other identified services and resources available to the member. This process will be fully outlined in policy and referenced in MaineCare rule. Members will have normal appeal rights if they disagree with the outcome of the process.

Enrollment Groups and Proposed Services Available for Each Group

Group #1 Individuals who are aged 14-17, as well as those aged 18-21, who with Lifespan Group #1 services, are able to:

- Live independently (ages 18-21 only)
- Live with natural family
- Live in supported living arrangement (ages 18-21 only); and/or
- Live in a Shared Living-Related setting with paid family supports (ages 18-21 only).

In addition to the supports and services proposed to be offered through the Lifespan Waiver, youth under age 21 will continue to have access to the full array of benefits provided through EPSDT[8]. Additionally, all youth and young adults enrolled in the Lifespan Waiver will continue to have access to NET (non-emergency transportation) and other Medicaid State Plan services for which they are eligible, public school system supports including special education services, vocational rehabilitation services including pre-employment transition services, workforce system services and other community resources available to youth, young adults and their families. Lifespan Group #1 supports will be designed to ***supplement and sustain***, but not completely nor unnecessarily replace these other unpaid and paid supports available to participants. Lifespan Group #1 services will fill gaps, thereby assisting transition-age youth in experiencing a successful transition to adulthood and further assisting their families in meeting the unique challenges of supporting a youth or young adult with ID, ASD or other related conditions to thrive in this phase of the lifespan.

[8] The Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. Under the Social Security Act Section 1905(r)(5), states are required to provide any medically necessary health care services listed at section 1905 (a) of the Social Security Act to correct and ameliorate physical and mental conditions even if the service is not included under the state's Medicaid plan.

Proposed Services and Supports Available for Lifespan Enrollment Group #1

Enrollment Group	**#1**
Target Population	All aged 14-17 will be enrolled in Group #1, as well as those aged 18-21 who, with Lifespan Group #1 services, are able to live: • Live independently (ages 18-21 only) • Live with natural family • Live in supported living arrangement (ages 18-21 only); and/or • Live in a Shared Living-Related setting with paid family supports (ages 18-21 only).
Services ***=Option to self-direct**	Community Resource Coordination (broad-based case management) Supported Employment – Individual including (when not otherwise available to the participant through vocational rehabilitation or special education): *Employment Exploration *Integrated Employment Path Services *Career Planning *Job Development or Self-Employment Start-Up Plan *Job Development or Self-Employment Start-Up Services *Job Coaching Co-Worker Supports (alternative to use of job coaching services) *Community Transportation (non-medical) Benefits and Work Incentives Counseling Assistive Technology and Adaptive Aids (including non-durable medical supplies) Remote Supports Technology and Real-Time Response Service Peer Specialist Services *Personal Care/Assistance Home Support (after first exhausting Section 96 Personal Care Services as applicable) *Home-Based Independent Living Skills Training (including financial literacy) *Personal Care/Assistance-Community Support *Community Membership, Volunteering, and Relationship Supports

	Positive Behavioral Support Services (including counseling and therapeutic services and crisis prevention/intervention/stabilization services) *Respite Breaks and Opportunities: regular and emergency (including, when necessary, temporary out-of-home placement) Family Empowerment and Systems Navigation Counseling Natural/Family Caregiver Education and Training *Individual-Directed Goods and Services (part of self-direction) *Support Broker (part of self-direction) Housing Counseling and Start-Up *Supported Living Services (ages 18-21) Shared Living-Related Services (ages 18-21) Physical, Occupational and Speech/Language Therapies (ages 18-21) *Skilled Nursing (age 21 only) Minor Home Modifications (cost outside of participant's annual funding limit) (Note: Representative Payee services cannot be covered under a Medicaid waiver, per federal regulations.)

Group #2: Working-age individuals, ages 22-64, who with Lifespan Waiver services available in this enrollment group, are able to:

- Live independently
- Live with natural family
- Live in a Supported Living arrangement; and/or
- Live in a Shared Living-Related setting with paid family supports.

In addition to the supports and services proposed to be offered through the Lifespan Waiver, working-age adult participants will continue to have access to non-emergency medical transportation as authorized through the States 1915(b) non-emergency transportation waiver and other Medicaid State Plan services for which they are eligible, public school system supports, including special education services, vocational rehabilitation services, including pre-employment transition services, workforce system services and other community resources available to working-age adults. Lifespan Group #2 supports will be designed to ***supplement and sustain***, but not completely or unnecessarily replace these other unpaid and paid supports available to participants. Lifespan Group #2 services will fill gaps, thereby assisting working-age adults in experiencing a full, productive life that maximizes their:

- Independence

- Community participation
- Interdependence with friends, family, and other members of the broader community
- Productivity
- Financial self-sufficiency
- Health, including mental health.

Group #2 services are identified and designed to enable working-age individuals with ID, ASD, and other related conditions to thrive in this lifespan phase.

Proposed Services and Supports Available for Lifespan Enrollment Group #2

Enrollment Group	**#2**
Target Population	With Lifespan Waiver services available in this enrollment group, the person is able to: • Live independently • Live with natural family • Live in a Supported Living arrangement; and/or • Live in a Shared Living-Related setting with paid family supports.
Services ***=Option to self-direct**	Community Resource Coordination (broad-based case management) Supported Employment – Individual including (when not otherwise available to the participant through vocational rehabilitation or special education): *Employment Exploration *Integrated Employment Path Services *Career Planning *Job Development or Self-Employment Start-Up Plan *Job Development or Self-Employment Start-Up Services *Job Coaching Co-Worker Supports (alternative to use of job coaching services) *Career Advancement *Community Transportation (non-medical) Benefits and Work Incentives Counseling Assistive Technology and Adaptive Aids (including non-durable medical supplies) Remote Supports Technology and Real-Time Response Service Peer Specialist Services

	*Consumer Education and Training (including education and training on supported decision-making) *Personal Care/Assistance Home Support (after first exhausting Section 96 Personal Care Services as applicable) *Home-Based Independent Living Skills Training (including financial literacy) *Personal Care/Assistance-Community Support *Community Membership, Volunteering, and Relationship Supports Positive Behavioral Support Services (including counseling and therapeutic services, crisis prevention/intervention/stabilization services) *Respite Breaks and Opportunities: regular and emergency (including, when necessary, temporary out-of-home placement) Family Empowerment and Systems Navigation Counseling *Home-Based Independent Living Skills including Financial Unpaid Natural/Family Caregiver Education and Training *Individual-Directed Goods and Services (part of self-direction) *Support Broker (part of self-direction) Housing Counseling and Start-Up *Supported Living Services Shared Living-Related Services Physical, Occupational and Speech/Language Therapies *Skilled Nursing (after first exhausting Section 96 Private Duty Nursing Services as applicable) Minor Home Modifications (cost outside of participant's annual funding limit) (Note: Representative Payee services cannot be covered under a Medicaid waiver, per federal regulations.)

Group #3: Individuals ages 65+ who with Lifespan Waiver services available in this enrollment group, are able to:

- Live independently
- Live with natural family
- Live in a Supported Living arrangement; and/or;
- Live in a Shared Living-Related setting with paid family supports.

In addition to the supports and services proposed to be offered through the Lifespan Waiver, available, retirement-age adult participants will continue to have access in accordance with Maine's approved 1915(b) waiver for non-emergency medical transportation and other Medicaid State Plan services for which they are eligible, senior services, vocational rehabilitation services, workforce system services and other community resources available to retirement-age adults. Lifespan Group #3 supports will be designed to ***supplement and sustain***, but not completely or unnecessarily replace these other unpaid and paid supports available to participants. Lifespan Group # services will fill gaps, thereby assisting retirement-age adults to age in place as long as possible, while enjoying a full and personally meaningful lifestyle, emphasizing multi-generational opportunities and specializing as needed to address with an ID, ASD or other related conditions.

Group #3 services are identified and designed to enable retirement-age individuals with ID, ASD and other related conditions to live with purpose and dignity in this final phase of their lifespan.

Proposed Services and Supports Available for Lifespan Enrollment Group #3

Enrollment Group	**#3**
Target Population	Individuals ages 65+ who with Lifespan Waiver services available in this enrollment group, are able to: • Live independently • Live with natural family • Live in a Supported Living arrangement; and/or; • Live in a Shared Living-Related setting with paid family supports.
Services ***=Option to self-direct**	Community Resource Coordination (broad-based case management) *Personal Care/Assistance Home Support (after first exhausting Section 96 Personal Care Services as applicable) *Home-Based Independent Living Skills Training (including financial literacy) *Personal Care/Assistance-Community Support *Community Membership, Volunteering, and Relationship Supports

	Supported Employment – Individual, including (when not otherwise available to the participant through vocational rehabilitation or special education): *Employment Exploration *Integrated Employment Path Services *Career Planning *Job Development or Self-Employment Start-Up Plan *Job Development or Self-Employment Start-Up Services *Job Coaching Co-Worker Supports (alternative to use of job coaching services) *Career Advancement *Community Transportation (non-medical) Benefits and Work Incentives Counseling Assistive Technology and Adaptive Aids (including non-durable medical supplies) Remote Supports Technology and Real-Time Response Service Peer Specialist Services *Consumer Education and Training (including education and training on supported decision-making) Positive Behavioral Support Services (including counseling and therapeutic services, crisis prevention/intervention/stabilization services) *Respite Breaks and Opportunities: regular and emergency (including, when necessary, temporary out-of-home placement) Family Empowerment and Systems Navigation Counseling *Home-Based Independent Living Skills including Financial Unpaid Natural/Family Caregiver Education and Training *Individual-Directed Goods and Services (part of self-direction) *Support Broker (part of self-direction) Housing Counseling and Start-Up *Supported Living Services Shared Living-Related Services

	Physical, Occupational and Speech/Language Therapies *Skilled Nursing (after first exhausting Section 96 Private Duty Nursing Services as applicable) Minor Home Modifications (cost outside of participant's annual funding limit) (Note: Representative Payee services cannot be covered under a Medicaid waiver, per federal regulations.)

Group #4: Adults 18+ who, with Lifespan Waiver services available in the enrollment group otherwise appropriate to age (i.e., Group #1, #2 or #3), are **not** able to:

- Live independently
- Live with natural family
- Live in a Supported Living arrangement; and/or
- Live in a Shared Living-Related setting with paid family supports

and therefore needs placement in a provider owned or controlled residential setting (i.e., Shared Living-Unrelated setting or Agency Group Home setting.)

In addition to the supports and services proposed to be offered through the Lifespan Waiver, Group #4 adult participants will continue to have access to non-emergency medical transportation and other Medicaid State Plan services for which they are eligible, vocational rehabilitation services, workforce system services and other community resources available based on the participant's age in accordance with Maine's approved 1915(b). In addition, Lifespan Group #4 participants will be assisted to maintain and develop natural (unpaid) supports and will continue to have access to age-specific services including:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (available to those under the age of 21)
- Pre-employment transition services (age 14-21)
- Senior services (based on age range established for these services)

Lifespan Group #4 supports will be designed to ***supplement and sustain***, but not completely or unnecessarily replace these other unpaid and paid supports available to participants. Lifespan Group #4 services will assist adults most at risk of institutionalization to avoid this outcome.

Group #4 services are identified and designed to enable working-age individuals with ID, ASD and other related conditions to experience a full, productive life that maximizes their:

- Independence
- Community participation
- Interdependence with friends, family and other members of the broader community
- Productivity
- Financial self-sufficiency
- Health, including mental health.

For retirement-age participants, Group #4 services are identified and designed to enable individuals with ID, ASD and other related conditions to live with purpose and dignity in this final phase of the lifespan.

