

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The following is a description of the changes and enhancements to the approved waiver that are being made in this renewal application:

- 1.) The service cap for Respite has been changed from 20% of the overall PDMS budget to \$7,500 per year, regardless of method of service delivery. This cap may be exceeded with prior approval from BDS. Camp has been moved from Community Integration Services to Respite. New provider qualifications have been added for Agency and Individual Camp providers.
- 2.) Provider qualifications for Wellness Coaching have been updated to provide clarity.
- 3.) The service caps on Community Integration Services, Consultations, and Individual Goods and Services have been amended to allow for the ability to exceed the service caps per year with prior approval from BDS.
- 4.) The service title for Community Support Services has been changed to Supported Independent Living Services.
- 5.) The Bureau of Developmental Services (BDS) will continue coordinating with the participant directed and managed services (PDMS) committee with broad stake holder participation.
- 6.) Performance measures have been amended in Appendix A, Appendix C, Appendix D, and Appendix G.
- 7.) Information regarding remote service provision has been removed from the individual service definitions to section C:1-d for Residential Habilitation, Community Participation Services, Supported Employment, Service Coordination, Assistive Technology, Community Integration Services, Supported Independent Living Services, Crisis Response Services, Specialty Services, Individual Goods and Services, and Wellness Coaching.

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

### 1. Request Information (1 of 3)

- A.** The **State of New Hampshire** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).
- B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

NH Acquired Brain Disorder Waiver 2026-2031

**C. Type of Request: renewal**

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

3 years    5 years

**Original Base Waiver Number: NH.40177**

**Draft ID: NH.011.07.00**

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

Regular Waiver

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

11/01/26

**PRA Disclosure Statement**

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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

**1. Request Information (2 of 3)**

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

**Hospital**

Select applicable level of care

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

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

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

**Nursing Facility**

Select applicable level of care

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

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

of care:

N/A

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

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

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

**1. Request Information (3 of 3)**

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

New Hampshire's 1915(b) waiver, for the delivery of Removable Prosthodontic Services via managed-care authority in this waiver only, is effective October 1, 2024 to September 30, 2026.

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

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

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

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

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

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

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

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

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

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

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

## 2. Brief Waiver Description

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

Purpose/Goal: The purpose of the Acquired Brain Disorder (ABD) Waiver is to provide services which maximize the ability and informed decision-making authority of people with acquired brain disorders and which promote the individual's personal development, independence and quality of life in a manner that is determined by the individual.

The waiver incorporates the core beliefs that individuals with acquired brain disorders live, work and pursue their life aspirations within their communities. It is the State's intention to support positive life trajectories, particularly through identified transitions that are known to be challenging, in a manner that ensures that waiver participants receive the necessary supports to access the broader community, build upon relationships, aspire to meet personal goals, and have access to technology, goods & services as well as access to qualified providers in order to lead a good life.

Program Description: Individuals must qualify for the Developmental Services System under RSA 137:K (Brain and Spinal Cord Injuries <http://www.gencourt.state.nh.us/rsa/html/X/137-K/137-K-mrg.htm> ) and He-M 522 (Eligibility Determination and Service Planning for Individuals with an Acquired Brain Disorder [https://gc.nh.gov/rules/state\\_agencies/he-m500.html](https://gc.nh.gov/rules/state_agencies/he-m500.html)) and 517 (Medicaid-Covered Home and Community Based Care Services for Persons with Developmental Disabilities and Acquired Brain Disorders [https://gc.nh.gov/rules/state\\_agencies/he-m500.html](https://gc.nh.gov/rules/state_agencies/he-m500.html)), the State Administrative Rules which establish standards and procedures for the determination of eligibility, the development of service agreements, and the provision and monitoring of services. To qualify for services under the ABD Waiver, individuals must be eligible for Medicaid and meet Nursing Facility (NF) level of care.

The State has defined within this waiver a range of home and community-based services which support waiver participants. Individuals and/or their guardians work with Service Coordinators to identify, through a person-centered service planning process, those specific services and supports offered under this waiver that are needed to avoid placement in an institutional setting. The State maintains the ability to control costs and, in conjunction with area agencies, service coordinators and individuals/guardians, establish mutual expectations regarding available resources.

Covered services include: Community Participation Services, Residential Habilitation, Respite, Service Coordination, Supported Employment, Assistive Technology, Community Integration Services, Supported Independent Living Services, Crisis Response Services, Environmental and Vehicle Modification Services, Individual Goods and Services, Non-Medical Transportation, Personal Emergency Response Services, Specialty Services, Wellness Coaching and Removable Prosthodontic Services.

The State ensures the health and welfare of the individuals in the program through the provision of services and supports identified through the person-centered service plan, implementation of assessment based decision-making, operation of a quality assurance and improvement program, and implementation of an enhanced complaint investigation process. In addition, the program provides assurances of fiscal integrity and includes participant protections that are effective and understandable as outlined in He-M 202 Rights Protections Procedures and He-M 310 Rights of Individuals.

The State has identified the functions of the Financial Management Services (FMS) entity, which manages and is the employer of record for support staff under the Participant and Directed Service (PDMS) method of service delivery. FMS will be billed as a Medicaid Administrative function and will be processed through the Department's Center for Medicare and Medicaid Services (CMS) approved Public Assistance Cost Allocation Plan (PACAP). Waiver participants and/or their guardian (if applicable) have a choice of their service coordinator as well as the ability to choose provider agencies. Provider agencies have the ability to bill Medicaid directly.

Organizational Structure: The waiver is implemented by the State in collaboration with New Hampshire's ten Area Agencies, designated in accordance with New Hampshire administrative Rule He-M 505, to plan, establish and maintain a comprehensive service delivery system. New Hampshire's Area Agencies additionally operate as an Organized Health care delivery System and are nonprofit, 501(c)(3) entities that are governed by independent Boards of Directors. One-third of each Area Agency's Board membership consists of individuals with disabilities and/or family members. Further, area agencies are advised by regional Family Support Councils. NH's long-standing tradition of "local control" is a prominent element of the system and the overarching concepts of choice, control, and self-direction underpin the New Hampshire developmental service system.

Program Description continued on Main: 8,B Optional.

### 3. Components of the Waiver Request

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

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

waiver.

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

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

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

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

**Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

#### 4. Waiver(s) Requested

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

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

**Not Applicable**

**No**

**Yes**

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

**No**

**Yes**

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

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

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

*Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

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

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

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

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

## 7. Contact Person(s)

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

**Last Name:**

Lipman

**First Name:**

Henry

**Title:**

State Medicaid Director

**Agency:**

NH Department of Health and Human Services

**Address:**

129 Pleasant Street

**Address 2:**

Brown Building

**City:**

Concord

**State:**

New Hampshire

**Zip:**

03301

**Phone:**

(603) 271-9434 Ext:  TTY

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **New Hampshire**

Zip:

Phone: (603) 271-8942 Ext:  TTY

Fax:

E-mail:

**8. Authorizing Signature**

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: New Hampshire

Zip:

Phone:  Ext:  TTY

Fax:

E-mail:

**Attachments**

**Attachment #1: Transition Plan**

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

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

Reducing the unduplicated count of participants (Factor C).

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

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

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

Specify the transition plan for the waiver:

In the waiver application, "Residential Habilitation" has replaced the previous covered service named "Residential Habilitation / Personal Support". This change does not eliminate, limit or change previously covered service. This change was made to bring the Residential Habilitation service name into alignment with the other 2 BDS waivers.

Participant Directed and Managed Services (PDMS) has been deleted as a service, however, services outlined in Appendix C are available via PDMS as outlined in Appendix E.

Additional covered services include: Goods and Services, Personal Emergency Response Services (PERS), Non-Medical Transportation, and Community Integration Services.

Capitation amounts for services noted in the approved waiver have been increased or remained the same to offer greater flexibility and increased coverage. Several covered services have been added and include limits as noted in Appendix C.

Transition Plan:

To ensure a smooth transition, participants will be notified in public comment sessions, via power point, of the new name & definition of Residential Habilitation that will replace the previous Residential Habilitation / Personal Support service definition.

BDS will provide statewide trainings on the contents of the approved waiver within a six month period of time from receiving CMS approval for the renewal.

Given CMS approval, assessment based person-centered planning sessions will include the appropriate covered services which will meet the individual's needs. Individualized Service Agreements (ISAs) are renewed annually.

To ensure all participant's plans have the correct services identified the transition will be a twelve month process. Instead of amending each plan, changes will be made at the time of the development of the written individual service agreement.

Fair Hearing: Service agreements have attachments for guardian's signature that outline the process for requesting a fair hearing.

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

Continued from Main, 2. (Program Description)

#### Service Delivery Methods:

Initial application for Acquired Brain Disorder services eligibility shall be submitted to the Bureau of Developmental Services (BDS). BDS shall review the referral made pursuant to He-M 522 and shall, within 15 business days of receipt of the referral, make a decision on eligibility. If found eligible for services under He-M 522, application for access to the Acquired Brain Disorder (ABD) Waiver is submitted to BDS. Following determination that an individual meets the level of care for the ABD waiver, an individual Service Agreement (ISA) and budget are developed using a person-centered service planning process. Individual budget proposals are submitted to BDS, which makes all final budget determinations based on the cost effectiveness of proposed services. With an approved individualized budget, the individual and/or guardian selects from all qualified and willing providers, and the entity or person(s) to provide services are outlined in the service agreement.

Waiver participants will work with their chosen Service Coordinator to identify, through an assessment based, person-centered service planning process, specific services and supports offered under this waiver that are needed to avoid placement in an institutional setting. The state maintains the ability to control costs and establish expectations regarding available resources.

The Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST) are used to establish the written service agreement and the overall supervision and individual needs.

Per NH's corrective action plan for conflict of interest compliance, provider selection will enable individuals/guardians to choose from a variety of resources by having access to a statewide electronic listing (provider directory) of all willing and qualified providers.

The State provides the final approval of services and cost allocation based on the cost effectiveness of proposed services. BDS processes all Level of Care (LOC) determination reviews and applications for prior authorization of services. All waiver services must be authorized by State BDS staff. No Medicaid billing can be done without a current prior service authorization and claims submission in the Medicaid Management Information System (MMIS).

Temporary provision of services in acute care hospitals, based on an individual's needs has been added to this Waiver as identified in Appendix C. All Home and Community Based Services in this Waiver are not duplicative of services available in the acute hospital setting. Services that may be temporarily provided in acute hospitals include: Community Participation Services, Residential Habilitation, Service Coordination, Supported Employment, Assistive Technology, Community Integration Services, Community Support Services, Crisis Response Services, Individual Goods and Services, Specialty Services, Wellness Coaching and Removable Prosthodontic Services. These services are provided to meet needs of the individual that are not met through the provision of acute care hospital services; Are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide; Will be identified in the individual's person-centered service plan; and will be used to ensure smooth transitions between acute care hospitals and community-based settings and to preserve the individual's functional abilities.

For individuals that are in an acute hospital setting, the utilization of HCBS may assist with returning to the community by maintaining and/or developing an individualized person-centered service agreement, the development of a community-based network of support, the strengthening of and/or maintenance of levels of independence that were in place prior to hospitalization and the preparation for the individual to return to the community through the acquisition of home or vehicle modifications. There will be no difference in rate for HCBS that are provided during a hospitalization from that of a typically billed rate.

Offering of services via a remote method of service delivery will be at the option of each provider agency and not required. A Waiver participant will select their service provider based on the services offered by the provider agency, including if they offer the desired method of service delivery. Service providers will be expected to provide services in the amount, frequency and duration that is outlined in the service agreement. Should a provider agency choose to stop offering services via remote access to a Waiver participant already receiving services, the provider will be expected to continue providing services in the same amount, frequency and duration during the transition. The person-centered service planning team will review to determine if the Waiver participants wishes to remain with the same service provider and utilize in-person service delivery or wishes to find another service provider who offers service delivery via remote access.

He-M 522 requires monthly contact and quarterly visits for service coordination. The provision of Home and Community Based Services via remote service delivery will be reviewed and approved by the person-centered service planning team on a quarterly basis. Remote access as a method of service delivery will be allowable for as long as it meets the need of the individual. As indicated in the service definition, remote access is an available method of service delivery to ensure services are delivered while

considering individual choice, cost effectiveness, compliance with CMS requirements and identified in the individual's service agreement.

An approved Electronic Visit Verification (EVV) system was not implemented by January 1, 2021. The State has been paying the penalty for Personal Care and Respite services since January 1, 2021.

If anomalies are found, during on-site reviews, which require further review, a referral will be made to Program Integrity (PI), which is part of the Bureau of Improvement and Integrity. PI provides oversight and monitoring of MCO contracts for fraud, waste and abuse. PI also does queries on services and looks for anomalies on all Medicaid services, including Home and Community Based Care Services. If they find anomalies they follow up with provider to do an audit on them. In addition, they audit providers if they get referrals or complaints.

## Appendix A: Waiver Administration and Operation

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

Bureau of Developmental Services

(Complete item A-2-a).

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

Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

RSA 137-K and 171-A establish the program requirements and direct the NH Department of Health and Human Services (DHHS), which is the single state Medicaid agency, in its performance of ensuring that the waiver program requirements are met. As required by RSA 137-K, DHHS has adopted administrative rules (He-M 522) which define how the BDS must establish, implement, and maintain a comprehensive service delivery system for people with acquired brain disorders.

The BDS Bureau Administrator reports to the Director of the Division of Long Term Supports and Services (DLTSS). Frequent and ongoing communications occur between the State Medicaid Director and the Director of DLTSS.

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

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

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

**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

## Appendix A: Waiver Administration and Operation

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

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions

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

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

In accordance with RSA 171-A:18, New Hampshire's ten Area Agencies, designated in accordance with New Hampshire administrative Rule He-M 505, plan, establish and maintain a comprehensive service delivery system. New Hampshire's Area Agencies operate as an Organized Health Care Delivery System and each serves as the single point of entry for acquired brain disorder services within the Area Agency's designated catchment area.

The Centers for Medicare and Medicaid Services had previously determined that New Hampshire was out of compliance with direct pay and conflict of interest requirements and the Acquired Brain Disorder Waiver (NH.4177) was operationalized under a CMS-approved corrective action plan. As of 7/1/2023, ABD waiver operations are in compliance with these requirements.

NH's ten area agencies are:

-Locally Controlled: Governed by independent, volunteer Boards of Directors made up of individuals, families and community business professionals;

-Family Driven: Advised by Regional Family Support Councils;

-Regionally Based: Responsible for planning, establishing and monitoring a comprehensive service system to individuals with developmental disabilities and their families within their catchment area; and

-Overseen by the Bureau of Developmental Services: Redesignated every 5 years.

## Appendix A: Waiver Administration and Operation

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

The Bureau of Developmental Services has the primary responsibility to assess the performance of and recommend to the Commissioner of Health and Human Services designation and redesignation of each area agency. Additional ongoing assessments are performed by other entities within the single state Medicaid Agency/Department of Health and Human Services (DHHS) including the Office of Program Integrity, Bureau of Program Quality, DHHS Finance Administration, and Utilization Review Services.

## Appendix A: Waiver Administration and Operation

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

As outlined in New Hampshire Administrative Rule He-M 505, "Establishment and Operation of Area Agencies", the Bureau of Developmental Services (BDS) conducts redesignation of each area agency on a rotating five-year schedule. The redesignation process involves a review of annual governance desk audit data, ongoing quality review of key indicator data, stakeholder forums, surveys and meetings with each area agency Board of Directors.

In addition to the five-year redesignation schedule, BDS has developed an annual quality review process that includes elements of the redesignation process. Information from the annual quality reviews informs the redesignation process and provides meaningful data on an ongoing basis to help inform the performance of area agencies and identify issues with compliance.

The Governance Desk Audit includes a review of the following:

- Area Agency Board of Directors composition
- Area Agency Board by-laws, policies and procedures;
- Area Agency Executive Director qualifications;
- Current Area Plan (AKA strategic plan) and any amendments;
- Board of Directors meeting minutes;
- Information on how the Area Agency assures individuals, families and stakeholders in its region are involved in planning for the provision of and satisfaction of the services;
- Review of the Human Rights Committee membership and minutes;
- Information on how the Area Agency communicates with sub-contract agencies;
- Report of the Area Agency on-going quality assurance activities;
- Contract compliance; and
- Adherence to New Hampshire’s Corrective Action Plan.

Additionally, Area Agency data is collected to demonstrate satisfactory performance in other key areas, including:

- Monthly review of financial indicators
- Billing activity
- Quarterly funding utilization
- Annual reports from Human Rights Committees
- Annual Health Risk Screening Tool Data; and
- Other existing data, as available.

## Appendix A: Waiver Administration and Operation

**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		

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

**Appendix A: Waiver Administration and Operation**

**Quality Improvement: Administrative Authority of the Single State Medicaid Agency**

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

**The number and percent of designated geographical area with at least 4% of new enrollees.**

**Numerator:** Number of designated geographical areas with at least 4% of new enrollees;

**Denominator:** Total number of designated geographical areas.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Waitlist Registry**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**The number and percent of area agencies engaged in a quality improvement process that resulted in a current area plan approved by the agency's Board of Directors. Numerator: Number of area agencies engaged in a quality improvement process that resulted in a current area plan approved by the agency's Board of Directors. Denominator: Total number of area agencies**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

The number and percent of residency agreements reviewed which met the specifications required by 42 CFR 441.301(c)(4)(vi)(A). Numerator: The number of residency agreements which met the specifications required by 42 CFR 441.301(c)(4)(vi)(A). Denominator: Total number of residency agreements reviewed.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

The State requires a plan of correction for failure to submit evidence of a formal quality improvement process that informs the agency's area plan.

The State will review the quality improvement process documentation and issue a plan of correction to an area agency whose quality improvement process does not meet the requirements of He-M 505, the state administrative rule that governs area agency operations.

Area agencies must submit a corrective action plan to the State within 30 days of the State's request

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**c. Timelines**

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

No

Yes

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

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Aged			
		Disabled (Physical)			
		Disabled (Other)			
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury	22		
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism			
		Developmental Disability			
		Intellectual Disability			
<b>Mental Illness</b>					
		Mental Illness			
		Serious Emotional Disturbance			

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

The target group(s) for this waiver are those specified in NH Law RSA 137:K. Pursuant to He-M 522.02 (a)(3), the acquired brain disorder shall have occurred prior to the age of 60.

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

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

**Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to

that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. Complete Items B-2-b and B-2-c.

The limit specified by the state is (select one)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

**Appendix B: Participant Access and Eligibility**

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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

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

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

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

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

**Other safeguard(s)**

Specify:

**Appendix B: Participant Access and Eligibility**

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	238
Year 2	238
Year 3	238
Year 4	

Waiver Year	Unduplicated Number of Participants
	238
Year 5	238

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

**Appendix B: Participant Access and Eligibility**

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

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

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

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

**Appendix B: Participant Access and Eligibility**

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

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

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

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

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

Selection of entrants to the waiver is in accordance with state administrative rule He-M 517, which is entitled Medicaid-Covered Home and Community-Based Care Services for Persons with Developmental Disabilities and Acquired Brain Disorders, and state administrative rule He-M 522 governing eligibility for acquired brain disorder services.

He-M 517 provides in part that eligibility for the waiver is contingent on the availability of funding. He-M 522 incorporates the language of State law RSA 171-A:1-a,I, which provides the criteria for funding for services and limitations on wait lists. Individuals are prioritized on the waiting list based on a number of objective factors.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

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

**Section 1634 State**

**SSI Criteria State**

**209(b) State**

**2. Miller Trust State.**

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

**No**

**Yes**

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

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

**Parents and Other Caretaker Relatives (42 CFR § 435.110)**

**Pregnant Women (42 CFR § 435.116)**

**Infants and Children under Age 19 (42 CFR § 435.118)**

**SSI recipients**

**Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**

**Optional state supplement recipients**

**Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

**100% of the Federal poverty level (FPL)**

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

Specify percentage:

**Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**

**Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**

**Medically needy in 209(b) States (42 CFR § 435.330)**

**Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**

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

Specify:

Individuals eligible under §1902(a)(10)(A)(i)(VIII) (42CFR 435.119)

Medicaid State Plan Individuals aged 19 or older and under age 65 with income 133% FPL (42 CFR 435.119)

---

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

---

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

**Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

**All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

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

Check each that applies:

**A special income level equal to:**

Select one:

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

**A dollar amount which is lower than 300%.**

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

**Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under section 1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).*

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

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

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

**Use spousal post-eligibility rules under section 1924 of the Act.**

*(Complete Item B-5-c (209b State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**

*(Complete Item B-5-c (209b State). Do not complete Item B-5-d)*

Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

**Appendix B: Participant Access and Eligibility**

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

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

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

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

**Appendix B: Participant Access and Eligibility**

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

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

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

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR § 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in section 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

**The following standard included under the state plan**

(select one):

**The following standard under 42 CFR § 435.121**

Specify:

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

(select one):

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state plan**

*Specify:*

The Standard of Need (SON), as outlined by the New Hampshire Department of Health and Human Services, plus \$148, increased annually by the COLA, or a portion of the COLA, is the limit for individuals who live in homes owned and/or operated by providers unrelated to the individual by ancestry, marriage, or other legal arrangement. For individuals who live independently or with their families, it is the SON, plus the special income level for an institutionalized person of 300% of SSI (FBR).

**The following dollar amount**

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

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

*Specify:*

**Other**

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**The following standard under 42 CFR § 435.121**

*Specify:*

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

Specify:

**Other**

Specify:



---

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

---

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

Select one:

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

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

**The state establishes the following reasonable limits**

Specify:

The State uses the same reasonable limits as specified in He-W 530, "Service Limits, Co-Payments and Non-Covered Services"

**Appendix B: Participant Access and Eligibility**

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

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

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

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

---

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

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**Appendix B: Participant Access and Eligibility**

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

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

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

---

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

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**Appendix B: Participant Access and Eligibility**

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

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

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

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR § 435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

**The following standard included under the state plan**

*(select one):*

**The following standard under 42 CFR § 435.121**

*Specify:*

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

*(select one):*

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state plan**

*Specify:*

**The following dollar amount**

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

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

*Specify:*

**Other**

*Specify:*

The Standard of Need (SON), as outlined by the New Hampshire Department of Health and Human Services, plus \$148, increased annually by the COLA, or a portion of the COLA, is the limit for individuals who live in homes owned and/or operated by providers unrelated to the individual by ancestry, marriage, or other legal arrangement. For individuals who live independently or with their families, it is the SON, plus the special income level for an institutionalized person of 300% of SSI (FBR).

---

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

---

**Not Applicable (see instructions)**

**The following standard under 42 CFR § 435.121**

*Specify:*

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**AFDC need standard****Medically needy income standard****The following dollar amount:**

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

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

Specify:

**Other**

Specify:



---

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


---

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

Select one:

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

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

**The state establishes the following reasonable limits**

Specify:

The State uses the same reasonable limits as specified in He-W 530, "Service Limits, Co-Payments and Non-Covered Services"

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**Appendix B: Participant Access and Eligibility**


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

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

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

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

**i. Allowance for the personal needs of the waiver participant**

*(select one):*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

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

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

*Specify formula:*

**Other**

*Specify:*

The Standard of Need (SON), as outlined by the New Hampshire Department of Health and Human Services, plus \$148, increased annually by the COLA, or a portion of the COLA, is the limit for individuals who live in homes owned and/or operated by providers unrelated to the individual by ancestry, marriage, or other legal arrangement. For individuals who live independently or with their families, it is the SON, plus the special income level for an institutionalized person of 300% of SSI (FBR).

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

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

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

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

Select one:

**Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant,*

*not applicable must be selected.*

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

**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

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

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

**i. Minimum number of services.**

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

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

**The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

Individuals receiving Residential Habilitation shall receive monthly monitoring and quarterly in-person visits, in the individual's residence. Individuals receiving Community Participation Services, Supported Independent Living Services, and Supported Employment shall receive monthly monitoring and quarterly visits. All other services shall require quarterly monitoring in accordance with Appendix D and He-M 522.

The minimum number of services an individual must require in order to be determined to need waiver services shall not only include Service Coordination.

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

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By an entity under contract with the Medicaid agency.**

*Specify the entity:*

**Other**

*Specify:*

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

applicants:

Level of Care determinations are made by staff within the Bureau of Developmental Services (BDS) with a Bachelor's degree from a recognized college or university with a major study in human services, business, or health care administration, and four years' experience in developmental services. Each additional year of required work experience may be substituted for one year of required formal education. Each additional year of relevant formal education may be substituted for one year of required work experience.

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

Pursuant to State Administrative Rule He-M 517, an individual requires a skilled nursing facility level of care, which means requiring skilled nursing or skilled rehabilitative services on a daily basis for at least one of the following:

1. Services on a daily basis for:
  - (i) Performance of basic living skills;
  - (ii) Intellectual, physical, or psychological development and well-being;
  - (iii) Medication administration and instruction in, or supervision of, self-medication by a licensed medical professional; or
  - (iv) Medical monitoring or nursing care by a licensed professional person;
2. Services on a less than daily basis as part of a planned transition to more independence; or
3. Services on a less than daily basis but with continued availability of services to prevent circumstances that could necessitate more intrusive and costly services.

Initial requests for HCBS-ABD require area agencies to submit the application for waiver services using the NH Bureau of Developmental Services Functional Screen signed by a licensed practitioner.

The state utilizes the Functional Screen submitted by the area agency to determine if an individual meets the level of care initially and in the case of a request for redetermination. The Functional Screen details the individual's diagnosis, support needs in the areas of activities of daily living and instrumental activities of daily living, communication and cognition, behavior, risk to community safety, and other medical conditions.

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

**The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

The State uses the Bureau of Developmental Services (BDS) Functional Screen (FS) tool to make level of care (LOC) determinations for the Acquired Brain Disorder (ABD) Waiver. The BDS FS tool is comparable to the Medical Eligibility Assessment (MEA) utilized for LOC determinations for non-community based institutions, such as nursing facilities. The Functional Screen uses the same domains as the MEA with the exception of the area of supervision; which is included in the FS but not in the MEA. The outcome of the determination of the FS is comparable to the valid and reliable MEA because it uses the same domains, and therefore is also reliable and valid.

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

The Bureau of Developmental Services (BDS) Functional Screen (FS) form is submitted to BDS by the Area Agency to be reviewed for initial evaluation and then submitted by the Service Coordinator to be reviewed in order to redetermine the individual's eligibility for the Acquired Brain Disorder Waiver.

Reevaluations are completed annually through the submission of an updated NH BDS FS form. The reevaluation process does not differ from the evaluation process.

The state assures health and welfare of the waiver's target population post-waiver enrollment through the following means in accordance with He-M 522:

- Quarterly visits by the Service Coordinator are required for all individuals receiving a waiver service.
- For individuals receiving Residential Habilitation, the quarterly visits must take place in the individual's residence.
- Service Coordinators must contact the individual and guardian at least monthly for individual's receiving Residential Habilitation, Community Participation Services, Supported Independent Living Services, and Supported Employment and at least quarterly for individual's receiving all other services unless additional contacts are outlined in the individual service agreement.
- Quarterly satisfaction surveys are completed by the Service Coordinator with the individual and guardian for all individuals receiving waiver services.

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

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

**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

**The qualifications are different.**

*Specify the qualifications:*

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

The Bureau of Developmental Services (BDS) utilizes the following procedure to ensure timely reevaluations of level of care: To request reevaluation for Acquired Brain Disorder (ABD) Waiver services for an individual, a revised Functional Screen (FS) must be submitted at least 30 days prior to expiration of the current determination.

If the Functional Screen does not have sufficient information for BDS to determine whether the individual continues to meet the level of care requirements, the BDS staff requests that additional information be provided. The additional information requested could include, but is not limited to, recent assessments or evaluations that speak to the individual's assessed needs such as neuropsychological evaluations, Supports Intensity Scale, or SIB-R. If additional information received does not provide enough evidence for staff to determine the individual meets the level of care, the request would be denied.

BDS staff review all Functional Screen forms for each waiver participant at least annually, or more often when there are changes in needs.

Annual redeterminations occur for all individuals, unless an individual wishes to disenroll from waiver services.

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

Prior to the implementation of the MMIS system in April 2013, a hard copy file for each individual is maintained at BDS that includes his/her waiver service history, including all waiver request forms, required service agreements, level of care determination decisions completed and signed by a BDS staff, requests for service changes relative to change in developmental, functional, and/or medical status, as well as other relevant materials in file. Since implementation of the MMIS system, all files are stored electronically in the MMIS system.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

##### **i. Sub-Assurances:**

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

##### **Performance Measures**

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

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

##### **Performance Measure:**

**# & % of applicants for whom there is a reasonable indication that there may be services needed in the future who received a LOC. Numerator: # of applicants for whom there is a reasonable indication that there may be services needed in the future who received a LOC. Denominator: Total number of all applicants for whom there is reasonable indication that services may be needed in the future.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Individual Record**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of level of care (LOC) reviews for which a current functional**

screen has been used appropriately, as outlined in the approved Waiver, to determine LOC. Numerator: Number of LOC reviews for which a current functional screen has been used appropriately, as outlined in the approved Waiver, to determine LOC. Denominator: Total number of LOC reviews completed for applicants.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Individual Record**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1025 1264 1111" type="text"/>
Other Specify: <input data-bbox="408 1249 647 1335" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1249 1264 1335" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1473 1264 1559" type="text"/>
	Other Specify: <input data-bbox="718 1697 954 1783" type="text"/>	

Data Aggregation and Analysis:

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

Number and percent of level of care (LOC) reviews that were completed using New Hampshire (NH) Bureau of Developmental Services' (BDS) approved processes and forms. Numerator: Number of level of care (LOC) reviews that were completed using NH BDS' approved processes and forms. Denominator: Total number of LOC reviews completed for applicants.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Individual Record**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>

<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the state's method for addressing individual problems as they are discovered. Include information

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

Services cannot be approved nor will a prior authorization (PA) be issued if all required documents and eligibility criteria are not provided. If data elements are not found, or are found to be incomplete or inconclusive, BDS staff void the PA request in the Medicaid Management Information System (MMIS). A communication is sent through MMIS explaining the reason for voiding the request including details on what specific information is needed for resubmission and consideration.