Proposed Services and Supports Available for Lifespan Enrollment Group #4

Enrollment Group	**#4**
Target Population	Adults 18+ who, with Lifespan Waiver services available in the enrollment group otherwise appropriate to age (i.e., Group #1, #2 or #3), are **not** able to: • Live independently • Live with natural family • Live in a Supported Living arrangement; and/or • Live in a Shared Living-Related setting with paid family supports and therefore needs placement in a provider owned or controlled residential setting (i.e., Shared Living-Unrelated setting or Agency Group Home setting.)
Services ***=Option to self-direct**	Community Resource Coordination (broad-based case management) Supported Employment – Individual, including (when not otherwise available to the participant through vocational rehabilitation or special education): *Employment Exploration *Integrated Employment Path Services *Career Planning *Job Development or Self-Employment Start-Up Plan *Job Development or Self-Employment Start-Up Services *Job Coaching Co-Worker Supports (alternative to use of job coaching services) *Career Advancement *Community Membership, Volunteering, and Relationship Supports *Community Transportation (non-medical, for employment only) Benefits and Work Incentives Counseling Assistive Technology and Adaptive Aids (including non-durable medical supplies) Remote Supports Technology and Real-Time Response Service *Consumer Education and Training (including education and training on supported decision-making) Positive Behavioral Support Services (including counseling and therapeutic services and crisis prevention/intervention/stabilization

	services) *Individual-Directed Goods and Services (part of self-direction) *Support Broker (part of self-direction) Housing Counseling and Start-Up (to transition out of provider owned or controlled residential setting) Shared Living-Unrelated Services Agency Group Home Support Services Physical, Occupational and Speech/Language Therapies (Notes: Representative Payee services cannot be covered under a Medicaid waiver, per federal regulations. Also, certain services available in other enrollment groups but not listed for Group #4 are proposed to be included in residential services and rates, including Community Transportation (for non-employment purposes), in-home Personal Care/Assistance, Independent Living Skills Training, Personal Care/Assistance for Community Participation, Skilled Nursing and Minor Home Modifications.)

Strategy for Establishing Annual Funding Allocations for Lifespan Enrollment Groups

The proposed Lifespan Waiver design includes annual funding allocations for participants in each enrollment group. Participants receive the annual funding allocation that is calculated for their enrollment group. Those determined through the SIS-A to have exceptional needs will receive the higher "exceptional needs" annual funding allocation calculated for their enrollment group.

The annual funding allocation levels will be established by a qualified actuary and evaluated for appropriateness at regular intervals. The methodology proposed for establishing and updating the annual funding allocations is anticipated to include the following elements:

1. **Payment rates for Lifespan Waiver services, developed through a rate study** following federal and state requirements for establishing payment rates, including:
   - The federal requirement that rates "*are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers".*
   - State legislation that calls for "*simplified and effective payment methods"* to promote quality and efficiency and reduce administrative burden for service providers and the DHHS ; and
   - The state regulatory requirement to ensure the direct service professional's wage included in each reimbursement rate model is no less than 125% of the state minimum wage.

   The process proposed is also expected to:

- Utilize Lifespan service definition and provider qualification requirements to develop appropriate rate methodologies for each service.
- Design a tiered rate structure for certain services including Shared Living and Agency Group Home Support Services; and
- Consider the opportunity to utilize outcome and value-based payment approaches (also known as alternative payment methodologies) to better align payments for services with quality, provider high-performance and program goals.

2. **For each enrollment group, projected utilization of available Lifespan Waiver services,** including the types and amounts of services projected to be utilized by participants in each Lifespan enrollment group. These projections will be informed by:
   - Needs profiles of individuals on the waiting list and members in Section 20, 21 and 29; and
   - Historical service authorizations and service utilization by members in Section 20, 21, and 29 who have needs similar to those on the waiting list and expected to be enrolled in the Lifespan Waiver. This process will take into consideration recent challenges with the availability of direct support professionals for some services, as appropriate, by including service authorization data in addition to service utilization data.

3. **Determination of exceptional needs (e.g., medical and/or behavioral needs),** which indicate enhanced supports and services are likely to be necessary, and quantifying the projected amount of enhanced supports that will be needed.
   - The state is using the Supports Intensity Scale for Adults® (SIS-A®) because it is a valid and reliable tool for member needs assessment. Developed and maintained by the American Association on Intellectual and Developmental Disabilities (AAIDD), the SIS-A® is a comprehensive tool that fairly and objectively measures support needs in the areas of: home living; community living; health and safety; lifelong learning; work; social; and advocacy activities. It has been in use since 2004. Through the comprehensive application of the SIS-A®, a person with exceptional needs can be accurately identified.

4. **Calculation of costs for projected service utilization, by enrollment group and according to whether a participant has exceptional needs.**
   - This step in the proposed process is designed to result in actuarily sound annual funding allocations for each enrollment group, including appropriate annual funding allocations for those with exceptional needs in each enrollment group. Projected costs will be based on payment rates for Lifespan services, developed as described above, and applied to projected service utilization.

It is important to note that the initial annual funding allocations set for each enrollment group, including those set for participants with exceptional needs, will be adjusted over time based on actual authorizations and utilization by Lifespan enrollees.

The Self-Direction Option within the Lifespan Waiver

One goal of the Lifespan Waiver is to increase opportunities for self-direction. Stakeholder support for this goal is strong. OADS has a stakeholder group specifically focused on self-

direction that has been meeting for more than two years. For all Lifespan Waiver participants, a Person-Centered Plan is established based on a comprehensive assessment of the participant's desired outcomes and related needs for assistance to achieve these outcomes. If the Person-Centered Plan includes specific Lifespan Waiver services that can be self-directed, the option to self-direct will be presented and discussed to ensure informed choice. The self-direction model proposed for the Lifespan Waiver will:

- **Allow enrollees of all ages to self-direct.** For minors the responsible adult or legal guardian will act for the minor participant, including acting as employer of record.

- **Offer a Support Broker service as an administrative cost, not included in the annual funding allocation or self-direction budget for participants choosing to self-direct.** This service can provide support to a participant choosing to self-direct, including support to recruit, hire, and manage self-direction workers and support to utilize a self-direction budget in creative ways that conform to the waiver rules for self-direction. Based on the number of services a participant chooses to self-direct, an annual allocation of Support Broker hours will be authorized. To ensure adequate Support Broker capacity, the state proposes to conduct a request-for-proposal process to recruit and select Support Broker agencies and qualified individual providers. A nationally recognized curriculum is proposed to be required for those providing Support Brokerage services. The state proposes to explore how to include stakeholder representatives in the RFP development and scoring process.

- **Provide Financial Management Services** (FMS) **as an administrative cost, not included in the annual funding allocation or self-direction budget for participants choosing to self-direct.** The state proposes to offer choice of FMS by conducting a request-for-proposal process to select two FMSs. Each contracted FMS will be required to produce written materials in language accessible for individuals with ID and ASD. Selected FMSs will also be eligible to respond to the request-for-proposal to provide Support Broker services; but FMSs will not be the only eligible provider for Support Broker services. The State would require an FMS to undergo a readiness review as part of the provider approval process.

- **Implement budget authority and employer authority for each service a participant chooses to self-direct.** Once a participant identifies the service(s) in their Person-Centered Plan that they wish to self-direct, a budget for each service will be established. The participant, with assistance as needed from a Support Broker (if desired), natural supports, and/or legally appointed representative will be able to manage each service budget by hiring any qualified provider (individual or agency) that they choose to deliver the service and to train/direct/supervise and, if necessary, fire the qualified provider. Wage negotiation is proposed to be part of the authority granted to the participant, with minimum and maximum wage levels for each self-directed service set in policy based on three factors: (1) existing state regulatory requirement to pay no less than 125% of minimum wage; (2) wage assumptions in the service-specific rates used to calculate the self-direction budget; (3) worker qualifications required to provide each specific service. The model allows a qualified self-direction worker to provide multiple services to a

participant. The Community Resource Coordinator (case manager) will be responsible for monitoring the participant's use of self-direction, including budget utilization to ensure the budget is not exceeded and is being used consistently with the approved service definitions for the self-directed services.

- **Establish Individual-Directed Goods and Services as a waiver service option** to allow a participant to use an unexpended portion of a self-directed service(s) budget(s) to purchase items or services that are needed but not otherwise offered through the waiver. These purchases must follow federal guidelines and are designed to help participants become more independent, more integrated in their community, safer and/or healthier. The purchases link to a desired outcome or assessed need in the participant's Person-Centered Plan. A participant may set aside up to $10,000 at any given time for purchases under Individual-Directed Goods and Services, with their plan for using the funds outlined in the Person-Centered Plan. OADS will publish a list of items and services not coverable under Individual-Directed Goods and Services, per federal requirements. Any denial of a request for a purchase under this category will prompt a notice of action and corresponding appeal rights. OADS will consider publishing a list of pre-approved items and services if the standard conditions noted above are met. Some common examples of purchases include gym memberships, Uber/Lyft rides to and from places in the community, therapeutic horseback riding and music therapy.

- **Include the following proposed Lifespan Services as self-direction options** in addition to providing Support Broker and Financial Management Services outside of the annual funding allocation and self-direction budget of the participant:
    - Supported Employment – Individual, including (when not otherwise available to the participant through vocational rehabilitation or special education):
        - Employment Exploration
        - Integrated Employment Path Services
        - Career Planning
        - Job Development or Self-Employment Start-Up Plan
        - Job Development or Self-Employment Start-Up Services
        - Job Coaching
        - Career Advancement
    - Community Transportation (non-medical)
    - Consumer Education and Training (including education and training on supported decision-making)
    - Personal Care/Assistance: at home and in the community
    - Home-Based Independent Living Skills Training (including financial literacy)
    - Community Membership, Volunteering and Relationship Supports
    - Respite Breaks and Opportunities: regular and emergency (including, when necessary, temporary out-of-home placement)
    - Skilled Nursing

    - Supported Living Services (not including provider owned or controlled residential settings)
    - Individual-Directed Goods and Services (part of self-direction)
    - Support Broker (part of self-direction)