**ii. Remediation Data Aggregation**

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

Prior to the provision of services, the service coordinator convenes a meeting during which the individual or legal guardian is informed of service options available through this waiver as well as the New Hampshire Medicaid State Plan, including institutional settings, community resources, and other alternatives that may be pertinent to the specific situation of the individual.

As part of the person-centered service planning process outlined in State Administrative Rule He-M 522, all individual service agreements document evidence of the individual or guardian's informed consent of community and institutional service alternatives.

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

An individual's service agreement documents freedom of choice. The service agreement is stored in the individual's record which is located at the Service Coordination agency.

## Appendix B: Participant Access and Eligibility

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

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

By signing "The State of New Hampshire Department of Health and Human Services New Hampshire Medicaid Provider Participation Agreement" all enrolled providers agree to provide services or items without discrimination as required by Title VI of the Civil Rights Act of 1964, and without discrimination on the basis of handicap as required by Section 504 of the Rehabilitation Act of 1973 as amended.

State regulation He-M 522 requires informed consent relative to services and service provision. It reads "All service planning shall occur through a person-centered planning process that: Reflects cultural considerations of the individual and is conducted in clearly understandable language and form". Samples of informational brochures in various languages are available.

Additionally, all contracts with the Department of Health and Human Services include a special provision for Limited English Proficiency (LEP) that requires contractors to take reasonable steps to ensure LEP persons have meaningful access to their programs. BDS monitors contract compliance within this area annually during the governance audit.

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Community Participation Services		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Service Coordination		
Statutory Service	Supported Employment		
Other Service	Assistive Technology		
Other Service	Community Integration Services		
Other Service	Crisis Response Services		
Other Service	Environmental and Vehicle Modification Services		
Other Service	Individual Goods and Services		

Service Type	Service		
Other Service	Non-Medical Transportation		
Other Service	Personal Emergency Response Services		
Other Service	Removable Prosthodontic Services		
Other Service	Specialty Services		
Other Service	Supported Independent Living Services		
Other Service	Wellness Coaching		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

**Alternate Service Title (if any):**

Community Participation Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Day Habilitation/Community Participation Services are provided as part of a comprehensive array of community-based services for individuals with acquired brain disorders that:

Assist the individual to attain, improve, and maintain a variety of life skills, including vocational skills;  
 Emphasize, maintain and broaden the individual’s opportunities for community participation and relationships;  
 Support the individual to achieve and maintain valued social roles, such as of an employee or community volunteer;

Promote personal choice and control in all aspects of the individual's life and services, including the involvement of the individual, to the extent he or she is able, in the selection, hiring, training, and ongoing evaluation of his or her primary staff and in determining the quality of services; and  
Are provided in accordance with the individual's service agreement and goals and desired outcomes.

All community participation services shall be designed to:

Support the individual's participation in and transportation to a variety of integrated community activities and settings;

Assist the individual to be a contributing and valued member of his or her community through vocational and volunteer opportunities;

Meet the individual's needs, goals, and desired outcomes, as identified in his or her service agreement, related to community-based opportunities for volunteerism, employment, personal development, socialization, communication, mobility, and personal care;

Help the individual to achieve more independence in all aspects of his or her life by learning, improving, or maintaining a variety of life skills, such as:

Traveling safely in the community;

Managing personal funds;

Participating in community activities; and

Other life skills identified in the service agreement;

Promote the individual's health and safety;

Protect the individual's right to freedom from abuse, neglect, and exploitation; and

Provide opportunities for the individual to exercise personal choice and independence within the bounds of reasonable risks.

Levels of Day Habilitation/Community Participation Services include:

Level I: Intended primarily for individuals who require intermittent supports on a regular basis;

Level II: Intended for individuals who require supports and supervision throughout the day;

Level III: Intended for individuals who require substantial supports and supervision;

Level IV: Intended for individuals who require frequent supports and supervision;

Level V: Intended for individuals who have significant medical and /or behavioral needs and require critical levels of supports and supervision; and

Level VI: Intended for individuals with the most extraordinary medical and behavioral needs and require exceptional levels of supervision, assistance and specialized care.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Community Participation Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Community Participation Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the

exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital under the following conditions:

- (A) Identified in an individual’s person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

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

The provision of Community Participation Services in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional"

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Participation Services (CPS)
Individual	Community Participation Services (CPS)

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Community Participation Services**

**Provider Category:**

Agency

**Provider Type:**

Community Participation Services (CPS)

**Provider Qualifications**

**License** (specify):

None

**Certificate** *(specify):*

In the event that a Community Participation Services Provider is required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

**Other Standard** *(specify):*

State Administrative Rule He-M 507 provides qualifications and training required for CPS providers. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers of CPS must be enrolled Medicaid providers.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Participation Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS's Bureau of Certification and Licensing, Health Facilities Administration reviews provider qualifications during certification reviews.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Participation Services definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to hiring and service delivery.

The Bureau of Health Facilities Administration verifies provider qualifications at certification site visits.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Participation Services definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type:** Statutory Service

**Service Name:** Community Participation Services

**Provider Category:**

Individual

**Provider Type:**

Community Participation Services (CPS)

**Provider Qualifications****License (specify):**

None

**Certificate (specify):**

In the event that a Community Participation Services Provider is required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

**Other Standard (specify):**

State Administrative Rule He-M 507 provides qualifications and training required for CPS providers. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers of CPS must be enrolled Medicaid providers.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Participation Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DHHS's Bureau of Certification and Licensing, Health Facilities Administration reviews provider qualifications during certification reviews.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Participation Services definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to hiring and service delivery.

The Bureau of Health Facilities Administration verifies provider qualifications at certification site visits.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Participation Services definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Residential Habilitation

**Alternate Service Title (if any):**

Residential Habilitation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Residential Habilitation includes a range of individually tailored supports to assist with the acquisition, retention, or improvement of community living skills including but not limited to: Assistance with activities of daily living and personal care such as meal preparation, eating, bathing, dressing, personal hygiene, medication management, community inclusion, transportation, social and leisure skills, and adaptive skill development to assist the individual to reside in the setting most appropriate to his/her needs.

Services and supports may be furnished in the home or outside the home. Services are provided to eligible individuals with the following general assistance needs:

Level I: Intended primarily for individuals who require intermittent supports on a daily basis;

Level II: Intended for individuals who require supports and supervision throughout the day;

Level III: Intended for individuals who require substantial supports and supervision;

Level IV: Intended for individuals who require frequent supports and supervision;

Level V: Intended for individuals who have significant medical and /or behavioral needs and require critical levels of supports and supervision; and

Level VI: Intended for individuals who have extraordinary medical and behavioral needs and require exceptional levels of assistance and specialized care.

Level VII: intended for individuals with the most extensive and extraordinary medical or behavioral management needs.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Residential Habilitation in another state, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service

agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual’s community during person-centered planning, the participant may receive Residential Habilitation in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

**BDS Out-of-State Review**

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital under the following conditions:

- (A) Identified in an individual’s person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

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

This waiver service is not available to individuals who are eligible to receive such service through the Medicaid State Plan.

Payment is not made for the cost of room and board, building maintenance, upkeep or improvement.

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

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

**Provider managed**

**Remote/via Telehealth**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Direct Service Provider
Individual	Direct Service Provider

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Residential Habilitation**

**Provider Category:**

Agency

**Provider Type:**

Direct Service Provider

**Provider Qualifications**

**License (specify):**

If services are being provided in conjunction with a practice act, the provider must comply with the State's licensure and certification laws as appropriate.

**Certificate (specify):**

Direct Service providers are unlicensed and uncertified personnel. In the event they are required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

**Other Standard (specify):**

State Administrative Rule He-M 1001 provides qualifications and training required for direct service providers. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers must be enrolled NH Medicaid Providers.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Residential Habilitation, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS's Bureau of Certification and Licensing, Health Facilities Administration reviews this during certification and licensing reviews.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Residential Habilitation service definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

The Bureau of Health Facilities Administration verifies provider qualifications at certification and/or licensing site visits.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Residential Habilitation service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Residential Habilitation**

**Provider Category:**

Individual

**Provider Type:**

Direct Service Provider

**Provider Qualifications**

**License (specify):**

If services are being provided in conjunction with a practice act, the provider must comply with the State's licensure and certification laws as appropriate.

**Certificate (specify):**

Direct Service providers are unlicensed and uncertified personnel. In the event they are required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

**Other Standard (specify):**

State Administrative Rule He-M 1001 provides qualifications and training required for direct service providers. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers must be enrolled NH Medicaid Providers.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Residential Habilitation, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS's Bureau of Certification and Licensing, Health Facilities Administration reviews this during certification and licensing reviews.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Residential Habilitation service definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

The Bureau of Health Facilities Administration verifies provider qualifications at certification and/or licensing site visits.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and

documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Residential Habilitation service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

In accordance with He-M 513, Respite Services consist of the provision of short-term care for participants unable to care for themselves because of the absence or need for relief of those persons who live with and normally provide care for the participant. Respite services can be provided in or out of the participant's home. Respite services should be provided in accordance with He-M 513.04 and/or He-M 513.05.

Community based camperships are allowable.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Respite

services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Respite services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

#### BDS Out-of-State Review

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital under the following conditions:

- (A) Identified in an individual's person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

This service has an annual service limit cap of \$7,500. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered service plan.

The cost of camp shall not count towards the \$7,500 service limitation.

The BDS Bureau Chief has the ability to determine limits on a case by case basis due to capacity issues.

The provision of Respite in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional"

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

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

**Provider managed**

**Remote/via Telehealth**

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

**Legally Responsible Person**

Relative

Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Camp
Agency	Camp
Individual	Respite Provider
Agency	Respite Provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Camp

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Camps shall be certified by the American Camping Association (ACA) or demonstrate the ability to meet the individual's assessed needs as outlined in the person-centered service agreement.

**Other Standard (specify):**

He-M 504 provides operating responsibilities for all providers and provider agencies.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

The agency has the primary responsibility to verify provider qualifications when the agency has arranged the respite service.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Camp

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Camps shall be certified by the American Camping Association (ACA) or demonstrate the ability to meet the individual’s assessed needs as outlined in the person-centered service agreement.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

**Other Standard (specify):**

He-M 504 provides operating responsibilities for all providers and provider agencies.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

**Frequency of Verification:**

The agency has the primary responsibility to verify provider qualifications when the agency has arranged the respite service.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Respite Provider

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

Respite providers are unlicensed and uncertified personnel. In the event they are required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

**Other Standard (specify):**

State Administrative Rule He-M 513 provides qualifications and training required for direct service providers. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

The agency has the primary responsibility to verify provider qualifications when the agency has arranged the respite service.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Respite Provider

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

Respite providers are unlicensed and uncertified personnel. In the event they are required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

**Other Standard** (*specify*):

State Administrative Rule He-M 513 provides qualifications and training required for direct service providers. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

The agency has the primary responsibility to verify provider qualifications when the agency has arranged the respite service.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

Service Coordination

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Services which will assist eligible individuals in gaining access to needed waiver and or State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source.

Service coordination activities completed as required in He-M 522.11 (m) (2) may be completed via telehealth service delivery through telephone contact or video-call platforms. Service coordination activities completed as required in He-M 522.11 (m) (3) may be completed via telehealth service delivery through a video-call platform in order to ensure face-to-face contact. Service Coordination activities completed as required in He-M 522.11 (m) (4) must be completed in-person. Participant Directed and Managed Services home visits must be completed in-person.

This service may be provided in an acute care hospital under the following conditions:

- (A) Identified in an individual’s person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

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

Service Coordination shall not be a standalone service. This service must be provided in conjunction with at least one other waiver service, unless the individual intends to add additional services within the service plan year. An individual may be able to exceed this limit on a case-by-case basis with the prior approval of BDS.

The provision of Service Coordination in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional"

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Service Coordinator
Agency	Service Coordinator

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Service Coordination**

**Provider Category:**

Individual

**Provider Type:**

Service Coordinator

**Provider Qualifications**

**License (specify):**

State administrative rule He-P 819 requires licensing of case management agencies defined therein.

**Certificate (specify):**

None

**Other Standard (specify):**

State Administrative Rule He-M 522 provides qualifications and training required for service coordinators. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers.

All providers of this service must be an enrolled NH Medicaid Provider.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Service Coordination**

**Provider Category:**

Agency

**Provider Type:**

Service Coordinator

**Provider Qualifications**

**License (specify):**

State administrative rule He-P 819 requires licensing of case management agencies defined therein.

**Certificate (specify):**

None

**Other Standard (specify):**

State Administrative Rule He-M 522 provides qualifications and training required for service coordinators. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers.  
  
All providers of this service must be an enrolled NH Medicaid Provider.  
  
Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.  
  
The FMS is responsible for verification of provider qualifications for participants who self-direct their services.  
  
BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.  
  
BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Supported Employment

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Employment services will provide access to community-based employment and make available, based upon individual need and interest: employment supports, transportation to work, training and educational opportunities, the use of co-worker supports and generic resources to the maximum extent possible.

All employment services shall be designed to:

Assist the individual to obtain employment, customized employment or self-employment, including the development of microenterprises that are integrated in the community, that is based on the individual's employment profile and goals in the service agreement;

Provide the individual with opportunities to participate in a comprehensive career development process that helps to identify the individual's employment profile;

Support the individual to develop appropriate skills for job searching, including:

Creating a resume and employment portfolio;

Practicing job interviews; and

Learning soft skills that are essential for succeeding in the workplace;

Assist the individual to become as independent as possible in his or her employment, internships, and education and training opportunities by:

Developing accommodations;

Utilizing assistive technology; and

Creating and implementing a plan to fade services;

Help the individual to:

Meet his or her goal for the desired number of hours of work as articulated in the service agreement; and

Earn wages of at least minimum wage or prevailing wage, unless the individual is pursuing income based on self-employment;

Assess, cultivate, and utilize natural supports within the workplace to assist the individual to achieve independence to the greatest extent possible;

Help the individual to learn about, and develop appropriate social skills to actively participate in, the culture of his or her workplace;

Understand, respect, and address the business needs of the individual's employer, in order to support the individual to meet appropriate workplace standards and goals;

Maintain communication with, and provide consultations to, the employer to:

Address employer specific questions or concerns to enable the individual to perform and retain his/her job; and

Explore opportunities for further skill development and advancement for the individual;

Help the individual to learn, improve, and maintain a variety of life skills related to employment, such as:

Traveling safely in the community;

Managing personal funds;

Utilizing public transportation; and

Other life skills identified in the service agreement related to employment;

Promote the individual's health and safety;

Protect the individual's right to freedom from abuse, neglect, and exploitation; and

Provide opportunities for the individual to exercise personal choice and independence within the bounds of reasonable risks.

SEP Level I: Intended primarily for individuals whose level of functioning is relatively high but who still require intermittent supports on a regular basis;

SEP Level II: Intended for individuals whose level of functioning requires substantial supports and supervision;

SEP Level III: Intended for individuals with the most extensive and extraordinary medical or behavioral management needs.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Supported Employment in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Supported Employment in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

#### BDS Out-of-State Review

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.

• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital under the following conditions:

(A) Identified in an individual’s person-centered service plan;  
 (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;  
 (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and  
 (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

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

The provision of Supported Employment in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Employment Consultant
Agency	Employment Consultant

## Appendix C: Participant Services

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

**Service Type:** Statutory Service  
**Service Name:** Supported Employment

**Provider Category:**

Individual

**Provider Type:**

Employment Consultant

**Provider Qualifications**

**License** (specify):

None

**Certificate** (specify):

None

**Other Standard** (specify):

State Administrative Rule He-M 518 provides qualifications and training required for SEP providers. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers of this service must be an enrolled Medicaid provider.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Supported Employment, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Supported Employment service definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Supported Employment service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

Employment Consultant

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

None

**Other Standard (specify):**

State Administrative Rule He-M 518 provides qualifications and training required for SEP providers. He-M 504 provides operating responsibilities for all providers and provider agencies and He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers of this service must be an enrolled Medicaid provider.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Supported Employment, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Supported Employment service definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Supported Employment service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Assistive Technology

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

This service covers assistive technology and any related assistive technology services. Assistive technology means an item, piece of equipment, certification and training of a service animal (service animal as defined by the American Disabilities Act (ADA)), or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve functional capabilities of participants. Assistive technology services means a service that directs/assists a participant in the selection, acquisition or use of an assistive technology device.

Assistive technology includes: (A) The evaluation of the assistive technology needs of a participant including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; (B) Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology/devices for participants. (C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices such as therapies, interventions, or services associated with other services in the service plan. (D) Coordination and use of necessary therapies, interventions or services associated with other services in the service plan. (E) Training or technical assistance for the participant or where appropriate, the family members, guardians, advocates or authorized representatives of the participant; and (F) Training or technical assistance for professional or other individuals who provides services to, employ or are otherwise substantially involved in the major life functions of participants.

Devices, controls, or appliances, specified in the individual service agreement that enable the individual to increase their ability to perform activities of daily living, and/or perceive, control, or communicate with the environment in which they live will be covered. Adaptive equipment may only include items of durable and non-durable medical equipment necessary to address the individual’s functional limitations and specified in the plan of care. Adaptive equipment may be covered so long as the equipment is necessary to address the individual’s functional limitations and is not to be used for recreational purposes.

May include performance of assessments to identify type of equipment needed by the participant.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Assistive Technology in another state, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual’s community during person-centered planning, the participant may receive Assistive Technology in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

**BDS Out-of-State Review**

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital under the following conditions:

- (A) Identified in an individual's person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

There is a service limitation cap of \$10,000 over the course of a five year period of time.

An individual may be able to exceed this cap on a case by case basis with the prior approval of BDS. A prior authorization for the amount requested above the service limit cap must include supporting documentation, identify need, and correlate to the person centered plan.

Assistive technology provided through the waiver is over and above that which is available under the state plan or that is the obligation of the individual's employer.

Individual service agreement (ISA) will specify the following:

- 1) The item;
- 2) The name of the healthcare practitioner recommending the item;
- 3) An evaluation or assessment regarding the appropriateness of the item;
- 4) A goal related to the use of the item;
- 5) The anticipated environment that the item will be used;
- 6) Current modifications to item/product and anticipated future modifications and anticipated cost.

The provision of Assistive Technology in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

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

**Provider managed**

**Remote/via Telehealth**

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

**Legally Responsible Person**

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology Provider
Individual	Assistive Technology Provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Assistive Technology**

**Provider Category:**

Agency

**Provider Type:**

Assistive Technology Provider

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

None

**Other Standard (specify):**

Specialized training in equipment, item or product.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Assistive Technology, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Assistive Technology service definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Assistive Technology service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Assistive Technology**

**Provider Category:**

Individual

**Provider Type:**

Assistive Technology Provider

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

None

**Other Standard (specify):**

Specialized training in equipment, item or product.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Assistive Technology, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Assistive Technology service definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification

standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Assistive Technology service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Community Integration Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Community integration services utilize activity based interventions to address the assessed needs of an individual as a means to health and well being as outlined in the service agreement. Community integration services are designed to support and enhance a person's level of functioning, independence and life activities, to promote health and wellness as well as reduce or

eliminate the activity limitations and restrictions to participation in life situations caused by a disability.

Community integration services include activities outlined in the individual's service agreement as assessed needs that promote an individual's health and well-being. For those Community Integration Services that issue memberships or passes, they shall be purchased as day, monthly, or annual passes, whichever is the most cost effective. Fees for water safety training are allowable. Community Integration Services shall not include services that are recreational or diversional in nature.

The coverage of this service authorizes the purchase of goods and services that are not otherwise offered in the waiver or the state plan. The specific goods and services that are purchased under this coverage must be documented in the service agreement.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Community Integration Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Community Integration Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

#### BDS Out-of-State Review

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

Community integration services inclusive of therapeutic services and camperships will have an \$8,000 cap. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered service plan.

Any single community integration service over \$2,000 will require a licensed healthcare practitioner's recommendation.

The coverage of this service authorizes the purchase of goods and services that are not otherwise offered in the waiver or the state plan.

Individual service agreement (ISA) will specify the following:

- 1) The service;
- 2) The name of the healthcare practitioner recommending the item (for single services \$2,000 and over);
- 3) An evaluation or assessment regarding the appropriateness of the service;

4) A goal related to the use of the service;

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Community Integration Services (CIS) Provider
Agency	Community Integration Services (CIS) Provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Community Integration Services**

**Provider Category:**

Individual

**Provider Type:**

Community Integration Services (CIS) Provider

**Provider Qualifications**

**License** (specify):

None

**Certificate** (specify):

None

**Other Standard** (specify):

Specialized training in equipment, item or product.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Integration Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Integration Services definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Integration Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Community Integration Services**

**Provider Category:**

Agency

**Provider Type:**

Community Integration Services (CIS) Provider

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

None

**Other Standard (specify):**

Specialized training in equipment, item or product.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Integration Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Integration Services definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Integration Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Crisis Response Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Includes direct consultation, clinical evaluation, staffing supports and transportation to individuals who are experiencing a behavioral, emotional or medical crisis or challenge. These services are intended to address the individual's specific problems, thereby reducing the likelihood of harm to the individual or others, and assisting the individual to return to their pre-crisis status.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Crisis Response Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Crisis Response Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

**BDS Out-of-State Review**

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital under the following conditions:

- (A) Identified in an individual's person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

Authorized provision of Crisis Response Services with review by BDS prior to service authorization may be provided for no more than 5 days, in accordance with the Crisis Policy, and only to ensure health and welfare of an individual.

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

This waiver service is not available to individuals who are eligible to receive such service through the Medicaid State Plan.

Limited to six month approval. Six month approvals may be renewed based on individual need.

The provision of Crisis Response Services in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Clinician, or consultant, behavioral specialist, or direct support staff
Individual	Clinician, or consultant, behavioral specialist, or direct support staff

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Crisis Response Services**

**Provider Category:**

Agency

**Provider Type:**

Clinician, or consultant, behavioral specialist, or direct support staff

**Provider Qualifications**

**License** *(specify):*

Certain provider types may require licensure depending on what service is provided.

**Certificate** *(specify):*

Certain provider types may require certification depending on service provided.

**Other Standard** *(specify):*

Direct service staff would be required to meet, at minimum, requirements as outlined under day and residential habilitation or meet the necessary specialized training in equipment, item or products, as applicable.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Crisis Response Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Crisis Response Services service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Crisis Response Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Crisis Response Services**

**Provider Category:**

Individual

**Provider Type:**

Clinician, or consultant, behavioral specialist, or direct support staff

**Provider Qualifications**

**License (specify):**

Certain provider types may require licensure depending on what service is provided.

**Certificate (specify):**

Certain provider types may require certification depending on service provided.

**Other Standard (specify):**

Direct service staff would be required to meet, at minimum, requirements as outlined under day and residential habilitation or meet the necessary specialized training in equipment, item or products, as applicable.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Crisis Response Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Crisis Response Services service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Crisis Response Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Environmental and Vehicle Modification Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**



Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Environmental and Vehicle Modification Services: Include those physical adaptations to the private residence of the participant, or vehicle that is the waiver participant's primary means of transportation, required by the individual's service plan, that 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 and community, and without which, the individual would require institutionalization.

Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.(e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

All modifications will be provided in accordance with applicable State or local building codes.

Relative to vehicle modification, the following are excluded: Those adaptations or improvements to a vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; purchase or lease of a vehicle; and regularly scheduled upkeep and maintenance of a vehicle with the exception of upkeep and maintenance of the modifications.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Environmental and Vehicle Modification Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Environmental and Vehicle Modification Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

**BDS Out-of-State Review**

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the

- previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital under the following conditions:

- (A) Identified in an individual’s person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

For individuals with unsafe wandering and running behaviors, outdoor fencing may be provided under this waiver. Waiver funds allocated toward the cost of such a fence shall not exceed \$5,000 which can provide approximately 3,500 square feet of a safe area.

Exceptions to this service limitation may be made on a case by case basis.

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services.

The provision of Environmental and Vehicle Modifications in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

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

**Provider managed**

**Remote/via Telehealth**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Private Contractor, or other similarly qualified provider
Agency	Private Contractor, or other similarly qualified provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Environmental and Vehicle Modification Services**

**Provider Category:**

Individual

**Provider Type:**

Private Contractor, or other similarly qualified provider

**Provider Qualifications**

**License** (*specify*):

As required by state law or local ordinance.

**Certificate** (*specify*):

As required by state law or local ordinance.

**Other Standard** (*specify*):

Permits relative to state and/or local building codes.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Environmental and Vehicle Modification Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Environmental and Vehicle Modification Services service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Environmental and Vehicle Modification Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Environmental and Vehicle Modification Services**

**Provider Category:**

Agency

**Provider Type:**

Private Contractor, or other similarly qualified provider

**Provider Qualifications**

**License** *(specify):*

As required by state law or local ordinance

**Certificate** *(specify):*

As required by state law or local ordinance.

**Other Standard** *(specify):*

Permits relative to state and/or local building codes.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Environmental and Vehicle Modification Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Environmental and Vehicle Modification Services service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Environmental and Vehicle Modification Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Individual Goods and Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Individual Goods and Services are services, including caregiver supports, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the individual service agreement (ISA) (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: The item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; and the participant and their family does not have the funds to purchase the item or service is not available through other sources. Must not be an otherwise covered state plan service.

Goods and Services are purchased based on needs identified in the individual service agreement. Experimental or prohibited treatments are excluded. Individual Goods and Services must be documented in the ISA.

The coverage of these services permits a state to authorize the purchase of goods and services that are not otherwise offered in the waiver or the state plan. The goods and services purchased under this coverage may not circumvent other restrictions on the claiming for the costs of room and board.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Individual Goods and Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Individual Goods and Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the

services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

#### BDS Out-of-State Review

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital under the following conditions:

- (A) Identified in an individual's person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

There is an annual \$1,500 service limit. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered plan.

The item or service must be identified as necessary in the individual service agreement. A goal related to the use of the item or service should be available in the individual service agreement, amendments to the service agreement should indicate this item if it wasn't in the original service agreement.

Documentation related to the use of the item should be available for review in monthly notes. This item should have an anticipated shelf life. The frequency of purchase would be contingent upon the continued need of the item and the item's ability to continue to meet that need.

he provision of Individual Goods and Services in acute care hospitals will be reviewed and approved by the person centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

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

**Provider managed**

**Remote/via Telehealth**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

#### **Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Individual Goods and Services (IG&S) Provider
Individual	Individual

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Individual Goods and Services**

**Provider Category:**

Agency

**Provider Type:**

Individual Goods and Services (IG&S) Provider

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

None

**Other Standard (specify):**

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Individual Goods and Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Individual Goods and Services service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Individual Goods and Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Individual Goods and Services**

**Provider Category:**

Individual

**Provider Type:**

Individual

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

None

**Other Standard (specify):**

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Individual Goods and Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Individual Goods and Services service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Individual Goods and Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Non-Medical Transportation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Transportation services are designed specifically to improve the individual's and the caregiver's ability to access community activities within their own community in response to needs/choices identified through the individual's service agreement. Transportation services include:

1. Transport for safe movement from one place to another;
2. Travel training such as supporting the individual in learning how to access and use informal and public transport for independence and community integration;
3. Transportation service provided by different modalities, including; public and community transportation, taxi services, transportation specific to prepaid transportation cards, mileage reimbursement, volunteer transportation, and non-traditional transportation providers, and
4. Prepaid transportation vouchers and cards.
5. Parking and toll fees

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Non-Medical Transportation in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented

in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Non-Medical Transportation in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

#### BDS Out-of-State Review

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

Payment for transportation under the waiver is limited to the costs of transportation needed to access a waiver service included in the participant's service plan or access to other activities and resources identified in the service plan.

Non-Medical Transportation is capped at \$5,000 annually.

Up to \$10,000 annually is allowable for individuals that require specialized transportation including wheelchair van/lift and/or a van that allows the individual being transported to "not" be within arm's reach of the driver for safety reasons. Verification of an individual's need for specialized transportation will be required upon request to the Bureau of Developmental Services.

The Bureau of Developmental Services Administrator reserves the right to approve requests that exceed the cap on a case by case basis. Proof of this need to exceed the cap will be required upon request to the Bureau of Developmental Services.

When the provider is transporting the individual, the individual is with the caretaker and the only transportation that may be covered is when the transportation that occurs is directly related to the individual's disability or specific to a caretaker providing the transportation to activities determined in the individual service agreement.

Caretakers will provide proof of insurance, complete all required registry checks, and have a completed driving record check. Youth under the age of 16 shall not be reimbursed for public transportation expenses.

The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Coverage of non-medical transportation may be permitted when non-medical transportation is not otherwise available through a service in the waiver or the state plan.