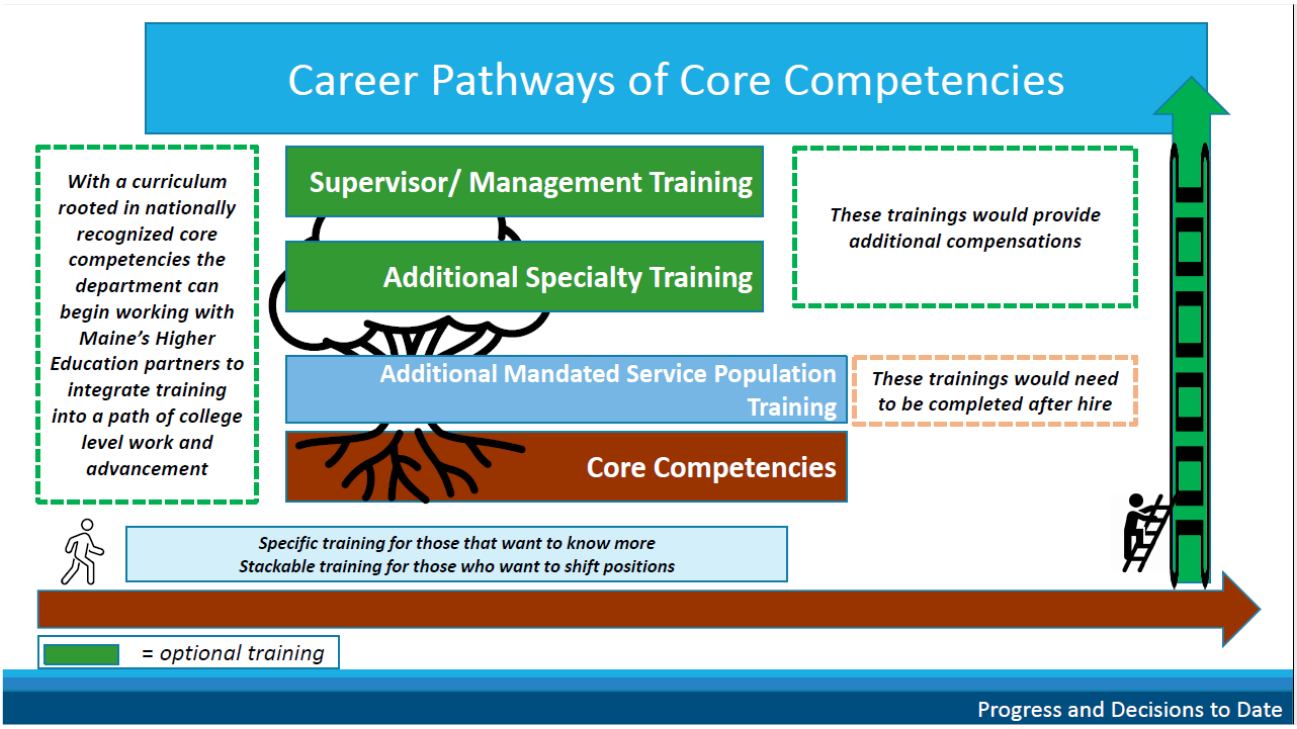
Lifespan Provider Network

When stakeholders were asked to provide input on how the Lifespan Waiver could ensure a high-quality provider network with sufficient capacity to provide the proposed services to Lifespan participants, they made a range of comments and suggestions that shaped the proposed provider network approach for the Lifespan Waiver:

- Maintain the commitment to welcoming any willing and qualified provider to be part of the Lifespan Waiver to maximize capacity and choices, while setting minimum provider qualifications to ensure a base level of performance that supports the success of the Lifespan Waiver and the services available;
- Utilize a comprehensive provider network development approach that includes:
    - Meaningful new provider application review, considering experience, existing service delivery, person-centeredness and, as required under federal regulation, ensuring full compliance with the HCBS Settings Rule;
    - Implement a provider network quality assurance team within OADS and a provider network quality assurance process that not only ensures ongoing minimum compliance, but also promotes and supports continuous quality improvement;
    - Adopt an overall approach to monitoring and evaluating the quality of services delivered by provider organizations that focuses on those things that most impact quality of life for individuals served and ensures everyone involved understands why certain things are being monitored and evaluated;
    - Offer a payment structure for Lifespan services that includes simplified and effective payment methods to promote both quality and efficiency while also reducing administrative burdens for service providers, ensures appropriate direct support professional (DSP)[9] compensation occurs, offers some outcomes or performance-based financial incentives to increase quality, uses strategies to fade paid supports over time, effectively serves individuals with exceptional needs and provides services in ways that align with the Lifespan Waiver's overall program goals; and
    - Implement other strategies to reduce administrative burden and lower administrative overhead costs for providers, including avoidance of rules and restrictions that unnecessarily limit flexibility for individuals served and provider agencies.
- Ensure direct support professionals (DSPs) are adequate in number, appropriately prepared for the work, knowledgeable about the services they are providing, fairly compensated and incentivized to stay using effective supervision and career ladder opportunities that do not take DSPs away from the direct service role by:

[9]In Lifespan, it is proposed that qualified DSPs, not Personal Support Specialists (PSSs), will deliver the services that do not require a license (i.e., services other than Skilled Nursing, therapies).

- Ensuring provider agencies have access to the most current and evidence-based strategies for recruitment and retention in use nationally for HCBS waivers serving individuals with ID, ASD and other related conditions.
- Facilitating provider agency access to non-traditional workforce, including individuals with disabilities who want to work in service provision, family members and workers who can be recruited from out-of-state, etc.
- Implementing a levels-based professional development approach for DSPs focusing on foundational pre and early service core competencies as minimum requirements with additional post-hire opportunities for DSPs to complete additional training to increase their qualifications and compensation.



Source: OADS

- Establishing appropriate expectations and support for the professional development and performance of the direct supervisors of DSPs.
- Utilizing strategies that have been successful in other states to ensure DSP compensation (pay and benefits) is sufficiently aligned with the level of compensation assumed in the reimbursement rate for the Lifespan service that the DSP is providing.
- Ensuring DSPs who have more experience, training and/or certifications necessary to effectively support individuals with exceptional medical and/or behavioral needs have compensation which reflects the fact they are more highly qualified and serving individuals with exceptional needs; and

- Recognizing and elevating the stories of DSPs who are performing at an exceptional level and/or responsible for a Lifespan participant(s) achieving exceptional outcomes.

Ensuring Comprehensive, Effective Case Management through Implementation of a Community Resources Coordination Service

In the initial stakeholder engagement sessions conducted in the fall of 2022, the state proposed a more broad-based coordination role for case management in the Lifespan Waiver program. Support for this was reinforced by stakeholders who raised many concerns about the lack of coordination at the individual participant level between HCBS waiver programs and other service systems, including education, vocational rehabilitation, behavioral health, and children's services. Stakeholders noted that good case management makes all the difference in quality of services and that individuals cannot be enrolled in an HCBS waiver without a case manager being available to them. Recognizing the critical importance of this role, stakeholders identified a range of concerns with case management that the Lifespan Waiver should attempt to address:

- Dealing with two different case management systems, one for children and one for adults, can be challenging for individuals and families and interfere with successful transition to adulthood.
- Case managers:
    - Carry high caseloads causing them to burn out and/or not being able to help those who rely on them;
    - Are perceived to be filling entry-level positions;
    - Have few opportunities for advancement to earn higher pay for higher qualifications, skills and/or experience;
    - May often lack critical skills for the role: facilitation skills, mediation skills, listening and reflection skills, consensus-building skills, motivational interviewing skills and life coaching skills;
    - Do not typically teach and support individuals to manage their own Person-Centered Plans and the process to develop these plans;
    - Are challenged by administrative requirements and bureaucracy;

To attempt to address the many varied issues raised by stakeholders and the expectations for a case management service that will support the success of the Lifespan Waiver, the state is proposing the following:

- Developing a case management service that is defined uniquely for the Lifespan Waiver, preliminarily titled "Community Resource Coordinator" to differentiate it from other case management roles. This service will encompass the critical importance of coordinating natural supports, services across systems and community resources as part of assisting

individuals to fully develop their Person-Centered Plans and achieve their desired outcomes through effective implementation of their plans.

- Establishing caseload maximums based on the core functions of the Lifespan Community Resource Coordinator that will include greater expectations for coordination and connecting individuals and their families to resources outside of the Lifespan Waiver.
- Exploring the feasibility of strategies that have been successful in other states to ensure compensation (pay and benefits) for this role is sufficiently aligned with the level of compensation assumed in the reimbursement rate for this service in the Lifespan Waiver.
- Offering effective competency-based training on the Community Resource Coordinator role and functions, including person-centered thinking, comprehensive strengths-based assessment, the Person-Centered Plan, and person-centered planning process expectations, focused on identifying the individual's:
    - **Vision** for a good life
    - **Goals and desired outcomes** that are necessary for the person to achieve or sustain their vision for a good life
    - **Needs** that must be met to ensure the person can achieve or sustain their vision for a good life
    - **Supports and services** available through natural relationships, local community resources and other service systems
    - **Specific Lifespan Waiver services** needed.
    - **Lifespan Service provider(s)** selected by the individual to provide the needed Lifespan services

Regarding the person-centered planning process for the Lifespan Waiver, there is a need to ensure every part of the process provides value for participants and contributes to a strong and holistic Person-Centered Plan. Policy, training content and requirements, and monitoring will focus on ensuring a process that can be fluid while still meeting state regulatory requirements.[10]

Proposed Strategy for Ending the Waiting List

After the initial 540 slots are established in the Lifespan Waiver, additional slots are proposed to be created using funding from vacated slots in the Section 20, 21 and 29 waivers. Vacated slots occur each year when a waiver participant passes away, moves out-of-state, or otherwise decides to disenroll from a waiver. By transferring the funding associated with these vacated slots to the Lifespan Waiver, the state will be able to increase the total slots available in the Lifespan Waiver and serve new enrollees seamlessly across the lifespan. The proportions of newly created Lifespan Waiver slots allocated to youth and adults will be adjusted over time, based on demand and waiting list information. In addition to this strategy for ending the waiting list, additional appropriations may be sought to keep up with new demand and accelerate the pace at which the state can completely eliminate the waiting list.

Prior to the opening of the Lifespan Waiver (estimated 2025 for ID/ASD and 2026 for ORC), based on the Governor's proposed budget under deliberation in the Legislature, the Department

[10] See Maine's Global HCBS Waiver Person-Centered Settings Rule

expects to eliminate the Section 29 waiver waiting list. Assuming this, the Department expects to be able to completely eliminate the waiting list for individuals with ID, ASD and other related conditions by July 2028 using the strategies proposed above and assuming adequate capacity of the service delivery network. As noted previously, individuals with other related conditions will be included in the Lifespan Waiver, starting in the second year (estimated July 2026). Transfer of funding from vacated Section 20 slots is proposed to begin to occur after the Lifespan Waiver is open for individuals with other related conditions. The Department expects to be able to eliminate the waiting list for individuals with other related conditions by July 2029.

As newly created enrollment slots in the Lifespan Waiver are filled over time, the Department proposes to use the same prioritization policy as used for the initial 540 slots, offering slots based on the following prioritization policy until the waiting list is eliminated and individuals can be enrolled as soon as they are found eligible:

1. Adults on the waiting list that are receiving no HCBS (i.e., those not already enrolled in another HCBS waiver)
2. Youth as they apply and are found eligible. Once all slots allocated to youth are filled, youth will be enrolled as slots become available, with those youth who have waited the longest being enrolled first.
3. Other adults on the waiting list, with those who have waited the longest being enrolled first.

It is critically important to note that the strategies described above will not force a change for those already enrolled in the Section 20, 21 and 29 waivers. Individuals already enrolled in Section 20, 21 or 29 waivers will be able to remain on those waivers when the Lifespan Waiver opens in 2025 for individuals with ID and ASD, and 2026 for individuals with other related conditions. If an individual already enrolled in Section 20, 21 or 29 waiver services is happy with their services, they will not be required to transition to the Lifespan Waiver. **Additionally, funding associated with occupied slots in the Section 20, 21 and 29 waivers will continue to remain with those waivers until individuals leave those slots, at which time the funding will transfer to Lifespan.**

Addressing the Requirement for a Quality Assurance System

The proposed Lifespan Waiver must meet all assurances required under Section 1915(c) waivers, including assurances related to full and ongoing compliance with the HCBS Settings Rule. DHHS is committed to continuing to solicit input from stakeholders to ensure a person-centered approach and define a comprehensive quality assurance and continuous quality improvement strategy for all aspects of the proposed Lifespan Waiver. The proposed approach includes the use of quality measures from the first federally released HCBS measure set.[11] Also proposed is the use of the HCBS CAHPS survey[12] with Lifespan participants, including the supplemental Employment Module[13]. CAHPS stands for "Consumer Assessment of Healthcare Providers and Systems" and the HCBS version of this survey is designed to assess the experiences of adult

[11] See: HCBS Measure Set SMDL (medicaid.gov)
[12] See: CAHPS Home and Community Based Services Survey, August 30, 2016 (medicaid.gov)
[13] See: CAHPS Home- and Community-Based Services Survey: Supplemental Employment Module, English, August 10, 2016 (medicaid.gov)

Medicaid beneficiaries who receive long-term services and support from State HCBS programs. In Maine this survey is currently being piloted using ARPA Section 9817 grant funding. Additionally, as described above, the provider certification process utilized in Lifespan will focus on engagement with providers to continue to increase their qualifications and associated expertise, thus building quality over time. DHHS invites comments addressing how quality can be defined, measured, monitored, encouraged, and assured in the proposed Lifespan Waiver program.