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

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

**Provider managed**

**Remote/via Telehealth**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Direct Support Professional
Agency	Direct Support Professional

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Non-Medical Transportation**

**Provider Category:**

Individual

**Provider Type:**

Direct Support Professional

**Provider Qualifications**

**License (specify):**

Any direct support professional driving a waiver participant shall have a current driver's license.

Transportation agencies, such as Uber, Lyft, and state licensed agencies, that complete record checks on all drivers initially and ongoing shall be considered to have met this requirement

**Certificate (specify):**

None

**Other Standard (specify):**

A driving record check completed, a criminal record check completed, and proof of insurance and a waiver on file, if applicable. The Bureau of Adult and Aging Services (BAAS) registry and Division of Child, Youth, and Families (DCYF) are required to be checked as well. A transportation agency registered with the state to provide public transportation is an approved standard as a provider for this service.

Transportation agencies, such as Uber, Lyft, and state transportation agencies must comply with state inspection, registration, and insurance requirements as applicable.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Non-Medical Transportation, the following documentation must be provided:

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Non-Medical Transportation service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Non-Medical Transportation service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Non-Medical Transportation**

**Provider Category:**

Agency

**Provider Type:**

Direct Support Professional

**Provider Qualifications**

**License (specify):**

Any direct support professional driving a waiver participant shall have a current driver's license.

Transportation agencies, such as Uber, Lyft, and state licensed agencies that complete record checks on all drivers initially and ongoing shall be considered to have met this requirement.

**Certificate (specify):**

None

**Other Standard (specify):**

A driving record check completed, a criminal record check completed, and proof of insurance and a waiver on file, if applicable. The Bureau of Adult and Aging Services (BAAS) registry and Division of Children, Youth, and Families (DCYF) registry are required to be checked as well. A transportation agency registered with the state to provide public transportation is an approved standard as a provider for this service.

Transportation agencies, such as Uber, Lyft, and state licensed agencies must comply with state inspection, registration, and insurance requirements as applicable.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Non-Medical Transportation, the following documentation must be provided:

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Non-Medical Transportation service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Non-Medical Transportation service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Personal Emergency Response Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Smart technology including electronic devices that enable participants at risk of institutionalization to summon help in an emergency. Covered devices include wearable or portable devices that allow for safe mobility, response systems that are connected to the participant’s telephone and programmed to signal a response center when activated, staffed and monitored response systems that operate 24 hours/day, seven days/week and any device that informs of elopement such as wandering awareness alerts. Other covered items include seatbelt release covers, ID bracelets, GPS devices, monthly expenses that are affiliated with maintenance contracts and/or agreements to maintain the operations of the device/item.

Devices can be an option to consider as a part of a multifaceted safety plan or behavior plan, specific to a participant's unique needs.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Personal Emergency Response Services in another state, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual’s community during person-centered planning, the participant may receive Personal Emergency Response Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

**BDS Out-of-State Review**

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in acute care hospital setting under the following conditions:

- (A) identified in an individual’s person-centered service plan;
- (B) provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under

Federal or State law, or under another applicable requirement; and  
 (D) designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

There is an annual \$2,000 service limit. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered plan.

Any device that might be considered restrictive will be part of a multifaceted safety plan or behavior plan, specific to a participant's unique needs, and will be approved by the individual, guardian and the local Human Rights Committee.

The provision of Personal Emergency Response Services in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional"

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Contractor, or other similarly qualified provider
Individual	Private Contractor, or other similarly qualified provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Personal Emergency Response Services**

**Provider Category:**

Agency

**Provider Type:**

Private Contractor, or other similarly qualified provider

**Provider Qualifications**

**License** (specify):

As required by state law or local ordinance.

**Certificate** (specify):

As required by state law or local ordinance.

**Other Standard** (specify):

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Personal Emergency Response Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Personal Emergency Response Services service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Personal Emergency Response Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response Services**

**Provider Category:**

Individual

**Provider Type:**

Private Contractor, or other similarly qualified provider

**Provider Qualifications**

**License (specify):**

As required by state law or local ordinance.

**Certificate (specify):**

As required by state law or local ordinance.

**Other Standard (specify):**

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit

forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Personal Emergency Response Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Personal Emergency Response Services service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Personal Emergency Response Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Removable Prosthodontic Services

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11070 dental services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Removable Prosthodontic Services under this waiver are limited to the provision of dentures, routine post-delivery care and other associated procedures connected to the prosthodontic service that are not included in the New Hampshire Medicaid State Plan, "Adult Dental Services".

Removable Prosthodontic Services are intended to assist individuals as a means to prevent functional limitations in order to support community integration and avoid isolation or institutionalization and when, if not otherwise provided:

- The individual's health would be compromised through reduced food options and result in restrictive nutritional intake, impacting overall health; and/or
- When considerations interfere with supported employment or social development. For example, an individual who has a severe dental deformity may receive treatment if during person-centered-planning, it is determined that provision of dentures would enhance the individual's opportunities for community integration.

Covered services include:

- Complete Dentures, including immediate prosthetic appliances and routine post-delivery care
- Partial Dentures, including immediate prosthetic appliances and routine post-delivery care
- Adjustments to dentures
- Repairs to complete and partial dentures
- Denture rebase procedures
- Denture relines procedures

Removable Prosthodontic Services must be rendered by a qualified provider through the approved Prepaid Ambulatory Health Plan (PAHP), as outlined in the associated Provider Qualifications section for this service.

Services provided through this waiver are intended to support those services that exceed the New Hampshire Medicaid State Plan coverage for fitting, maintenance and other services associated with the removable prosthodontic item.

A goal is not required in the individual's service agreement, however, the need for this service shall be reflected. If this service was selected to support community integration and prevent isolation, the decision to select this service shall be made by the individual and guardian, as applicable, during the person-centered planning process. All treatment notes, radiographic images, laboratory prescriptions and laboratory invoices should be made part of the individual's treatment record with the PAHP and be made available upon request to support any treatment provided.

Out-of-state Removable Prosthodontic Services provision is limited to individuals who are participating in Bureau of Developmental Services-approved out-of-state residential services, as outlined in the Residential Services definition in Appendix C, or if the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning.

Removable Prosthodontic Services may be provided in an acute care hospital if the service is alternatively not available and

with prior approval from the PAHP if the service is:

- Identified in the individual’s person-centered service agreement;
- Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

The provision of Removable Prosthodontic Services in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in, “Brief Waiver Description” under section, "Main, B. Optional.”

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

Removable Prosthodontic Services are limited to additional services for individuals over the age of 21 that are not otherwise covered under the New Hampshire Medicaid State Plan. All medically necessary Removable Prosthodontic Services and Dental Services for individuals under the age of 21 are covered under New Hampshire State Plan Dental Services as a Children’s Medicaid benefit. This waiver service is only provided to individuals age 21 and over.

There is a \$1500 annual service limit for Removable Prosthodontic Services. An individual may be able to exceed this cap due to medical necessity, on a case-by-case basis, with prior approval from New Hampshire DHHS. A prior authorization for the amount requested above the service limit cap must include supporting documentation, identify need, and correlate to the person centered plan. Removable Prosthodontic Services are overseen by the approved Prepaid Ambulatory Health Plan (PAHP) and payment for this service is included in the PAHP agreement. Medicaid payment is considered payment in-full. Except for members with a "spend down," members cannot be charged beyond the Medicaid fee. Deposits, down-payments or advance payments are prohibited.

Dentures may be provided no more than once in a five-year period. This service limit may be exceeded with prior approval from DHHS.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Dentist
Individual	Dentist

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Removable Prosthodontic Services**

**Provider Category:**

Agency

**Provider Type:**

Dentist

**Provider Qualifications**

**License (specify):**

A rendering service provider shall be a licensed dentist in the state where they practice and have the necessary professional licenses and credentials required by federal, state and local statutes and regulations, as applicable.

Unlicensed dental interns and dental students of university-based dental programs may provide services under the general supervision of a licensed, New Hampshire Medicaid enrolled and participating dentist but cannot act as a treating provider or bill Medicaid for covered services.

**Certificate (specify):**

**Other Standard (specify):**

Removable Prosthodontic Services must be rendered by a qualified provider and coordinated through the NH Medicaid approved Prepaid Ambulatory Health Plan.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Prepaid Ambulatory Health Plan (PAHP) shall ensure that participating providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with the provider disclosure, screening and enrollment requirements. The PAHP shall demonstrate that its participating providers are credentialed. The State Medicaid Agency will screen and enroll all PAHP-participating providers.

**Frequency of Verification:**

The State Medicaid Agency will revalidate all Prepaid Health Plan-participating providers every five years.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Removable Prosthodontic Services**

**Provider Category:**

Individual

**Provider Type:**

Dentist

**Provider Qualifications**

**License (specify):**

A rendering service provider shall be a licensed dentist in the state where they practice and have the necessary professional licenses and credentials required by federal, state and local statutes and regulations, as applicable.

Unlicensed dental interns and dental students of university-based dental programs may provide services under the general supervision of a licensed, New Hampshire Medicaid enrolled and participating dentist but cannot act as a treating provider or bill Medicaid for covered services.

**Certificate (specify):**

**Other Standard (specify):**

Removable Prosthodontic Services must be rendered by a qualified provider and coordinated through the NH Medicaid approved Prepaid Ambulatory Health Plan.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Prepaid Ambulatory Health Plan (PAHP) shall ensure that participating providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with the provider disclosure, screening and enrollment requirements. The PAHP shall demonstrate that its participating providers are credentialed. The State Medicaid Agency will screen and enroll all PAHP-participating providers.

**Frequency of Verification:**

The State Medicaid Agency will revalidate all Prepaid Health Plan-participating providers every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Specialty Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Intended for recipients whose needs in the areas of medical, behavioral, therapeutic, health and personal well-being require services which are specialized pertaining to unique conditions and aspects of acquired brain disorder. Specialty Services are utilized to provide assessments and consultations and are used to contribute to the design, development and provision of services, training support staff to provide appropriate supports as well as the evaluation of service outcomes and transportation if applicable.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Specialty Services in another state, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30

minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Specialty Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

#### BDS Out-of-State Review

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in acute care hospital setting under the following conditions:

- (A) Identified in an individual's person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

Any items provided under this category must be based on an assessed need by a qualified provider and cannot be available as a benefit under the NH State Medicaid Plan.

The provision of Specialty Services in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

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

**Provider managed**

**Remote/via Telehealth**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

#### **Provider Specifications:**

Provider Category	Provider Type Title
Agency	Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.
Individual	Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Specialty Services**

**Provider Category:**

Agency

**Provider Type:**

Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.

**Provider Qualifications**

**License (specify):**

Psychiatrist, Psychologist or other consulting health care of disability professional requiring licensure under state law to practice, the provider is required to have the appropriate licensure or certification as outline in state law.

**Certificate (specify):**

None

**Other Standard (specify):**

Other consulting healthcare or disability professionals with specialized knowledge will not need state licensure or certification, but will require meeting the requirements for their specialized field. Forensic specialist are masters level clinicians with the expertise and experience to provide supports to individuals with acquired brain disorder who are at risk for unsafe sexual behaviors or arson.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Specialty Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Specialty Services service definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Specialty Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Specialty Services**

**Provider Category:**

Individual

**Provider Type:**

Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.

**Provider Qualifications**

**License (specify):**

Psychiatrist, Psychologist or other consulting health care or disability professional requiring licensure under state law to practice, the provider is required to have the appropriate licensure or certification as outline in state law.

**Certificate (specify):**

None

**Other Standard (specify):**

Other consulting healthcare or disability professionals with specialized knowledge will not need state licensure or certification, but will require meeting the requirements for their specialized field. Forensic specialist are masters level clinicians with the expertise and experience to provide supports to individuals with acquired brain disorder who are at risk for unsafe sexual behaviors or arson.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Specialty Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Specialty Services service definition and provider qualification criteria.

BDS audits provider qualifications as part of its service review audits and evaluates compliance with provider qualification standards.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Specialty Services service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Supported Independent Living Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Supported Independent Living Services are intended for the individual who has developed, or is trying to develop, skills to live independently within the community. Supported Independent Living Services consist of assistance provided to an individual to improve or maintain his or her skills in basic daily living, transportation and community integration; to enhance their personal development and well being in accordance with goals outlined in the individual's service agreement.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Community Support Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Community Support Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

**BDS Out-of-State Review**

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in an acute care hospital, only when the parent or guardian is not available and under the following conditions:

- (A) Identified in an individual's person-centered service plan;
- (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
- (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

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

Supported Independent Living Services are capped at 30 hours per week.

Services may begin and continue for up to 24 consecutive months (two years) while the individual is still residing with their family.

This service does not include costs related to room and board.

The BDS Administrator reserves the right to exceed the cap and/or time limitations placed on this service on a case by case basis.

An individual may exceed the above service limit caps with prior authorization approval from BDS. A prior authorization

for the amount requested beyond the service limit caps must include supporting documentation, identify need and correlate to the person centered service plan.

The provision of Supported Independent Living Services in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

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

**Provider managed**

**Remote/via Telehealth**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Direct Support Professional
Individual	Direct Support Professional

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Supported Independent Living Services**

**Provider Category:**

Agency

**Provider Type:**

Direct Support Professional

**Provider Qualifications**

**License** (*specify*):

None

**Certificate** (*specify*):

Direct Service providers are unlicensed and uncertified personnel. In the event they are required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

**Other Standard** (*specify*):

State Administrative Rule He-M 506 provides qualifications and training required for Community Support Services providers. He-M 504 provides operating responsibilities for all providers and provider agencies. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers of this service must be an enrolled Medicaid provider.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Support Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Administrative Rule He-M 506 provides qualifications and training required for Community Support Services providers. He-M 504 provides operating responsibilities for all providers and provider agencies. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers of this service must be an enrolled Medicaid provider.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Support Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Support Services definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Supported Independent Living Services**

**Provider Category:**

Individual

**Provider Type:**

Direct Support Professional

**Provider Qualifications**

**License (specify):**

None

**Certificate (specify):**

Direct Service providers are unlicensed and uncertified personnel. In the event they are required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

**Other Standard (specify):**

State Administrative Rule He-M 506 provides qualifications and training required for Community Support Services providers. He-M 504 provides operating responsibilities for all providers and provider agencies. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers of this service must be an enrolled Medicaid provider.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Support Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Administrative Rule He-M 506 provides qualifications and training required for Community Support Services providers. He-M 504 provides operating responsibilities for all providers and provider agencies. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

All providers of this service must be an enrolled Medicaid provider.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Support Services, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Support Services definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Wellness Coaching

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Plan, direct, coach and mentor individuals with disabilities in community based, inclusive exercise activities based on a healthcare practitioner's recommendation. Develop specific goals for the individual's service agreement, including activities that are carried over into the individual's home and community; demonstrate exercise techniques and form, observe participants, explain to them corrective measures necessary to improve their skills, and transportation if applicable. Collaborate with the individual, his or her guardian (if applicable) and other caregivers and with other health and wellness professionals as needed. The Services must not otherwise be covered by NH State Plan.