Plans for Additional Public Comment on the Lifespan Waiver

DHHS is planning for the following additional public comment opportunities:

- A draft of the Lifespan Waiver application(s) for federal approval will be posted for a thirty-day public comment period. Comments received will be used to finalize the Lifespan Waiver application(s) submitted to CMS for federal approval. CMS may also post the submitted application(s) for an additional thirty-day public comment period; and

- Once federal approval is received MaineCare administrative rules for the Lifespan Waiver will be posted for public comment. Comments received will be used to finalize the administrative rules to implement the Lifespan Waiver.

To keep up with the process and progress on the development of the Lifespan Waiver, please regularly check the DHHS Lifespan Waiver webpage at: https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs-lifespan-project.

Appendix 1: Proposed Legislation to Support the Creation of the Lifespan Waiver

Lifespan Authorizing Language—LD 659

The Department put forth a bill that establishes the goals of the Lifespan program, LD 659, ***An Act to Promote Seamless and Flexible Home and Community Supports Across the Lifespan for Individuals with Intellectual and Developmental Disabilities or Autism***, presented by Rep. Crockett of Portland.

As of 6/23/23, the bill as amended and passed unanimously by the Joint Standing Committee on Health and Human Services, had received preliminary approval by the House and Senate and placed on the Special Appropriations Table.

The current status of the bill can be tracked on the Maine Legislature Bill search pages here.

Appendix 2: Sample Definitions for Lifespan Waiver Services

Note: These definitions are **samples** for stakeholder feedback. **These definitions are not proposed definitions for the Lifespan Waiver.** These definitions are provided only as examples to gather stakeholder feedback and inform the proposed service definitions that will be included in the Lifespan Waiver applications, which will be posted for public comment in the future.

LIFESPAN SERVICE	SAMPLE SERVICE DEFINITION
Community Resource Coordination (case management) *This is a waiver service that is an alternative to Targeted Case Management (TCM) available to participants in other MaineCare Waiver(s). This waiver service definition is an example of definition customized specifically for a single waiver. Provider qualifications, unit of service, reimbursement methodology and rate can also be customized to a single waiver if a waiver service, rather than TCM, is used to provide required case management.* *While TCM can be customized for a specific target population, it cannot be customized for a specific waiver.*	A case management and comprehensive supports/services coordination role involving direct assistance with gaining access to waiver program services and the effective coordination of waiver program services with other Medicaid-funded services, other publicly-funded services and programs (e.g. VR, school, workforce and other publicly-funded services), and other generic community services and resources (e.g. social, educational, religious, etc.) available to the individual, and family as applicable, regardless of the funding source. Community Resource Coordinators are responsible for: ● Conducting a comprehensive assessment of the individual, using both strengths and needs-based assessment methods and tools provided by OADS, in collaboration with the individual and others that know the individual well. ● Engaging with the individual (and legal representative/involved family members, as applicable) to accurately identify the individual's vision for his/her life and key goals/outcomes the individual wants to achieve. ● Providing education to individuals (and legal representatives/involved family as applicable) about: o The various services and supports available through the waiver that are effective options for enabling the individual to achieve each of the key goals/outcomes identified by the individual. o The option to self-direct certain services and supports that are available through the waiver. o The available providers for each service and support available through the waiver. o The person's rights, including choice of providers. ● Coordinating a person-centered planning process, consistent with the HCBS Settings Rule requirements, and developing a written person-centered plan (PCP), utilizing a template provided by OADS, which defines and documents: o The individual's goals/outcomes desired by the individual as part of his/her vision for a good and full life.

	o The individual's needs related to achieving his/her identified goals/outcomes necessary for achieving his/her vision for a good and full life. o The natural supports, other publicly funded supports and other community supports that the individual has available to assist him/her with achieving his/her identified goals/outcomes necessary for achieving his/her vision for a good and full life. o The types and amounts of waiver services and supports that are needed, in addition to the natural supports, other publicly funded supports and other community supports that the individual has available to assist him/her, in order to ensure the individual can achieve his/her identified goals/outcomes which are considered necessary for achieving his/her vision for a good and full life. o The setting in which the individual chooses to receive each waiver service, chosen from among setting options that are also documented in the PCP, including at least one non-disability specific setting option for each service. o The individual's choices regarding the option to self-direct certain services and supports that are included in the PCP. o The individual's choice of provider for each service and support included in the PCP that will not be self-directed. This includes assisting the person to consider and select from available providers. o Any modification(s) to HCBS Setting Rule requirements that may be necessary consistent with federal requirements for including such modification(s) in the PCP. o Required signatures. ● Providing ongoing coordination of the natural/unpaid supports, waiver services and services, supports and resources available from other sources including other publicly funded systems. ● Undertaking ongoing monitoring of the provision, adequacy, quality and effectiveness of waiver services/supports included in the person's PCP and progress toward goals/outcomes documented in the PCP. ● Undertaking ongoing monitoring of the person's health, safety and welfare. ● Providing ongoing support and information, as needed, to individuals (and legal representatives/involved family as

	applicable) who choose to self-direct certain services and supports that are included in the PCP and who do not utilize Support Broker services. ● Coordinating services and supports over time, which preserve the individual's ability to live in a community setting. ● Gathering information and completing evaluations specified by OADS related to continued functional and financial eligibility for the waiver; and ● There is a requirement of at least one (1) face-to-face visit with the person every other month during the first twelve (12) months of enrollment and then a minimum of quarterly after that time period, in addition to any other Community Resource Coordination activities.
Supported Employment-Individual **Employment Exploration**	This is a time-limited and targeted service designed to help a person make an informed choice about whether s/he wishes to pursue competitive integrated employment or self-employment (CIE). This service is not appropriate for waiver participants who already know they want to pursue CIE. This service includes career exploration activities to identify a person's specific interests and aptitudes for CIE, including experience and skills transferable to CIE. This service also includes exploration of CIE opportunities in the local area that are specifically related to the person's identified interests, experiences and/or skills through four to five uniquely arranged business tours, informational interviews and/or job shadows. Each person receiving this service should participate in business tours, informational interviews and/or job shadows uniquely selected based on his or her individual interests, aptitudes, experiences, and skills most transferable to CIE. (All people should not participate in the same experiences.) Each business tour, informational interview and/or job shadow shall include time for set-up, prepping the person for participation, and debriefing with the person after each opportunity. This service also includes introductory education on the numerous work incentives for individuals receiving publicly funded benefits (e.g., SSI, SSDI, Medicaid, Medicare, etc.). This service further includes introductory education on how Supported Employment services work (including Vocational Rehabilitation services). Educational information is provided to the person and the legal guardian and/or most involved family member(s), if applicable, to ensure legal guardian/family support for the person's choice to pursue CIE. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the person and the legal guardian/family, if applicable.

Supported Employment-Individual **Integrated Employment Path Services**	The provision of time-limited learning and work experiences, including volunteering opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in individualized competitive integrated employment or self-employment (CIE). Services are expected to specifically involve strategies that facilitate a participant's successful transition to CIE. Individuals receiving Integrated Employment Path Services must have a desire to obtain some type of CIE and this goal must be documented in the person-centered plan as the goal that Integrated Employment Path Services are specifically authorized to address. Services should be customized to provide opportunities for increased knowledge, skills and experiences specifically relevant to the person's *specific* individualized CIE goals and career goals. The expected outcome of this service is measurable gains in knowledge, skills and experiences that contribute to the individual achieving CIE. Integrated Employment Path Services are intended to develop and teach general skills that lead to CIE including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training. For a CIE goal that is self-employment, general skills also may include: scheduling; ordering; invoicing; managing business equipment/inventory and business accounts; and customer service. This service is not available if it is otherwise available to the individual, within typical timeframes, from Vocational Rehabilitation.
Supported Employment-Individual **Career Planning** *This is a service that exists in other MaineCare Waiver(s). The service definition sample is the definition already being used in other MaineCare Waiver(s).*	Career planning is a person-centered, comprehensive employment planning and direct support service. It is a focused, time-limited service engaging a member, who wants to work in competitive, integrated employment or self-employment (CIE), in identifying a career direction and developing a plan for achieving CIE paying at or above the State's minimum wage. The service provides assistance for members to obtain or advance in CIE. Career Planning assists in identifying skills, priorities, and capabilities determined through an individualized discovery process. This may include a referral to benefits planning, referral for an assessment for potential use of assistive technology to increase independence in the workplace, and/or for development of experiential learning opportunities and career options consistent with the member's skills and interests. Career Planning may be used to gather information to be used as

	part of preparation of a referral to Vocational Rehabilitation. When career exploration identifies an interest in competitive, integrated self-employment, the member will have the opportunity to explore similar businesses and determine potential steps necessary to develop a business. The outcome of this service is documentation (using the DHHS-OADS Maine Career Planning Tool) of the member's stated career objective and a career plan used to guide individual employment support. The member's support needs and Career Planning supports are documented in their Person-Centered Plan.
Supported Employment-Individual **Job Development or Self-Employment Start-Up Plan**	This is a time-limited and targeted service designed to create a clear and detailed plan for Job Development or for the start-up phase of Self-Employment. This service includes a planning meeting involving the individual and other key people who will be instrumental in supporting the individual to become employed in CIE. This service results in a written plan that incorporates the results and learning from other employment services, if previously authorized. For self-employment goals, this service results in the development of a self-employment business plan, including potential sources of business financing given that Medicaid funds may not be used to cover the capital expenses associated with starting a business. This service can also include development of a plan for career advancement for a person who wishes to obtain a promotion and/or a second individualized competitive integrated employment or self-employment (CIE) opportunity. The service is time-limited and focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to higher paying position or through a second individualized integrated employment or self-employment opportunity. For career advancement, the outcomes of this service are: (1) the identification of the person's specific career advancement objective; and (2) development of a viable plan to achieve this objective. This service is not available if it is otherwise available to the individual, within typical timeframes, from Vocational Rehabilitation.
Supported Employment-Individual **Job Development or Self-Employment Start-Up**	This is a time-limited service designed to implement a Job Development or Self-Employment Plan as follows: o **Job Development** is support to obtain an individualized competitive or customized job in an integrated employment setting in the general workforce, for which an individual is compensated at or above the minimum wage, but ideally not less than the customary wage and level of benefits paid by

	the employer for the same or similar work performed by individuals without disabilities (CIE). The Job Development strategy should reflect best practices and be adjusted based on whether the individual is seeking competitive or customized CIE. o **Self-Employment Start Up** is support in implementing a self-employment business plan. The outcome of this service is expected to be the achievement of an individualized competitive integrated employment or self-employment (CIE) outcome consistent with the individual's personal and career goals, as determined or validated through Exploration and Career Planning, if authorized, and as identified in the service authorization that guides the delivery of this service. This service can also assist a person who wishes to obtain a promotion and/or a second individualized competitive integrated employment or self-employment (CIE) opportunity. For these career advancement goals, the outcomes of this service is the person successfully achieving his/her specific career advancement objective. This service is not available if it is otherwise available to the individual, within typical timeframes, from Vocational Rehabilitation.
Supported Employment-Individual **Job Coaching** -	**Job Coaching** includes using job analysis to identify and provide services and supports that assist the individual in maintaining CIE, using the most effective and efficient means possible. Job coaching includes supports provided to the individual and his/her supervisor and/or co-workers, either remotely (via technology) or face-to-face. When Job Coaching is provided for someone working in competitive integrated **Self-Employment**, Job Coaching includes identifying and providing services and supports that assist the individual in maintaining self-employment, using the most effective and efficient means possible. Job coaching for self-employment includes supports provided to the individual, either remotely (via technology) or face-to-face. Supports must enable the individual to successfully operate the business (with assistance from other sources of professional services or suppliers of goods necessary for the type of business). Job Coaching supports should never supplant the individual's role or responsibility in all aspects of the business. Supports during each phase of employment or self-employment must be guided by a Job Coaching Fading Plan which incorporates an appropriate mix of best practices for the individual to achieve fading goals as identified in the Plan. Best practices typically include: (1) systematic teaching and instruction; (2) use of

	technology and adaptive aids; and (3) engagement of natural supervisor(s) and co-worker(s); and (4) job duty customization as necessary. Job Coaching must promote the individual's positive relationship with supervisor(s), interaction with coworkers without disabilities, suppliers/customers (if applicable), and overall integration into the workplace. Job Coaching must address the individual's health and safety needs in the workplace through use of best practices that will typically allow for fading over time. Job Coaching may include supports to ensure the individual, with supports otherwise provided by the employer, learns and adheres to workplace policies, safety, productivity, dress code, and work schedule. Job Coaching may include support to ensure the individual timely reports earnings to public programs. Job Coaching is provided where the member works, where the member chooses to meet the job coach outside of work, where the job coach is located (if service being provided remotely), and may also be provided at the individual's home, to assist the individual with home-based self-employment or to assist the individual with preparation for work if the service does not duplicate other services in the person-centered plan. Job Coaching requires, at minimum, a monthly contact with the individual and the employer. This service is not available if it is otherwise available to the individual, within typical timeframes, from Vocational Rehabilitation. This service may be used to continue needed Job Coaching after Vocational Rehabilitation-funded job coaching services have ended.
Supported Employment-Individual **Co-Worker Supports**	This service involves a contracted Supported Employment-Individual service provider (who receives a monthly service fee for their ongoing oversight and involvement) entering into an agreement with an employer to reimburse the employer for job coaching supports, beyond natural supports, provided by one or more co-workers and/or supervisors, agreeable to the person supported, in lieu of a provider agency job coach. This service can be considered at any time the individual wishes to have Co-Worker Supports rather than traditional agency job coach, given that Co-Worker Supports are less intrusive and expected to be less costly to implement than traditional agency Job Coaching service. This service can also be used when an employer wants to hire an individual; but has reasons for not wanting an external job coach in the workplace. The use of this service should also be authorized on a time limited basis (i.e., no more than six months at a time) and reviewed to determine ongoing need. This service cannot include payment for the supervisory and co-worker activities rendered as a

	normal part of the business setting and that would otherwise be provided to an employee without a disability. The co-worker(s) and/or supervisor(s) identified to provide the support to the person must pass background check and receive training from the Supported Employment-Individual provider agency, which is responsible for oversight and monitoring of paid Co-Worker Supports. The actual amount of Co-Worker Supports authorized is based on individual need as determined through an on-the-job support assessment, the format for which is prescribed by OADS and as outlined in a Co-Worker Supports Agreement using a template prescribed by OADS and jointly signed by the person, the Supported Employment-Individual provider and the employer.
Non-Medical Transportation **Community Transportation**	Community Transportation services are non-medical transportation services offered to enable individuals, and their personal assistants as needed, to gain access to competitive integrated employment, integrated community activities, resources, places and opportunities to engage with others to increase social connections and decrease isolation, as identified in the person-centered plan. These services allow individuals to get to and from typical day-to-day, non-medical activities such as employment, volunteer opportunities, the grocery store or bank, social events, clubs and associations, other civic activities, religious services and other opportunities to engage with fellow community members. This service is made available when public or other no-cost community-based transportation services are not available and the person does not have access to transportation through any other means (including natural supports). Whenever possible, family, friends, neighbors, co-workers or carpools are utilized to provide transportation without charge. When this service is authorized, the most cost-effective option should be considered first. This service is in addition to the medical non-emergency medical transportation (NET) service offered under the Medicaid State Plan through a transportation broker, which provides transportation to/from medical appointments and services. This service is also in addition to emergency medical transportation offered under the Medicaid State Plan.
Community Membership, Volunteering and Relationship Supports	Time-limited services which identify and arrange integrated community opportunities for the person to achieve his/her unique goals for community participation, involvement, membership, contribution and building/sustaining relationships and social connections. The service includes targeted education and training for specific skill development to enable the waiver participant to independently (or with natural supports and technology) engage in integrated community opportunities as specified in the person's Person-Centered Plan. This service focuses specifically on successful participation in community opportunities that offer the opportunity for meaningful, ongoing interactions with members of the broader community. This service also focuses on ensuring the

	ongoing interactions with members of the broader community lead to the development of a broader network of natural supports for the individual. The community connections component of this service is focused on assisting the person to find and become engaged in specific opportunities for community participation, involvement, membership, or contribution, including volunteering. The service focus on community connections includes the following: ● Connections to volunteer opportunities focused primarily on community contribution rather than preparation for employment. Connections to members of the broader community who share like interests and/or goals for community participation, involvement, membership and/or contribution. ● Connections to community organizations and clubs to increase the individual's opportunity to expand community involvement and relationships consistent with his/her unique goals for community involvement and expanded natural support networks, as documented in the Person-Centered Plan. ● Connections to formal/informal community associations and/or neighborhood groups. ● Community classes or other learning opportunities related to developing passions, interests, hobbies and further mastery of existing knowledge/skills related to these passions, interests and hobbies. ● Connections to community members, opportunities and venues that support an individual's goals related to personal health and wellness (e.g., yoga class, walking group, etc.). This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve their personally identified goals for community participation, involvement, membership, contribution and relationships/social connections, including developing and sustaining a network of positive natural supports. The provider is expected to provide this service in the appropriate integrated community setting(s) where the opportunities take place and the skills will be used. The skills training component of this service is instructional and training-oriented, and not intended to provide substitute task performance by staff. Skill training is focused on the development of skills identified in the Person-Centered Plan that will enable the person to continue participation in integrated community opportunities without waiver-funded supports (except technology if needed). This service may only include education and training for skill development related to: ● Developing and maintaining positive reciprocal relationships with members of the broader community who are not other waiver participants, paid staff or family members. ● Participation in volunteering, community activities, clubs, formal or informal membership groups and other opportunities for

	community involvement, participation and contribution (all so long as the activity clearly meets a goal(s) designated in the PCP). ● Accessing and using community services and resources available to the general public. ● Safeguarding personal financial resources in the community. ● Mobility training and travel training. ● Training on use of cell phone, PERS, or other technology to support independence and safety in the community. ● Skills for personal safety in the community. The provider must prepare and follow a plan utilizing systematic instruction and other evidence-based strategies for teaching the specific skills identified in the Person-Centered Plan. The provider must further ensure consistent teaching methods if multiple staff share responsibility for delivery of the service to a waiver participant. Community Membership, Volunteering and Relationship Supports can be provided in 1:1 or 1:2 staffing ratios and may utilize a hub (provider leased or owned location within a reasonable distance of the home of the individual served, or home of individual served) for: individuals sharing staff to meet to start/stop the service; place to take break between community opportunities; place to eat meal/snack and/or receive personal care that can't be done in community; place to receive service if community opportunities are canceled or must be skipped due to health/safety issues for individual. Community Membership, Volunteering and Relationship Supports is differentiated from Personal Care/Assistance-Community by the intended outcomes of the service. Community Membership, Volunteering and Relationship Supports is a time-limited service to enable the participant to be able to perform specific activities or instrumental activities of daily living without ongoing paid staff support. In contrast, Personal Care/Assistance-Community is expected to be an ongoing support service where a participant needs this level of ongoing support.
Personal Care/Assistance - Community	A range of services and supports designed to assist an individual with a disability to participate fully in his/her community including supports for activities of daily living and instrumental activities of daily living that the individual would typically do for themselves if they did not have a disability and that occur outside the home. Personal Assistance-Community services are provided outside the person's home and may be provided at an integrated workplace where the person is paid a competitive wage, or other places in the broader community to support community participation, involvement and contribution by the person. Personal Assistance-Community services must be provided consistent with the

	goals/outcomes defined in the Person-Centered Plan and with the over-arching goal of ensuring the individual's full community participation and inclusion. Participant goals and support needs, as documented in the Person-Centered Plan, shall be addressed by the Personal Assistance-Community provider in a manner that supports and enables the individual to achieve the highest level of independence possible. Personal Assistance-Community may be used to address assistance needs in the workplace and community, if personal care and assistance/supervision are the only type of supports an individual needs in these locations. Otherwise, personal care and assistance is included in Supported Employment or Community Membership, Volunteering and Relationship Supports services and the provider of those services shall be responsible for these needs during the hours that these services are provided. Eligible Personal Assistance-Community services include the following: ● As appropriate to the individual need, based on the nature of the community involvement, this service includes: ○ Assistance, support, supervision and partial participation with eating, toileting, personal hygiene and grooming, and other activities of daily living as appropriate and needed to sustain competitive integrated employment, integrated community participation, involvement and contribution. ○ Assistance with activities of daily living and instrumental activities of daily living outside the home, including accompaniment and minor problem-solving necessary to achieve and sustain increased independence, competitive integrated employment and inclusion in the community. ● Assistance to ensure the individual is always supported to the extent needed to interact with other members of the broader community, including assistance with engaging co-workers and community members participating in the same places and activities. ● Assisting individuals to develop an increased range of positive, reciprocal relationships is a key goal of Personal Assistance-Community. ● With consent of the individual, if natural supports and/or workplace colleagues are willing to provide supports that would otherwise be provided by a Personal Assistance-Community worker, this service involves training on how to provide the specific Personal Assistance services they are willing to provide.

	Personal Care/Assistance-Community Support can be provided in 1:1, 1:2 or 1:3 staffing ratios and may utilize a hub (provider leased or owned location within a reasonable distance of the home of the individual served, or home of individual served) for: individuals sharing staff to meet to start/stop the service; place to take break between community opportunities; place to eat meal/snack and/or receive personal care that can't be done in community; place to receive service if community opportunities are canceled or must be skipped due to health/safety issues for individual. Personal Care/Assistance-Community is differentiated from Community Membership, Volunteering and Relationship Supports by the intended outcomes of the service. Community Membership, Volunteering and Relationship Supports is a time-limited service to enable the participant to be able to perform specific activities or instrumental activities of daily living without ongoing paid staff support. In contrast, Personal Care/Assistance-Community is expected to be an ongoing support service where a participant needs this level of ongoing support.
Benefits and Work Incentives Counseling	A service designed to inform the individual (and legal guardian and/or family, if applicable) of the multiple pathways to ensuring individualized competitive integrated employment or self-employment (CIE) results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives that further ensure no loss of Lifespan Waiver financial eligibility as a result of working in CIE. This service also addresses myths and alleviates fears and concerns related to seeking and working in CIE by providing an accurate, individualized assessment. The service provides information to the individual (and legal guardian and/or family, if applicable) regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, Lifespan Waiver, housing subsidies, food stamps, etc. The service also will provide information and education to the person (and legal guardian and/or family, if applicable) regarding income reporting requirements for public benefit programs, including the Social Security Administration. This service is for individuals actively considering or seeking CIE, or career advancement in CIE. Service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation/interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.