For those Wellness Coaching services that issue memberships or passes, they shall be purchased as day, monthly, or annual passes, whichever is the most cost effective.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Wellness Coaching in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Wellness Coaching in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

**BDS Out-of-State Review**

All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:

- A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
- Provider qualification criteria, as outlined for the Waiver service(s).
- The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
- A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
- A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

This service may be provided in acute care hospital setting under the following conditions:

(A) Identified in an individual’s person-centered service plan;  
 (B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;  
 (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and  
 (D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDs to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

Wellness coaching services has an annual cap of \$5,000. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered service plan.

The provision of Wellness Coaching in acute care hospitals will be reviewed and approved by the person-centered planning team on a quarterly basis. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional"

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Personal Trainer, Certified Instructor or Physical Therapist
Individual	Personal Trainer, Certified Instructor or Physical Therapist

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Wellness Coaching**

**Provider Category:**

Agency

**Provider Type:**

Personal Trainer, Certified Instructor or Physical Therapist

**Provider Qualifications**

**License (specify):**

Licensed physical therapist

**Certificate (specify):**

Certified personal trainer, certified occupational therapist or other relevant certifications.

**Other Standard (specify):**

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health

care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Wellness Coaching, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Wellness Coaching service definition and provider qualification criteria.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Wellness Coaching service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Wellness Coaching**

**Provider Category:**

Individual

**Provider Type:**

Personal Trainer, Certified Instructor or Physical Therapist

**Provider Qualifications**

**License (specify):**

Licensed physical therapist

**Certificate (specify):**

Certified personal trainer, certified occupational therapist or other relevant certifications.

**Other Standard (specify):**

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit

forms and documentation as required by the Fiscal Management Service (FMS).

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Wellness Coaching, the following documentation must be provided.

- The home-state license and/or certification for the applicable setting, service provided and/or providers.
- If applicable, accreditations for home and community based services.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

Provider qualification verification happens by the Department's Program Integrity Unit and the Bureau of Developmental Services upon enrollment to become a Medicaid provider in accordance with New Hampshire administrative rule He-M 504.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity uses an organized health care delivery system as a "pass-through" entity, in accordance with NH administrative rule He-M 504. In such case, verification of provider qualifications is done by the OHCDs.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Wellness Coaching service definition and provider qualification criteria.

##### Frequency of Verification:

Verification of provider qualification happens prior to service delivery.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Wellness Coaching service definition and provider qualification criteria.

BDS conducts service review audits on a sampling of records on an annual basis.

## Appendix C: Participant Services

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

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

**As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

**As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered

planning requirements:

**d. Remote/Telehealth Delivery of Waiver Services.** Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Community Participation Services
Residential Habilitation
Service Coordination
Supported Employment
Assistive Technology
Community Integration Services
Crisis Response Services
Individual Goods and Services
Specialty Services
Supported Independent Living Services
Wellness Coaching

1. Will any in-person visits be required?

**Yes.**

**No.**

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.

**The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Explain:**

The Individual Service Agreement (ISA) will identify how the services are delivered in a way that respects the privacy of the individual and will include consideration of the Waiver participant’s privacy expectations with respect to the location where they will participate in the service via remote access. The person-centered service planning process will determine where the devices will be stored when not in use, the protocols necessary to prepare and participate in services via remote access as well as the steps to end the service, including disconnecting from the remote service and storing of devices.

**How the telehealth service delivery will facilitate community integration. Explain:**

The ISA will identify that remote service delivery was chosen by the individual and this method of service delivery will not cause isolation.

**How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. Explain:**

Remote service delivery shall not be an option for individuals who requires hands-on assistance.

**How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:***

The ISA will describe the steps to prepare and participate in services remotely as well as the steps to end the service, including disconnecting from the remote service and storing of devices. The ISA will also describe the contingency plan that identifies the steps if there is a connectivity or device problem during services and who to notify when support is needed.

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

If remote service delivery is chosen by the participant, the service agreement will detail choice of method of service delivery was offered, remote service delivery will facilitate community integration and not cause isolation, and the participant has been informed of their rights as a recipient of services, including how to file a complaint with the State of New Hampshire.

## Appendix C: Participant Services

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### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

He-M 504.03 provides minimum staff qualifications for all provider agency staff.

Pursuant to He-M 504.03(l), A provider agency may hire a person, or permit the person to volunteer, with a criminal record listed in (k)(1) a. or b. above for a single offense that occurred 10 or more years ago in accordance with (m) and (n) below. In such instances, the individual, their guardian if applicable, and the provider agency shall review the person's history prior to approving the person's employment.

(m) Employment of a person pursuant to (l) above shall only occur if such employment:

- (1) Is approved by the individual, their guardian, if applicable, and the provider agency;
- (2) Does not negatively impact the health or safety of the individual; and
- (3) Does not affect the quality of services to the individual.

(n) Upon hiring or permitting a person to volunteer pursuant to (l) and (m) above, the provider agency shall document and retain the following information in the individual's record:

- (1) The date(s) of the approvals in (l) above;
- (2) The name of the individual for whom the person will provide services;
- (3) The name of the person hired or permitted to volunteer;
- (4) Description of the person's criminal offense;
- (5) The type of service the person is hired or volunteering to provide;
- (6) The provider agency's name and address;
- (7) A full explanation of why the provider agency is hiring or allowing the person to volunteer despite the person's criminal record;
- (8) Signature of the individual, or of the legal guardian(s) if applicable, indicating agreement with the employment and date signed;
- (9) Signature of the provider agency staff person who obtained the individual or guardian's signature and date signed;
- (10) Signature of the provider agency's executive director or designee approving the employment; and
- (11) The signature and phone number of the person being hired or permitted to volunteer.

The State ensures that criminal background checks and state registry screenings were completed for non-licensed and non-certified providers during Developmental Disability Waiver service record audits. The State ensures that criminal background checks and state registry screenings were completed for licensed and certified providers during inspections by the Health Facilities Administration.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

**No. The state does not conduct abuse registry screening.**

**Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which

abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)The DHHS maintains an abuse, neglect, and exploitation registry pursuant to state statute RSA 169-C:35 and state statute RSA 161-F:49. Information about this registry can be found at: <https://www.dhhs.nh.gov/programs-services/adult-aging-care/bureau-adult-and-aging-care-services-state-registry>

The registry is maintained by the Bureau of Adult and Aging Services (BAAS).

(b)Per He-M 504.03(i), all providers with direct contact with individuals are required to complete abuse registry screenings prior to hire and every two years thereafter.

(c) The State ensures that criminal background checks and state registry screenings are completed during on-site service review audits of DD Waiver service records.

(d) If an individual's provider is added to the abuse registry, the service coordinator will work with the individual and team to locate a new provider. In addition, a waiver may be requested through NH DHHS and the State Registry Office to allow the provider to continue to work.

## Appendix C: Participant Services

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

**Note: Required information from this page is contained in response to C-5.**

## Appendix C: Participant Services

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

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one:*

**No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Individual/guardian must be given a choice of providers. If the individual/ guardian choses the individual's spouse to provide personal care services, payment shall be available to the spouse, so long as it is determined that the spouse meets the necessary provider qualifications, the arrangement is in the best interest of the individual and when at least one of the following applies:

1. The individual's level of dependency in performing activities of daily living, including the need for assistance with toileting, eating or mobility, exceeds that of his or her peers with an acquired brain disorder ;
2. The individual requires support for a complex medical condition, including airway management, enteral feeding, catheterization or other similar procedures; or
3. The individual's need for behavioral management or cognitive supports exceeds that of his or her peers with an acquired brain disorder

The legally responsible person or spouse must meet all applicable provider qualifications, including the required criminal records check.

Additionally, in those instances where the spouse is providing personal care services, the spouse cannot provide more than 40 hours per week of personal care services.

The case manager shall review on a monthly basis the hours billed by the spouse for the provision of personal care. The case manager shall conduct monthly monitoring and quarterly visits in accordance with NH Administrative Rule He-M 522.

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

**The state does not make payment to relatives/legal guardians for furnishing waiver services.**

**The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

When relatives/legal guardians are paid for the provision of direct support, they are contracted or employed as direct support providers of the provider agency. On an annual basis a sampling of waiver participants records will be reviewed by BDS to ensure verification that payments are only made for services rendered.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Choice, control, and self-direction are fundamental elements of NH's Developmental Services System. Each participant is afforded choice of service provider(s). NH's Developmental Service System currently utilizes more than 65 developmental services agencies.

An individual and/or guardian may select any qualified provider to deliver one or more of the services identified in the individual's service agreement. The service agreement documents that the individual and/or guardian were offered a choice of providers.

All providers shall comply with the rules pertaining to the service(s) offered and meet the provisions specified within the individual's service agreement.

Waiver participants/guardians may select any willing and qualified provider without regard to whether or not that provider is currently a provider in the NH Developmental Services System. Any qualified prospective provider not already providing waiver services can be selected by the family or individual and thus become a provider within NH's developmental services system.

**g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act.** Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

**No, the state does not choose the option to provide HCBS in acute care hospitals.**

**Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

**The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

**The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

**The HCBS must be identified in the individual's person-centered service plan; and**

**The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:* (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

- a. Sub-Assurance:** *The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of existing providers demonstrating that they continually met required certification and/or licensing standards and adhered to other standards.**

**Numerator:** Number of existing providers demonstrating that they continually met required certification and/or licensing standards and adhered to other standards.

**Denominator:** Number of existing providers.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

New Hampshire Department of Health and Human Services, Bureau of Health Facilities Administration, Office of Legal and Regulatory Services		
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input data-bbox="1078 600 1264 680" type="text"/>
	<b>Other</b> Specify: <input data-bbox="719 824 954 904" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input data-bbox="405 1487 796 1568" type="text"/> NH DHHS Bureau of Health Facilities Administration	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input data-bbox="869 1765 1264 1845" type="text"/>

**Performance Measure:**

**# and % of new providers demonstrating that they initially met required certification and/or licensing standards and adhered to other standards prior to providing waiver services. N: Number of new providers demonstrating that they initially met required certification and/or licensing standards and adhered to other standards prior to**

providing waiver services. D: Number of new providers.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 891 1262 972" type="text"/>
Other Specify:  <input data-bbox="411 1115 651 1397" type="text" value="New Hampshire Department of Health and Human Services, Bureau of Health Facilities Administration, Office of Legal and Regulatory Services"/>	Annually	Stratified Describe Group:  <input data-bbox="1078 1115 1262 1196" type="text"/>
	Continuously and Ongoing	Other Specify:  <input data-bbox="1078 1536 1262 1617" type="text"/>
	Other Specify:  <input data-bbox="719 1760 954 1841" type="text"/>	

Data Aggregation and Analysis:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px; width: fit-content;">                     NH DHHS Bureau of Health Facilities Administration                 </div>	Annually
	Continuously and Ongoing
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

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

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

**Performance Measure:**

**Number and percent of non-licensed/non-certified providers demonstrating that waiver requirements were initially met. Numerator: Number of non-licensed/non-certified providers demonstrating that waiver requirements were initially met. Denominator: Number of new non-licensed/non-certified providers reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly	100% Review

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  95% confidence level with a +/- 5% margin of error.
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number and percent of non-licensed/non-certified providers demonstrating that waiver requirements were continually met. Numerator: Number of non-licensed/non-certified providers demonstrating that waiver requirements were continually met. Denominator: Number of existing non-licensed/non-certified providers reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">                         95% confidence level with a +/- 5% margin of error.                     </div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

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

**Performance Measure:**

**Number and percent of provider records reviewed that included evidence that the provider met training requirements per He-M 506 and the approved waiver.**

**Numerator: Number of provider records reviewed that included evidence that the provider met training requirements per He-M 506 and the approved waiver.**

**Denominator: Total number of provider records reviewed.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with a +/- 5% margin of error.                 </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 150px; height: 30px; margin: 5px 0;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 120px; height: 30px; margin: 5px 0;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 120px; height: 30px; margin: 5px 0;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 150px; height: 30px; margin: 5px 0;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

The Bureau of Developmental Services (BDS) will communicate any area found to be out of compliance to the area agency via written reports. If necessary, a corrective action plan will be requested within 30 days of receipt of the written report.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

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

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

*Furnish the information specified above.*

New Hampshire's Bureau of Developmental Services (BDS) has implemented service caps in the areas of Residential Habilitation, Respite, Assistive Technology, Community Integration Services, Supported Independent Living Services, Crisis Response, Environmental and Vehicle Modification Services, Individual Goods and Services, Non-Medical Transportation, Personal Emergency Response Services, Specialty Services and Wellness Coaching.

The service caps manage and preserve the primary use of the Acquired Brain Disorder Waiver for services which assist the individual to develop skills that promote greater independence, community participation, and the ability to remain living in the community.

Service limits are as follows:

**Residential Habilitation:** This waiver service is not available to individuals who are eligible to receive such service through the Medicaid State Plan. Payment is not made for the cost of room and board, building maintenance, upkeep, nor improvement.

**Respite:** There is a service limitation cap of \$7,500 per year. A community based campership does not count towards this service limitation. An individual may be able to exceed this cap on a case by case basis with the prior approval of BDS

**Assistive Technology:** There is a service limitation cap of \$10,000 over the course of a five year period of time. An individual may be able to exceed this cap on a case by case basis with the prior approval of BDS. A prior authorization for the amount requested above the service limit cap must include supporting documentation, identify need, and correlate to the person centered plan. Assistive technology provided through the waiver is over and above that which is available under the state plan or that is the obligation of the individual's employer. Individual service agreement (ISA) will specify the following:

- 1) The item;
- 2) The name of the healthcare practitioner recommending the item;
- 3) An evaluation or assessment regarding the appropriateness of the item;
- 4) A goal related to the use of the item;
- 5) The anticipated environment that the item will be used;
- 6) Current modifications to item/product and anticipated future modifications and anticipated cost.

**Community Integration Services:** Community integration services will have an \$8,000 cap. Any community integration services over \$2,000 will require a licensed healthcare practitioner's recommendation. An individual may be able to exceed this cap on a case by case basis with the prior approval of BDS.

**Supported Independent Living Services:** Supported Independent Living Services are capped at 30 hours per week. Services may begin and continue for up to 24 consecutive months (two years) while the individual is still residing with their family. This services does not include costs related to room and board. The BDS Administrator reserves the right to exceed time limitations placed on this service on a case by case basis.

**Crisis Response:** This waiver service is not available to individuals who are eligible to receive such service through the Medicaid State Plan. Limited to six month approval.

**Environmental and Vehicle Modification Services:** For individuals with unsafe wandering and running behaviors, outdoor fencing may be provided under this waiver. Waiver funds allocated toward the cost of such a fence shall not exceed \$5,000 which can provide approximately 3,500 square feet of a safe area. Exceptions to this service limitation may be made on a case by case basis.