	Benefits Counseling services are paid for on an hourly basis and limited in the following ways: a. Initial Benefits Counseling for someone actively considering or seeking CIE, or career advancement in CIE: up to twenty (20) hours. This service may be authorized no more than once every two (2) years (with a minimum of two 365-day intervals between services). b. Supplementary Benefits Counseling for someone evaluating a CIE job offer/promotion or CIE self-employment opportunity: up to an additional six (6) hours. This service may be authorized up to three (3) times per year if needed. c. PRN Problem-Solving services for someone to maintain CIE: up to eight (8) hours per situation requiring PRN assistance. This service may be authorized up to four (4) times per year if necessary for the individual to maintain CIE. This service is provided by a certified Community Work Incentives Coordinator (CWIC). This service is not available if it is otherwise available to the individual, within typical timeframes, from Vocational Rehabilitation or through the Federal Work Incentives Planning and Assistance (WIPA) program.
Consumer Education and Training	Consumer education and training services are designed to help participants develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over services and supports. Self-advocacy skills enable participants to communicate wants and needs, make informed decisions, and develop trusted supporters with whomever they can share concerns and consider decisions and choices. The consumer education and training service includes education and training for participants that is directly related to developing these skills. Covered expenses may include educational tutoring and training fees, enrollment fees, books and other educational materials, and transportation related to participation in training courses, conferences, and other similar events. This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.
Peer Specialist Services	A service that assists a person to develop and utilize skills and knowledge for self-determination in one or more of the following areas: ● Directing the person-centered planning (PCP) process; ● Understanding and considering self-direction; ● Understanding and considering individualized competitive integrated employment/self-employment (CIE); and ● Understanding and considering independent and supported and independent living options.

	The service is provided on a time-limited basis, determined by the person's individual need, by a peer with intellectual or developmental disabilities, autism or other related condition who has experience matched to the focus area(s), needs and goals of the person receiving this service: has successfully directed their own Person-Centered Planning process; has self-directed their own services; has successfully obtained CIE; and/or utilizes independent/supported living options. A qualified Peer Specialist service provider understands and empathizes with the person while working to empower the person, supporting three critical areas important for enhancing self-esteem and self-determination: ● The human need for connections, social supports and allies; ● Overcoming the disabling power of learned helplessness, low expectations, and the stigma of labels; and ● Supporting self-advocacy, informed choice and dignity of risk in decision making. The Peer Specialist service provider offers: ● Education and training on the principles of self-determination, informed decision making and informed risk-taking; ● One-on-one training, information and targeted support to encourage and support the person to lead their own Person-Centered Planning process, pursue self-direction, seek CIE and/or pursue independent living/supported living options in the community; ● Education on self-direction, including best practices recruiting, hiring and supervising staff; ● Planning support and support for exercising self-determination and using self-advocacy skills in regard to pursuing CIE; ● Planning support and support for exercising self-determination and using self-advocacy skills in regard to pursuing independent/supported living opportunities, including selection of place to live and, if needed or desired, housemates; and, ● Assistance with identifying opportunities for increasing natural allies a person has to rely on, including opportunities for the development of valued social relationships, and expanding unpaid sources of support in addition to, or reduce reliance on, paid services.
Family Empowerment and Systems Navigation Counseling	Family Empowerment and Systems Navigation Counseling matches the involved family members (e.g., support/care givers; legal guardians) of a participant with a local, trained family member or direct support professional with broad knowledge of the variety of programs and local community resources that are available to a participant and his/her family. The Family Empowerment Counseling and Systems Navigation Service is intended to be a time-limited service that involves assessment of the participant's situation (including needs, goals), assessment of the family's specific goals and needs for information, assistance, and referral to address the participant's and family's situation. The service further

	includes researching, as needed, and sharing of the identified information, connecting the family with assistance, and making referrals as appropriate. The goal of the service is to empower the family with the information, connections and referrals they need, and to work with the family to increase their skills in problem-solving and leveraging available programs and community resources, including Community Resource Coordination. This service is also intended, through temporary peer to peer supervision, to facilitate an opportunity for interested family members, who have received this service, to become providers of this service themselves in order to grow the network of providers of this service over time.
Unpaid Natural Family/Caregiver Education and Training	Definition: This service provides an unpaid natural support or caregiver unpaid caregiver of a waiver participant with education, training and technical assistance, as needed, to enable the unpaid natural family member/caregiver to effectively provide supports to the waiver participant as documented in the person-centered plan. The service enables the unpaid natural family member/caregiver for a waiver participant to: ● Achieve greater competence and confidence in providing supports ● Support the waiver participant's growth and development ● Sustain their role in providing natural, unpaid support and/or care for the waiver participant
Home-Based Independent Living Skills including Financial Literacy	Time-limited, focused service that provides targeted education and training for specific skill development to enable the waiver participant to develop ability to independently perform routine daily activities at home as specified in the person's Person-Centered Plan. Services are not intended to provide substitute task performance by staff. Services are instructional and training-oriented, focused on development of skills identified in the Person-Centered Plan. Independent Living Skills Training may include only education and training for skill development related to: ● Personal hygiene, self-care skills and routines ● Food and meal preparation, including menu planning ● Home upkeep/maintenance including outdoor upkeep/maintenance as applicable ● Money management including skills for controlling and safeguarding personal financial resources ● Home-based communication device use (e.g., computer/phone/cell phone) ● Skills for personal safety at home ● Parenting skills (if minor children of waiver participant residing with waiver participant) Independent Living Skills Training is intended as a short-term, targeted service designed to allow a person to acquire specific skills for independence in defined tasks and activities for community living.

	The provider must prepare and follow a plan utilizing systematic instruction and other evidence-based strategies for teaching the specific skills identified in the Person-Centered Plan. The provider must further ensure consistent teaching methods if multiple staff share responsibility for delivery of the service to a waiver participant. Because home-based skills are being taught, parents and/or other natural supports in the home will be encouraged to observe the training so they can learn how to use the instructional strategies, reinforce the learned skills and contribute to ensuring the maintenance of these skills after the service ends. This service is provided in the participant's home. Home-Based Independent Living Skills is differentiated from Personal Care/Assistance-Home by the intended outcomes of the service. Home-Based Independent Living Skills is a time-limited service to enable the participant to be able to perform specific activities or instrumental activities of daily living without ongoing paid staff support. In contrast, Personal Care/Assistance-Home is expected to be an ongoing support service where a participant needs this level of ongoing support.
Personal Care/Assistance – Home *This is a service that is similar to Home Supports-¼ Hour that currently exists in other MaineCare Waiver(s). However, this service and the sample definition **is not** the definition already in use for Home Support-1/4 Hour.*	A range of services and supports designed to complement but not supplant natural supports and assist an individual with a disability to perform, in his/her home, activities of daily living, including instrumental activities of daily living that the individual would typically do for themselves if they did not have a disability. Personal Care/Assistance-Home services are provided in the person's home and outside the home on the property where the home is located. Participant goals and support needs, as documented in the Person-Centered Plan, shall be addressed by the Personal Care/Assistance-Home provider in a manner that supports and enables the individual to acquire, retain and maximize skills and abilities to achieve the highest level of independence possible. Personal Care/Assistance-Home may be used to support the person in preparing for competitive integrated employment (CIE) which may include assistance getting ready for work and assistance while being transported to this employment. Eligible Personal Care/Assistance-Home services also include the following: ● Assistance and support for partial participation, as appropriate to the individual, with eating, toileting, personal hygiene and grooming, dressing and other activities of daily living or instrumental activities of daily living, as appropriate and needed to sustain community living. ● Meal preparation, homemaker tasks, and home chore services, specific and necessary for the waiver participant, involving the waiver participant to the greatest extent possible. ● Other instrumental activities of daily living (e.g., assistance with learning skills for managing finances, budgeting, using money,

	building credit and, if applicable, regaining authority to control personal financial affairs and resources; home-based support for communication including phone, internet use); and other appropriate activities falling under instrumental activities of daily living, as described in the participant's Person-Centered Plan. Personal Care/Assistance-Home is differentiated from Home-Based Independent Living Skills by the intended outcomes of the service. Home-Based Independent Living Skills is a time-limited service to enable the participant to be able to perform specific activities or instrumental activities of daily living without ongoing paid staff support. In contrast, Personal Care/Assistance-Home is expected to be an ongoing support service where a participant needs this level of ongoing support. Services, if needed, to support goals and needs related to instrumental activities of daily living that occur in the community (e.g., shopping; banking; competitive integrated employment (CIE); and community participation, involvement and contribution must also be addressed in the Person-Centered Plan using Personal Care/Assistance-Community, other appropriate Lifespan Waiver services, or available natural supports. Natural supports must be documented in the Person-Centered Plan and confirmed by the Community Resource Coordinator.
Respite Breaks and Opportunities	A service provided to a waiver participant that lives with family or other natural supports (excluding Shared-Living-Related providers) who are providing support, care and supervision to the waiver participant. The Respite Breaks and Opportunities service is provided for time-limited periods when the family or other natural supports are temporarily unable to continue to provide support, care and supervision to the waiver participant. This service can be provided: • In the waiver participant's home and home community; or • In a pre-approved setting operated by the Respite Breaks and Opportunities service provider and the local community surrounding that setting; or • During the participant's travel away from home which involves overnight stay(s). The Respite Breaks and Opportunities service is provided with two equally important goals which include: (1) sustaining the family/natural support and the natural living arrangement; and (2) providing the waiver participant with opportunities to continue his/her regular activities and relationships and/or to explore new opportunities and meet new individuals with the Respite Breaks and Opportunities service provider. This service is provided during specific periods of time when the unpaid family/natural supporters typically provide support, care and

	supervision to the waiver participant. This service is provided in a way that ensures the individual's typical routine and activities are not disrupted, if the individual desires this. This service is also tailored to the individual's goals and needs, as set forth in the person-centered plan, ensuring these are attended to without disruption.
Remote Supports	The provision of supports to a waiver participant at their place of residence by Remote Support staff housed at a remote location and who are engaged with the person through equipment with the capability for live, two-way communication. Remote Supports shall be provided in real time, not via a recording, by awake staff at a remote monitoring base using the appropriate stable, reliable connection. While Remote Supports are being provided, the remote support staff shall not have duties other than remote support. Equipment used to meet this requirement may include but is not limited to one or more of the following components: ● Sensor Based System (e.g. motion sensors, doors, windows, personal pagers, smoke detectors, bed sensors etc.) ● Radio frequency identification; ● Live video feed; ● Live audio feed; ● Web-based monitoring system; ● Another device that facilitates live two-way communication; ● Contact ID Remote Supports are provided pursuant to the Person-Centered Plan (PCP) and required protocol(s) that are developed from, and support implementation of, the PCP. Remote Supports are intended to address a person's assessed needs in his/her residence and are to be provided in a manner that promotes autonomy and minimizes dependence on paid support staff. Remote Supports should be explored prior to authorizing services that may be more intrusive, including Personal Assistance-Home. A person's team, including the person themselves, shall assess whether Remote Support is appropriate and sufficient to ensure the person's health and welfare assuming all appropriate protocols are in place to minimize risk as compared to the overall benefit of Remote Supports for the individual. A backup support person is always identified, available and responsible for responding to the site of the person's residence whenever the person otherwise needs in-person assistance, including emergencies. Backup support may be provided on an unpaid basis by a family member, neighbor, friend, or other person selected by the individual, or on a paid basis by a local provider of waiver services. When backup support is provided on a paid basis by a local provider, that provider shall be the primary contact for the Remote Support vendor. The Remote Support staff shall have detailed and current written protocols for responding to a person's needs as specified in the PCP, including contact information for the

	backup support person(s) to provide assistance when necessary. The PCP and written protocols shall also set forth the procedures to be followed should the person request that the equipment used for delivery of Remote Support be turned off. When a person needs assistance, but the situation is not an emergency, the Remote Support staff shall address the situation as specified in the individual's Remote Supports written protocol(s). If the protocol involves the Remote Support staff contacting backup support, the backup support person shall verbally acknowledge receipt of a request for assistance from the Remote Support staff and shall arrive at the person's location within a reasonable amount of time (as specified in the PCP, but no longer than one (1) hour) when a request for in-person assistance is made. If a known or reported emergency involving a person arises, the Remote Support staff shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the backup support person. The Remote Support staff shall stay engaged with the person during an emergency, as appropriate to the situation, until emergency personnel or the backup support person arrives. The Remote Supports vendor shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring base system and have training on the most recent versions of the written protocols for each person supported. The Remote Supports vendor shall ensure a suitably trained person from their agency, or from another provider agency for the person, provides the person who receives Remote Supports with initial and ongoing training on how to use the remote support system as specified in the PCP. The Remote Supports vendor shall have a backup power system (such as battery power and/or generator) in place at the monitoring base in the event of electrical outages. The Remote Supports vendor shall have other backup systems and additional safeguards in place which shall include, but are not limited to, contacting the backup support person in the event the monitoring base system stops working for any reason. The Remote Supports vendor shall comply with all federal, state, and local regulations that apply to the operation of its business or trade, including but not limited to, 18 U.S.C. section 2510 to section 2522 as in effect on the effective date of this rule. The Remote Supports vendor shall have an effective system for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities.
Assistive Technology and Adaptive Aids (Including Non-Durable Medical Supplies)	An item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities and to support the individual's increased independence in the home, community living and participation, and individualized competitive integrated employment or self-employment (CIE). The service covers purchases, leasing, shipping costs, and as necessary, repair of

	equipment required by the person to increase, maintain or improve his/her functional capacity to perform daily tasks in the community and in CIE that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation. The person-centered support plan must include, if needed, strategies for training the individual and any others who the individual will or may rely on in effectively using the assistive technology or adaptive equipment (e.g., his/her support staff; co-workers and supervisors in the place of employment; natural supports). Assistive Technology and Adaptive Aids (Including Non-Durable Medical Supplies) also covers the following: o Evaluation and assessment of the assistive technology and adaptive equipment needs of the individual by an appropriate professional, including a functional evaluation of the impact of the provision of appropriate assistive technology and adaptive equipment through equipment trials and appropriate services to him/her in all environments with which the person interacts over the course of any 24-hour day, including the home, integrated employment setting(s) and community integration locations; o Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices and adaptive equipment; o Adaptive equipment to enable the individual to feed him/herself and/or complete oral hygiene as indicated while at home, work or in the community (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, adaptive cups that are specifically designed to allow a person to feed him/herself or for someone to safely assist a person to eat and drink, and adaptive toothbrushes); o Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the person-centered support plan; o Training, programming, demonstrations or technical assistance for the individual and for his/her providers of support (whether paid or unpaid) to facilitate the person's use of the assistive technology and adaptive equipment; o Adaptive switches and attachments; o Adaptive toileting equipment; o Communication devices and aids that enable the person to perceive, control or communicate with the environment,

	including a variety of devices for augmentative communication; o Assistive devices for persons with hearing and vision loss (e.g. assistive listening devices, TDD, large visual display services, Braille screen communicators, FM systems, volume control telephones, large print telephones and tele touch systems and long white canes with appropriate tips to identify footpath information for individuals with visual impairment o Computer equipment, adaptive peripherals and adaptive workstations to accommodate active participation in the workplace and in the community; o Software also is approved when required to operate accessories included for environmental control; o Pre-paid, pre-programmed cellular phones that allow an individual who is participating in employment or community integration activities <u>without</u> paid or natural supports and who may need assistance due to an accident, injury or inability to find the way home. The person's Individual Support Plan outlines a protocol that is followed if the individual has an urgent need to request help while in the community; o Such other durable medical equipment and/or non-durable medical supplies not available under the Medicaid State Plan that is necessary to address functional limitations in the community, in the workplace, and in the home; o Repairs of equipment is covered for items purchased through this waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The individual must own any piece of equipment that is repaired. A written recommendation by an appropriate professional, supported by a professional assessment/evaluation must be obtained to ensure that the equipment will meet the needs of the person.
Individual Directed Goods and Services	Individual Directed Goods and Services refers to services, equipment, or supplies that addresses or enhances the participant's opportunity to achieve their long-term support need, but is not already coverable under another service category. The service, equipment, or supply must not be captured under an exclusion of another service category. Each service, equipment, or supply selected must clearly address a long-term support need documented in the Person-Centered Plan and meet the additional following requirements: • The participant is reasonably unable to obtain the good or service

	from another source; and
	• At least one of the following:
	  • The item or service must decrease the need for other Medicaid services (Medicaid State Plan or waiver services); or
	  • Promote or maintain inclusion in the community; or
	  • Increase or maintain the participant's safety in their home environment.
	Individual Directed Goods and Services are purchased from the self-directed budget. Any service, equipment or supply included under this service definition is subject to review by OADS, prior to service authorization and utilization. This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

Support Broker	A support broker is an individual who assists participants with self-directing services to achieve identified goals and ensure needs are effectively met. Support brokers must be knowledgeable about the self-direction option, all relevant policies, methods for effectively supporting the participant in managing the self-direction budget for each service being self-directed and in recruiting, hiring and managing self-direction workers. Support Brokers must fully understand the waiver program and have experience with the waiver target population(s). Support Brokers also use knowledge of other local community-integrated services and resources available to the participant to assist the person in leveraging these in concert with self-directed services. The Support Broker must be selected by the participant and meet qualifications set by the waiver program. Support brokers are subject to criminal background checks and must be independent of any waiver service provider serving the individual(s) for whom they are acting as Support Broker. This service may not duplicate services otherwise provided through the Medicaid State Plan or provided under another waiver service category, or through Fiscal Intermediary Services. Participant employer authority and budget authority responsibilities may not be delegated to a Support Broker providing this service.
Housing Counseling	Services which provide assistance to a person to successfully obtain an integrated community living arrangement in the community, where ownership or rental of housing is by the waiver participant and not any service provider. The purpose of Housing Counseling Services is to promote consumer choice and control of housing and access to housing that is affordable, accessible to the extent needed by the individual, and promotes community inclusion. Housing Counseling Services include counseling and assistance to the individual, based on individual needs and a plan reflecting these needs, in the following areas: ● Exploring both home ownership and rental options; ● Exploring both individual and shared housing situations;

	● Identifying financial resources and determining affordability; ● Identifying how earned income, or an increase in earned income, could impact choice, access and affordability of housing options ● Identifying preferences of location and type of housing; ● Identifying accessibility and modification needs; ● Locating available housing by educating and supporting the person to search for available housing; ● Identifying and assisting with access to financing if homeownership is goal; ● Identifying and assistant with access to rental subsidies if renting is goal; ● Educating the person on the rights and responsibilities of a tenant, including how to ask for reasonable accommodations and modifications, how to request repairs and maintenance, and how to file a complaint if necessary; and, ● Planning for ongoing management and maintenance if homeownership is goal. Housing Counseling Services are time-limited services but are not one-time services and may be accessed more than once if an individual's needs dictates this. A waiver participant who needs in-home support services to live in their own home may access these services under the waiver (e.g., Supported Living Services; Personal Care/Assistance-Home Services; Home-Based Independent Living Skills Training).
Housing Start-Up Assistance	A service intended to provide essential services and items needed to establish an integrated community living arrangement for persons relocating from an institution or a provider owned or controlled residential setting to one where the individual is directly responsible for his/her own living expenses. Housing Start-Up Assistance is intended to enable the person to establish an independent or supported living arrangement. Allowable costs include: ● Deposit required for a leased or rented living arrangement ● Initial fees and/or deposits to establish utility service for water, heat, electricity, phone ● Purchase of basic and essential items needed to establish a safe and secure home: • External locks and keys • Smoke and carbon monoxide detectors • Fire extinguisher • Flashlight • First Aid Kit ● Moving costs Housing Start-Up Assistance may also include person-specific services and supports that may be arranged, scheduled, contracted or purchased, which support the person's successful transition to a safe, accessible independent or supported living situation: • Moving service • Packing supplies

	• Cleaning service • Electronics set-up No institutional length of stay requirement is necessary to access this service.
Supported Living Services	Services that include training and assistance in maintaining a home of one's own: a residence not owned or controlled by a waiver service provider and not the home of a family caregiver. The home may be shared with other freely chosen housemates who may or may not also receive waiver services and/or have a disability. Supported Living Services are provided with the goal of maximizing the person's independence and interdependence with housemates and natural supports, using a combination of teaching, training, technology and facilitation of natural supports. Supported Living Services are delivered according to the person's Supported Living Service Plan and may include supports for any of the following: ● Maintaining home tenancy or ownership; ● Managing money, budgeting and banking; ● Planning and preparing meals; ● Shopping for food and home supplies; ● Maintaining personal appearance and hygiene; ● Health and wellness goals and activities; ● Developing and maintaining positive relationships with neighbors; and, ● Overseeing/assisting with managing self-administered medication and/or medication administration, as permitted under the Nurse Practice Act; ● Performing other non-complex health maintenance tasks, as needed and as permitted by state law. ● Travel training and support and/or assistance with arrangement of transportation by a third party, and/or provision of transportation as needed by the individual to support the person's employment and community involvement, participation and/or contribution; ● Assistance with building interpersonal and social skills through assistance with planning, arranging and/or hosting social opportunities with family, friends, neighbors and other members of the broader community with whom the person desires to socialize; ● Ensuring home and community safety is addressed including emergency preparedness planning; ● Implementation of behavioral support plans developed by qualified behavioral specialists; and ● On-call supports for as-needed or emergency assistance. This service is intended for persons who, with technology, natural supports and good advanced planning, need intermittent and/or on-call staff support to remain in their own home and do not need around-the-clock staffing. Supported Living Services are differentiated from Personal Care/Assistance-Home services by

	virtue of the 24-hour on-call access to supports on an as-needed/emergency basis that are part of Supported Living Services. It is the responsibility of the provider to ensure that the person has an emergency preparedness plan in place at all times, this plan is shared with the Community Resource Coordinator and others on the Person-Centered Planning team, and the person is supported to learn and practice this plan at regular intervals. All individual goals/objectives for Supported Living Services, along with a description of needed Supported Living Services supports to achieve them, shall be established via the person-centered planning process and documented in the Supported Living Service Plan which built to reflect the participant's goals, needs and preferences as outlined in the Person-Centered Plan. The Supported Living Service Plan and the corresponding goals/objectives, must consider: • The person's current level of independence • Availability of natural supports • Ability to utilize technology • Ability to rely on housemates, neighbors, etc. • Other services the person may be receiving, regardless of funding source
Minor Home Modifications	Modifications to the home, required to address goals and needs documented in the individual Person-Centered Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. Such modifications include: ● Provision and installation of certain home mobility aids, including: • A wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp. • Handrails for interior or exterior stairs or steps. • Grab bars and other devices. ● Minor physical adaptations to the interior of the individual's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, including: • Widening of doorways • Modification of bathroom facilities • Installation of electric and plumbing systems necessary to accommodate any medical equipment/supplies needed for the welfare of the individual. All services shall be provided in accordance with applicable state or local building codes.
Positive Behavioral Support Services	Expertise, training and technical assistance in evidence-based positive behavior support strategies to assist natural supports, paid/unpaid co-workers and/or paid staff in supporting individuals who have behavioral support needs. Positive Behavioral Supports

	are designed to improve the ability of unpaid natural supports, paid co-workers and paid direct support staff to carry out therapeutic interventions. As needed, providers of Positive Behavioral Supports conduct assessments, develop a person's behavior support plan and train/consult with paid/unpaid natural supports and/or co-workers and/or paid support staff who are implementing the person's behavior support plan, which is necessary to facilitate the person's successful participation in the community, in employment and to ensure the person can remain in his/her current community living situation or transition to a less restrictive living situation. Service includes: 1. Assessment to inform the development of behavior support plans for settings where needed (home; work; community), including methods for evaluating effectiveness. A Functional Assessment will be facilitated by the provider and will include: i. Interviews with the participant, team leaders, staff, guardian, and professionals across settings. ii. A review of background information. iii. Evaluation of interviews to examine function of behavior. iv. The identification and assessment of previously used strategies for effectiveness. v. The identification of staff/natural support/co-worker training needs. vi. The collection of data on behaviors to establish a baseline. ● Based on the needs and goals of the individual, development of a home and/or community and/or worksite behavior support plan and/or intervention plan. These plans should incorporate strategies for preventing negative behaviors, identify replacement behaviors, describe how staff/natural supports/co-workers should intervene in a behavioral situation and identify desired fading procedures if necessary. These plans should be understandable to the staff/natural supports/co-workers expected to implement them. Plans may include recommendations for assistive technology/equipment, workplace and community integration site modifications and clearly defined behavioral interventions. ● Training and technical assistance to carry out the behavior support plan and monitoring of the person and the natural support/co-worker/paid staff in the implementation of the plans. The provider will identify training needs and outline a training plan for natural supports/co-workers/paid staff. Training will include instruction about implementation of the behavior plan in the context of providing other services included in the person's Person-Centered Plan, and guidance, as necessary, to safely maintain and support the person in the relevant community settings. Training must be aimed at assisting the natural support/co-worker/paid staff in meeting the needs of the person.

	● Following the completion of identified training and technical assistance, the provider will provide consultation/follow up 1-2 times per month to examine plan implementation and effectiveness. As needed, revisions of the plan will be done to assure progress toward achievement of desired outcomes. Tele-consulting through the use of two-way, real time-interactive audio and video between places of greater and lesser clinical expertise to provide behavioral consultation services when distance separates the behavioral expert from the person. This service may also include time-limited consultation with the person and his/her Person-Centered Planning team to consider available service providers and potential providers and assist the person to identify and select providers that can meet the unique needs of the member and to identify additional supports necessary to implement behavior plans and perform therapeutic interventions. As needed, this service is also used to allow the behavioral specialist to be an integral part of the person-centered planning team, as needed, to participate in team meetings.
Shared Living-Related Services (Ages 18+)	Shared Living-Related Services are individually tailored direct support, personal care and medication oversight delivered to a Participant in private homes of individuals or families, whether owned or leased, in which life-shared, residential supports are provided to. This distinct service is for related immediate family and related legal guarans of individuals over the age of 18. Shared living related services are provided in conjunction with residing in the family home to ensure participants can remain in their family home. This option is only available after determining that immediate family as paid providers ensure the continuity of community participation for the participant in the least restrictive integrated setting. Shared Living is provided in a home that is the primary, legal residence of the participant service and the provider. The State allows payment to a family member or legal guardian (when the legal guardian is a parent, step-parent, sibling, step-sibling, or other biological family member) for Shared Living Services. The familial relationship is identified and options for potential service delivery are discussed with the case manager, the Shared Living Oversight Agency, and within the person-centered planning process. Furthermore, the Person- Centered Planning Team collectively determines whether relatives or legal guardians who are relatives are the ideal shared living provider for the Participant. Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the Participant's

	parent, sibling or other biological family member. This provision will not be avoided by adult adoption. The Case Manager is responsible for ensuring the Participant's health and safety needs are identified and for monitoring authorized services. The Shared Living provider enters a contract for professional support with the Administrative Oversight Agency. The shared living provider may not be employed by the Administrative Oversight agency that subcontracts for the Shared Living Home Service. The Administrative Oversight Agency (AOA) contracts with, supervises, and trains the Shared Living provider to comply with the applicable requirements of this waiver. The AOA is also responsible to ensure delivery of respite to the Participant. The Shared Living Provider, under the supervision of the AOA, is required to maintain a clean and healthy living environment addressing any necessary Participant-specific environmental or safety standards, consistent with the Participant's PCSP. The Shared Living Provider must ensure protective oversight and supervision that meets the Participant's assessed level of need. Additionally, the Shared Living Provider delivers services in accordance with the Participant's goals and preferences as documented within the PCSP including, but not limited to, the following: • Facilitating opportunities for the Participant to engage in family and community life • Assisting the Participant to develop healthy relationships • Assisting the Participant to increase independence across settings and receive services in their community of choice like individuals without disabilities • Providing transportation to appointments and activities • Ensuring the Participant has opportunities to seek employment and work in competitive, integrated settings • Ensuring the Participant retains and exercises control of personal resources • Maintaining and ensuring protection of the Participant's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint
Shared Living-Unrelated Services (Ages 18+)	Shared Living-Unrelated Services are individually tailored direct support, personal care and medication oversight delivered to a Participant in private homes of individuals or families, whether owned or leased, in which life-shared, residential supports are provided to one or two adults. The shared living provider may not be related to the participants in receiving services in their home either through blood, adoption or marriage. The Shared Living provider enters a contract for professional support with the

	Administrative Oversight Agency. The shared living provider may not be employed by the Administrative Oversight agency that subcontracts for the Shared Living Home Service. Shared Living is provided in a home that is the primary, legal residence of the participant service and the provider. The Administrative Oversight Agency (AOA) contracts with, supervises, and trains the Shared Living provider to comply with the applicable requirements of this waiver. The AOA is also responsible to ensure delivery of respite to the Participant. The Shared Living Provider, under the supervision of the AOA, is required to maintain a clean and healthy living environment addressing any necessary Participant-specific environmental or safety standards, consistent with the Participant's PCSP. The Shared Living Provider must ensure protective oversight and supervision that meets the Participant's assessed level of need. Additionally, the Shared Living Provider delivers services in accordance with the Participant's goals and preferences as documented within the PCSP including, but not limited to, the following: • Facilitating opportunities for the Participant to engage in family and community life • Assisting the Participant to develop healthy relationships • Assisting the Participant to increase independence across settings and receive services in their community of choice like individuals without disabilities • Providing transportation to appointments and activities • Ensuring the Participant has opportunities to seek employment and work in competitive, integrated settings • Ensuring the Participant retains and exercises control of personal resources • Maintaining and ensuring protection of the Participant's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint.
Group Home Services (Ages 18+)	Group Home Services is a per diem Habilitative Home Support which provides individually tailored support that assists Participants with acquiring, retaining, and/or improving skills related to living in the community. The provider managed setting is integrated in and facilitates the Participant's full access to the greater community including opportunities to seek employment and work in competitive, integrated settings; engage in community life, control personal resources, and receive services in the community like individuals without disabilities. These supports include adaptive skill development, assistance with activities of daily living, (ADLs) and instrumental activities of daily living (IADLs) community inclusion, transportation, and social and leisure skill development. Group Home Services also includes

	protective oversight and supervision. Services are developed in accordance with the needs of the Participant and include supports to foster independence and encourage development of a full life in the community, based upon what is important to and for the Participant, as documented in their Person-Centered Service Plan (PCSP). A Participant's essential personal rights of privacy, dignity, and respect, and freedom from coercion and restraint are protected. Individual initiative, autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact are optimized and not regimented. Individual choice regarding services and support, and who provides them, is facilitated. Providers may be reimbursed for Group Home Services so long as each Participant's health, safety, and individual service needs are addressed and consistent with each Participant's PCSP. Further, the provider assures that at least one qualified staff person is onsite (in the same setting as Participants receiving services in that setting) at all times (24/7) and available to respond immediately when any Participant requests or requires support, including during overnight hours. Participants cannot be made to attend a day program (any other service or support other than Home Support) if they choose to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if they are ill, or otherwise choose to remain at home. The Department reimburses providers per established level of service need as identified through the SIS-A.
Physical Therapy **(Ages 18+)**	Physical Therapy (Maintenance) includes direct therapy and consultation services to maintain the Participant's optimal level of functioning within the participant's current environment. The intent is to prevent regression, loss of movement, injury and medical complications that would necessitate a higher level of skilled care. The service may be provided to up to three (3) Participants at once. When the service is provided to a group, the appropriate group rate must be billed. Services related to activities for the general good and welfare of Participants, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversional or general motivation, do not constitute physical or occupational therapy for MaineCare purposes. Evaluative and rehabilitative Physical Therapy is included in the state plan and is not covered as a component of maintenance therapy. The service is not available for individuals under age 21, as it is covered under EPSDT.

Occupational Therapy (Ages 18+)	Occupational Therapy (Maintenance) includes direct therapy and consultation services to maintain the Participant's optimal level of functioning within the Participant's current environment. The intent is to prevent regression, loss of movement, injury and medical complications that would necessitate a higher level of skilled care. Occupational therapy (maintenance) under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from Occupational therapy (maintenance) services in the State plan. State plan coverage limits therapies to individuals with rehabilitation potential or to those individuals who would experience significant physical decline putting them at risk for institutionalization. Evaluative and rehabilitative Occupational Therapy is included in the state plan and is not covered as a component of maintenance therapy. The service is not available for individuals under age 21, as it is covered under EPSDT.
Speech/Language Therapy (Ages 18+)	Speech Therapy (Maintenance) Service supports the maintenance of the Participant's current abilities and level of functioning and may include the delivery of direct therapy and/or consultation services in the Participant's current environment. The intent is to prevent regression, loss of movement, injury and medical complications that may necessitate in a higher level of skilled care. Speech therapy (maintenance) under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from Speech Therapy (maintenance) services in the State plan. State plan coverage limits therapies to individuals with rehabilitation potential or to those individuals who would experience significant physical decline putting them at risk for institutionalization. Evaluative and rehabilitative Speech Therapy is included in the state plan and is not covered as a component of maintenance therapy. The service is not available for individuals under age 21, as it is covered under EPSDT.
Skilled Nursing **(Ages 21+)**	Skilled Nursing Service is the provision of nursing services on an intermittent or part-time basis. Services provided when nursing services furnished under the approved Home Health Services state plan limits are exhausted, the scope and natures of these services do not otherwise differ from nursing services furnished under the Home Health Services state plan. The provider qualifications specified in the state plan apply. And:

	Private duty nursing services are individual and continuous care provided by licensed nurses within the scope of state law. Private duty nursing services are provided when the limits of private duty nursing furnished under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from private duty nursing services furnished under the state plan. The provider qualifications specified in the state plan apply.