**Individual Goods and Services:** There is an annual \$1,500 service limit. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person-centered plan.

The item or service must be identified as necessary in the individual service agreement. A goal related to the

use of the item or service should be available in the individual service agreement, amendments to the service agreement should indicate this item if it wasn't in the original service agreement.

Documentation related to the use of the item should be available for review in monthly notes. This item should have an anticipated shelf life. The frequency of purchase would be contingent upon the continued need of the item and the item's ability to continue to meet that need.

Non-Medical Transportation: Non-Medical Transportation is capped at \$5,000 annually. Up to \$10,000 annual is allowable for individuals that require specialized transportation including wheelchair van/lift and/or a van that allows the individual being transported to "not" be within arm's reach of the driver for safety reasons. Verification of an individual's need for specialized transportation will be required upon request to the Bureau of Developmental Services. The Bureau of Developmental Services Administrator reserves the right to approve requests on a case by case basis. Proof of this need to exceed the cap will be required upon request to the Bureau of Developmental Services. When the provider is transporting the individual, the individual is with the caretaker and the only transportation that may be covered is when the transportation that occurs is directly related to the individual's disability or specific to a caretaker providing the transportation to activities determined in the individual service agreement that are not otherwise covered by NH State Plan or other state authorities. Caretakers will provide proof of insurance, complete all registry checks, and have a completed driving record check. Youth under the age of 16 shall not be reimbursed for public transportation expenses.

Personal Emergency Response Services: There is an annual \$2,000 service limit. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered plan. Any device that might be considered restrictive will be part of a modification plan (behavior plan) and will be approved by the individual, guardian and the local Human Rights Committee.

Specialty Services: Any items provided under this category must be based on an assessed need by a qualified provider and cannot be available as a benefit under the NH State Medicaid Plan.

Wellness Coaching: Wellness coaching services has an annual cap of \$5,000. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered service plan.

Removable Prosthodontic Services: There is a \$1500 annual service limit for the New Hampshire Medicaid State Plan Adult Dental Benefit, including Removable Prosthodontic Services. Dentures may be provided no more than once in a five-year period. This service limit may be exceeded with prior approval from DHHS.

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

*Furnish the information specified above.*

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

*Furnish the information specified above.*

**Other Type of Limit.** The state employs another type of limit.

*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

All settings in the Developmental Disabilities (DD) Waiver comply with federal Home and Community Based Services (HCBS) settings requirements. DD Waiver participants live at home with their families in private home dwellings located in the community or community based provider-owned or controlled residential homes. This waiver does not provide services to participants in either congregate living facilities, institutional settings or on the grounds of institutions. Based upon the New Hampshire Bureau of Developmental Services' assessment of the HCBS settings in this waiver, the state confirms that services in this waiver are rendered in HCBS compliant settings.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Ongoing monitoring of HCBS expectation compliance of settings will be completed through a comprehensive review process that includes the New Hampshire Department of Health and Human Services' Bureau of Developmental Services, the University of New Hampshire Institute on Disability - UCED, and the Waiver Transition Team with input from the Advisory Task Force. The following areas will be reviewed to ensure ongoing compliance:

- Quarterly Satisfaction Surveys with any identified areas of follow up being facilitated by the Service Coordinator.
- Visit from Service Coordinators to monitor HCBS expectations during in person visits to individuals' homes.
- Ongoing review of monthly progress reports.
- Complaint data regarding all of the HCBS expectations with appropriate follow-up identified by the complaint investigator. This includes coercion and restraint.
- Modification plans (approved by the local Human Rights Committee).
- Embedding the Final Settings Rule expectations into He-M 310, "Rights of Persons Receiving Developmental Services or Acquired Brain Disorder Services in The Community" for education.
- Annual training on the final rule and its expectations for both participants and providers.

Resources to be developed to ensure ongoing compliance:

- Development of a monthly progress report template.
- Human Rights Committee tool for modification reviews to ensure that all requirements for a modification are met.
- The development of a database for creating reports to monitor, analyze and trend data, including the ability to create systemic, provider and setting reports in order to share information with:
  - o Advisory Task Force
  - o Individuals, families and other stakeholders

By using the information obtained through the data identified above, ongoing compliance will be monitored on a consistent basis. Data regarding ongoing compliance with the HCBS expectations will be shared with the Advisory Task Force every six months. Additionally, Service Coordinators monitor choice and satisfaction of participants on a quarterly basis. If an individual, guardian, family member, provider or member of the community feels that an individual's rights are being violated (including the Final Settings Rule expectations) a complaint can be filed and an investigation will occur, resulting in recommendations, as appropriate.

In addition to the efforts noted above, new providers will be expected to be trained on the Final Settings Rule, submit relevant policies and procedures, and complete a self-assessment specific to the Final Settings Rule. The ongoing monitoring team will review the information submitted and give feedback as needed.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

**The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

**The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)**

**Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

**Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

**Facilitates individual choice regarding services and supports, and who provides them.**

**Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

**Provider-owned or controlled residential settings.** (Specify whether the waiver includes provider-owned or controlled settings.)

**No, the waiver does not include provider-owned or controlled settings.**

**Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

**The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

**Each individual has privacy in their sleeping or living unit:**

**Units have entrance doors lockable by the individual.**

**Only appropriate staff have keys to unit entrance doors.**

**Individuals sharing units have a choice of roommates in that setting.**

**Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

**Individuals have the freedom and support to control their own schedules and activities.**

**Individuals have access to food at any time.**

**Individuals are able to have visitors of their choosing at any time.**

**The setting is physically accessible to the individual.**

**Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan (*see Appendix D-1-d-ii of this waiver application*).**

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Service Agreement

**a. Responsibility for Service Plan Development.** Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (*Select each that applies*):

**Registered nurse, licensed to practice in the state**

**Licensed practical or vocational nurse, acting within the scope of practice under state law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

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**Appendix D: Participant-Centered Planning and Service Delivery**

**D-1: Service Plan Development (2 of 8)**

**b. Service Plan Development Safeguards.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:**

The waiver is implemented by the State in collaboration with New Hampshire's ten Area Agencies, designated in accordance with New Hampshire administrative Rule He-M 505, to plan, establish and maintain a comprehensive service delivery system. Area Agencies determine initial eligibility for acquired brain disorder services. Following this determination, Area Agencies assist individuals to apply for the Acquired Brain Disorder Waiver and will provide information and resources to assist them in selecting a Service Coordination entity. Person-centered service planning and the individualized service agreement (ISA) are completed by a service coordinator. Many area agencies provide Service Coordination Services as well as other direct waiver services, which is permissible so long as they do not provide both to the same participant.

In limited circumstances, as outlined in the Bureau of Developmental Services' (BDS) Only Willing and Qualified Provider (OWQP) policy, the State may approve an entity to provide both Service Coordination Services and other direct waiver services to the same individual. Agencies that are approved to provide both services must have a firewall in place to mitigate conflict in accordance with the OWQP. Additionally, during the person-centered service planning process, individuals/guardians will be educated on conflict of interest requirements in cases where a conflict is present.

In accordance with He-M 522.09(e), the OWQP may only be invoked in the following situations:

(d) A provider agency that provides direct services to the individual and seeks to also provide service coordination, shall be determined the only willing and qualified service coordination agency and permitted to provide service coordination and direct services if the following criteria are met:

- (1) There is a lack of another qualified service coordination agency willing to provide services to the individual as outlined in their service agreement; and
- (2) The individual, guardian, or representative agrees that the same agency shall provide both service coordination and direct services; and
- (3) The agency ensures that service coordination and direct services are located in different departments and different physical locations within the organization, and report to separate and equal organizational leadership; and
- (4) The direct services department shall not develop or have any influence on developing the individual's service agreement.

Safeguards to ensure that service plan development is conducted in the best interest of the participant include the following:

1. The ISA is housed within the platform, IntellectAbility, and will be moved to NH Easy when the service agreement functionality in IntellectAbility sunsets. These platforms offer a statewide template that all Service Coordinators must utilize for ISA development. The template for the ISA requires that individual choice of service providers is offered as an option during the person-centered planning process. Prior to this function sunseting in IntellectAbility, individuals receiving Service Coordination and Respite only may utilize a template outside of the IntellectAbility platform.
2. Annually during the person-centered service planning process, the individual and his/her legal guardian is informed of their "client rights" which include choice of services and providers.
3. BDS staff will review to ensure that choice of providers is offered during annual quality oversight process.
4. The BDS Complaint Process is in place if an individual/guardian feels as though their rights are being violated and/or needs are going unmet. The complaint process is utilized to improve quality of services statewide.

*(Complete only if the second option is selected)* The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- An opportunity for the participant to dispute the state's assertion that there is not another entity or**

**individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

**Direct oversight of the process or periodic evaluation by a state agency;**

**Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

**Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Service planning and development should prioritize opportunities for the waiver participant to lead service planning, even if he/she has a legal guardian.

He-M 522 requires that the Service Coordinator maximize the extent to which an individual participates in his or her person-centered service planning process by:

- Explaining to the individual his or her rights;
- Explaining to the individual the service planning process;
- Eliciting information from the individual regarding his or her personal preferences, goals, and service needs that shall be a focus of service planning meetings
- Reviewing with the individual issues to be discussed during service planning meetings; and
- Explaining to the individual the limits of the decision making authority of the guardian as described in He-M 310, if applicable, and the individual's right to make all other decisions related to services.

The planning process includes a discussion on strategies for solving conflict or disagreements within the process, including clear conflict of interest guidelines for all planning participants.

As part of the person-centered service planning process, the individual/guardian is provided the opportunity to fully participate and have the lead voice in the decision-making process in areas including:

- The number and length of meetings;
- The location and time of meetings;
- The meeting participants;
- Topics to be discussed;
- Whether any additional assessments or evaluations are necessary; and
- Reflect level of support needed to choose and direct services.

In addition, as outlined in He-M 522, at least 45 days prior to the annual person-centered service planning process, the service coordinator must:

- Ensure that all evaluations are up to date and then shared and discussed with the individual and guardian;
- Identify risk factors and plans to minimize them, if applicable;
- Assess the individual's interest in, or satisfaction with, employment; and
- Discuss the individual's progress on goals and prepare for the development of new goals to be included in the new service agreement.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

- d. i. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

According to New Hampshire Administrative Rule He-M 522 "Eligibility Determination and Service Planning for Individuals with an Acquired Brain Disorder", service coordinators are required to develop service agreements within the following requirements:

Within 21 days of a completed application for eligibility for New Hampshire's Developmental Services system, the area agency shall have conducted sufficient preliminary planning with the individual and guardian (if applicable) or representative to identify and document the specific services needed. Within 3 days of the determination of the individual's eligibility under He-M 503.05, the Area Agency shall review the Acquired Brain Disorder Waiver and if the individual, guardian, or representative is interested in pursuing the Acquired Brain Disorder Waiver within the next 12 months, within 5 business days of the individual's decision, the Area Agency shall submit a Functional Screen to the Bureau of Developmental Services (BDS) in order for the State to determine if the individual meets the level of care to access the waiver. Following determination of level of care, the Area Agency will provide information and resources to the individual in order to make an informed choice in the selection of any qualified Service Coordination entity within 15 days.

Within 15 business days of the acceptance by a service coordination entity, the service coordinator shall hold an initial person-centered service planning meeting with the individual, guardian or representative, and any other persons identified by the individual. The service coordinator shall develop the service agreement within 14 days of the initial service planning meeting. The service coordinator shall provide the completed and signed service agreement with the individual and guardian or representative within 5 business days of completion.

The service coordinator is responsible for monitoring services identified in the service agreement and assessing individual, family, or representative satisfaction quarterly. An area agency, service coordinator, provider agency, provider, individual, guardian, or representative shall have the authority to request a person-centered service planning meeting at any time. Service agreements are reviewed and updated annually, at minimum.

All service planning occurs through a person-centered service planning process that:

- Maximizes the decision-making of the individual and family,
- Is directed by the individual and family,
- Facilitates personal choice by providing information and support to assist the individual and family to direct the process, including information describing the array of services and service providers available and options regarding self-direction of services,
- Includes participants freely chosen by the individual and/or guardian,
- Reflects that the service agreement was developed through a person centered service planning process that included cultural considerations of the individual and is clear and understandable,
- Occurs at times and a location of convenience to the individual and/or guardian,
- Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants,
- Is consistent with the individual's rights to privacy, dignity, respect, and freedom from coercion and restraint,
- Includes a method for the individual and/or guardian to request amendments to the service agreement,
- Records the alternative home and community based settings that were considered by the individual, guardian, or representative,
- Includes information obtained through utilization of the SIS, when applicable, and HRST,
- Includes information obtained through a risk assessment if applicable,
- Includes information from specialty medical and health assessments and clinical assessments as needed,
- Includes information for personal safety assessments if applicable,
- Includes strategies to address co-occurring severe mental illness or behavioral challenges which are interfering with the individual's functioning,
- Includes individualized back up plans and strategies for when usual providers are unavailable,
- Includes strategies for solving disagreements,
- Uses a strengths based approach to identify the positive attributes of the individual,
- Includes the provision of auxiliary services as applicable,
- Provides the individual with information regarding the services and service providers available to enable the individual to make informed decisions as to whom they would like to provide services,
- Considers historical information about the individual's experiences,
- Addresses the individual's concerns about current or contemplated guardianship or other legal assignment of rights.
- Includes a discussion of the need for assistive technology that could be utilized to support all services and activities

identified in the proposed service agreement without regard to the individual's current use of assistive technology

The individual, guardian or representative determines the following elements of the service planning process:

- Number and length of meetings,
- Location, date, and time of meetings,
- Meeting participants, and
- Topics to be discussed

Service agreements are developed using a person-centered service planning approach, focusing on the life trajectory of the individual and how to best support their vision of a good life.

Service agreements shall describe the reporting mechanisms under He-M 522.11 Service Agreements and include:

- The specific waiver services to be provided including the amount, scope, frequency, and duration,
- The results of the SIS and the HRST,
- Service documentation requirements sufficient to describe progress on goals and the services received,
- If applicable, reporting mechanisms under self-directed services regarding budget updates and individual and guardian satisfaction with services,
- For individuals who reside in a provider owned or controlled residential setting, the service agreement shall document any modifications of the individual's rights in said setting to:
  - (1) Privacy in their sleeping or living unit, including doors lockable by the individual with only appropriate staff having keys to doors as needed;
  - (2) Freedom and support to control their own schedule and activities;
  - (3) Access to food at any time;
  - (4) Having visitors of their choosing at any time; and
  - (5) Freedom to furnish and decorate sleeping or living units.

- ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

**The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

**For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

**A specific and individualized assessed need for the modification.**

**Positive interventions and supports used prior to any modifications to the person-centered service plan.**

**Less intrusive methods of meeting the need that have been tried but did not work.**

**A clear description of the condition that is directly proportionate to the specific assessed need.**

**Regular collection and review of data to measure the ongoing effectiveness of the modification.**

**Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**

**Informed consent of the individual.**

**An assurance that interventions and supports will cause no harm to the individual.**

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

In accordance with He-M 522, service agreements for participants are completed at least annually, or as changes warrant. The service agreement addresses all aspects of the individual's service needs.

He-M 522.10 requires that at least 45 days prior to the expiration of the service agreement, the service coordinator ensure all assessments, including risk assessments have been completed, and also requires the identification of risk factors and plans to minimize them.

He-M 522.10 requires service planning to include information obtained through a risk assessment, which shall be administered as follows:

a. To each individual with a history of, or exhibiting signs of, behaviors that pose a potentially serious likelihood of danger to self or others, or a serious threat of substantial damage to real property, such as, but not limited to, the following:

1. Sexual offending;
2. Violent aggression; or
3. Arson;

b. Upon the earlier of service planning or the individual's receiving services under He-M 500;

c. Prior to any significant change in the level of the individual's treatment or supervision;

d. At any time an individual who previously has not had a risk assessment begins to engage in behaviors referenced in a. above; and

e. By an evaluator with specialized experience, training, and expertise in the treatment of the types of behaviors referenced in a. above;

Additionally, 522.11 requires that service agreements include, if applicable, risk factors and the measures required to be in place to minimize them, including backup plans and strategies.

The service agreement must also include the number of visits to be performed by the service coordinator. Health Risk Screening Tools are required to be completed annually and a Health Care Level must be indicated in the participant's file and reviewed annually.

Additionally, provider agencies are required to be available 24 hours a day.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Each individual is afforded choice of service provider(s) and may choose any qualified provider.

Individuals and/or guardians meet with their selected service coordinator to identify what services are appropriate to meet their needs and to develop a plan to meet identified needs.

When making provider selections, or at any time subsequent to initial selection, service coordinators will work closely with individuals/guardians to assist them to access available listings of all qualified providers. Individuals/guardians select the provider they wish to interview among all qualified providers.

Providers must meet the requirements specified for each of the individual service components, and in addition, each applicant for employment must:

- Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;
- Agree to 2 reference checks;
- Meet certification and licensure requirements of the position, if any;
- Agree to a criminal records check, in accordance with He-M 504 and 506, to ensure that the applicant has no history of a felony conviction;
- A check of the state Bureau of Adult and Aging Services (BAAS) and the Division for Child Youth and Families (DCYF) registries for founded reports of abuse, neglect and exploitation; and
- Be a minimum of eighteen years of age. However, on an individual basis and upon agreement between the individual/guardian and the area agency, persons as young as fifteen may be chosen as a provider.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The service agreement is reviewed by the Bureau of Developmental Services (BDS) for initial authorization and annual reauthorizations of waiver services.

One hundred percent of service agreements are reviewed by BDS staff, annually. Thereafter, a full review is conducted whenever significant changes occur, as indicated by the annual level of care redetermination, and annually.

All HCBS services must be approved by BDS and included in the service agreement to be billable.

## Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

When a service agreement has been approved by the individual or guardian, services are implemented and monitored as follows:

A provider responsible for implementing elements of a service agreement records information about services provided and summarizes progress as required by the service agreement, at a minimum monthly, for Residential Habilitation, Community Participation Services, Supported Independent Living Services, Supported Employment and at a minimum quarterly for all other services.

On at least a monthly basis, the service coordinator has written or verbal communications to monitor the implementation of the service agreement with the individual and/or persons responsible for implementing a service agreement.

On at least quarterly, or more frequently if specified in the service agreement, the service coordinator documents whether services:

- a. Match the interests and needs of the individual;
- b. Meet with the individual's/guardian's satisfaction;
- c. Meet the terms of the service agreement.

He-M 522 indicates that the service coordinator shall be responsible for monitoring services identified in the service agreement and for assessing individual/guardian satisfaction at least quarterly.

An area agency, service coordinator, provider, individual, guardian, or representative shall have the authority to request a service planning meeting at any time.

Service agreement amendments may be proposed at any time.

If the individual, guardian, or provider disapproves of the service agreement or service agreement amendment, the dispute shall be resolved:

- (1) Through informal discussions between the individual, guardian, or representative and service coordinator;
- (2) By reconvening a service planning meeting; or
- (3) By the individual, guardian, or representative filing an appeal to the bureau pursuant to He-C 200.

In addition, the BDS Liaison is a mechanism for receiving and following up on areas of individual or systemic concern. Participants and/or guardians have access to area agency as well as State BDS Liaisons to discuss issues and concerns.

Systemic issues are also identified and addressed during the annual service file review as well as the five-year area agency redesignation process.

- b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

**Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** (*Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation.*)

In limited circumstances, as outlined in the Bureau of Developmental Services' (BDS) Only Willing and Qualified Provider (OWQP) policy, the State may approve an entity to provide both Service Coordination Services and other direct waiver services to the same individual. Agencies that are approved to provide both services must have a firewall in place to mitigate conflict in accordance with the OWQP. Additionally, during the person-centered service planning process, individuals/guardians will be educated on conflict of interest requirements in cases where a conflict is present.

*(Complete only if the second option is selected)* The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

**Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

**An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

**Direct oversight of the process or periodic evaluation by a state agency;**

**Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

**Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

#### a. Methods for Discovery: Service Plan Assurance/Sub-assurances

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

##### i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

##### Performance Measures

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

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

##### Performance Measure:

**Number and percent of service agreements reviewed that address participants' assessed needs, including health and welfare risks. Numerator: Number of service agreements reviewed that address participants' assessed needs, including health and welfare risks. Denominator: Number of Service Agreements reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with a +/- 5% margin of error.                     </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**The number and percent of participants with a Health Care Level (HCL) of 3 or over who have received a clinical review by a nurse trainer. Numerator: Number of participants with a HCL of 3 or over who have received a clinical review by a nurse trainer. Denominator: Total number of participants with a HCL of 3 or over.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**HRST Customized Report**

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

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>

**Performance Measure:**

**Number and percent of service agreements that address participants' individualized goals. Numerator: Number of service agreements reviewed that address participants' individualized goals. Denominator: Number of service agreements reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b>
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<b>data collection/generation</b> <i>(check each that applies):</i>	<b>collection/generation</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  95% confidence level with a +/- 5% margin of error.
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<div style="border: 1px solid black; width: 200px; height: 40px; margin: 10px auto;"></div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; width: 200px; height: 30px; margin: 10px auto;"></div>

**b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.**

**Performance Measures**

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

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

**c. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.**

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of service agreements that were updated and revised when warranted by changes in the waiver participant's needs. Numerator: Number of service agreements that were updated and revised when warranted by changes in the waiver participant's needs. Denominator: Total number of participant records that reflect a change in the participant's needs that were reviewed.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with a +/- 5% margin of error.                     </div>
<b>Other</b> Specify:  <input style="width: 100px; height: 20px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100px; height: 20px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100px; height: 20px;" type="text"/>
	<b>Other</b> Specify:  <input style="width: 100px; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
Specify: <input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of service agreements that had been updated at least annually or had an approved amendment on file which extended the annual review. Numerator:** Number of service agreements that had been updated at least annually or had an approved amendment on file which extended the annual review. **Denominator:** Total Number of reviewed service agreements.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/> 95% confidence level with a +/- 5% margin of error.
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

**d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.**

**Performance Measures**

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

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

*identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of participants whose services were delivered in accordance with the service agreement including the type, scope, amount, duration and frequency. Numerator: Number of participants whose services were delivered in accordance with the service agreement including the type, scope, amount, duration and frequency. Denominator: Total number of service agreements reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with a +/- 5% margin of error.                     </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

e. *Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

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

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

**Performance Measure:**

**The number and percent of participants whose service agreements document that they have been provided choice among waiver services and providers. Numerator: The number of participants whose service agreements document that they have been provided choice among waiver services and providers. Denominator: Total number of service agreements reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
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<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with a +/- 5% margin of error.                 </div>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

The Bureau of Developmental Services completes annual service file reviews on a random sample of individuals receiving waiver services. If any area is found to be out of compliance, the State will communicate any area found to be out of compliance to the applicable agency via written report. If necessary, a corrective action plan will be requested within 30 days of receipt of the written report. If systematic deficiencies are identified, the State will update policy and procedure as necessary to ensure understanding of requirements and increase frequency of meetings with agencies as necessary.

The State also reviews information from individual problems as they are discovered.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

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

## Appendix E: Participant Direction of Services

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**Applicability** (from Application Section 3, Components of the Waiver Request):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.*

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

In NH, there are two methods of service delivery within the PDMS model for Acquired Brain Disorder Waiver services.

They include the following:

1.) Fiscal/Employer Agent (F/EA). Under this PDMS model, the participant (or a representative of their choosing) is the employer of the support workers they hire. The F/EA or Financial Management Services (FMS) entity is the agent to the employer (not the employer of support workers) and operates under Section 3504 of the IRS code and Revenue Procedure 2013-39. The participant can select a F/EA FMS entity to receive and disburse their individual budget funds, manage their support worker's payroll and related taxes, and perform some employer-related tasks (i.e., processing employment-related paperwork, conducting background and registry checks, processing and paying invoices for approved goods and services related to the participant's care needs and facilitating the receipt and payment of worker's compensation insurance). The F/EA FMS entity ensures the participant is compliant with any applicable Internal Revenue Services (IRS) and Department of Labor rules. Under this PDMS model, the participant may hire and manage support workers and purchase approved goods and services related to the participant's care needs.

2.) Agency of Choice Model (AoC). Under this PDMS model, the employment relationship is shared with the AoC FMS entity (Agency) and the participant or representative of their choosing as joint employers of participant's support workers. The Agency performs the employer tasks describe in the F/EA model and issues an IRS Form W-2 to support workers as their employer. However, unlike the F/EA model, the Agency also performs tasks directly related to the support worker (i.e., hiring, training and formally dismissing, providing regular and backup support workers as needed). The participant, or the representative of their choosing, is the "managing employer" of their support workers, responsible for recruiting and referring support worker candidates to the Agency for hire, establishing work schedules, managing the day-to-day performance and determining the rate of pay for their workers, providing evaluation feedback to the Agency on their support workers, dismiss their support workers from their homes and inform the Agency and manages the backup plan for their support workers.

The state is familiar with all state and federal requirements pertaining to FMS.

Participant Directed and Managed Services (PDMS) is available statewide and provides for the selection of two basic participant direction opportunities and these opportunities may be used in combination, which is common.

These opportunities include:

Participant Employer Authority. The participant is supported to recruit, hire, supervise, and direct the workers who furnish supports. In some cases, the participant is the co-employer of record of these workers who are referred to as Family Managed Employees (FME). The participant is responsible to document the training of the employee on the unique aspects of the person to whom they are assisting. Additional training responsibilities are outlined within the waiver and further identified in He-M 525 and He-M 506.

Participant Budget Authority. The participant has the authority and accepts the responsibility to manage their support plan and budget. The participant has the authority to make decisions about the acquisition of waiver goods and services that are authorized and documented in the individual's service plan and to make decisions based on a budget. Participants are expected to approve expenses within the budget and be provided assistance to prioritize the use of their funds, if needed.

When used in combination the above authorities promote a comprehensive, participant directed plan.

Two types of support are available to facilitate participant direction. The support furnished as a Medicaid administrative activity are in accordance with NH's approved cost allocation plan. Financial Management Services are furnished for two purposes: (a) to address federal, state, and local employment tax, labor and worker's compensation insurance rules and various requirements that apply when the participant functions as the employer and (b) to address changes in the recipient's wishes to demonstrate how the budget will be spent and to document expenditures and keep receipts from expenses in order to support the individual's service plan. Monthly documentation of both services chosen, and corresponding expenses are expected to be documented and available for annual audits during the service file reviews conducted by the BDS.

The services available through the Acquired Brain Disorder Waiver are allowed to be delivered through the participant

directed and managed service delivery model. Participants are defined as: (a) the individual acting independently on their own behalf; (b) the legal guardian(s) of the individual accessing the waiver and acting on behalf of the individual; and, (c) a non-legal, chosen representative to act on behalf of the waiver recipient.

Services provided through the waiver are specifically tailored to the competencies, interests, preferences, and needs of the participant and/or his/her guardian and are respectful of the personal values and lifestyle of the participant.

In extending the participant choice and control over their service agreements, the service coordinator provides information and assistance to facilitate and optimize participation, direction, and management of services.

Responsiveness to participant preferences and requests occur within the context of state and federal laws and regulations and policies of the provider agencies, service coordination agencies and area agencies.

Beginning with the initial discussion and education about Acquired Brain Disorder Waiver services, area agency staff share information with the participant regarding such expectations, requirements, and limitations.

The Division of Long Term Supports and Services (DLTSS), PDMS committee, will be making recommendations relative to the following:

- Adoption of a PDMS self-assessment screening tool;
- Development of a PDMS handbook;
- Development and implementation of Orientation, Remediation and Transition policies;
- Expectations relative to delegating direct services to another entity; and
- Clarification regarding opportunities to purchase additional assistance relative to documentation, recruitment, or supervision, if applicable.

Service agreements document choice and control as well as responsibilities of the different parties involved in the service arrangement and compliance with laws and regulations.

PDMS enables people to maximize self-direction and affords participants the option to fully exercise choice and control over the menu of waiver services. PDMS is utilized by those participants/guardians who want to be actively engaged in the planning, design, provision, and or delegation of the monitoring of services and allocation of authorized service funding.

PDMS is a method of service delivery of services and assistance for individuals with acquired brain disorders in order to improve and maintain opportunities and experiences in living, working, socializing, personal growth, safety and health.

The participant, guardian, area agency, service coordinator, provider agencies and the Bureau of Developmental Services (BDS) collaborate to identify the necessary level of service provision and funding while ensuring supervision, safety, satisfaction, and effective utilization of authorized funds.

In cases where services are to be provided by relatives or friends, these individuals must meet all relevant provider qualifications.

Service coordinators work with individuals and their team to develop an individualized service agreement identifying all supports, services and total cost. The service plan must identify services that are available through the waiver, any needs that are met outside of the waiver, as well as any unmet needs.

Individual service agreements (ISA) are created for all individuals and include the following:

- The participant or guardian may decide what services are needed based on assessments/evaluations such as the Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), Risk Assessments, etc. and how those services are provided within the scope of available resources;
- Funding is portable and service rates will be consistent statewide based on level of need;
- Utilization review is conducted by BDS to ensure the maximization of funding; and
- Allocated funds will be directed and spent where needed.

For participants that have a HRST, Health Care Level (HCL) score of 3 or over, a clinical review will be conducted by a Nurse Trainer.

Area agencies and service coordinators will be responsible to educate and hold individuals that utilize PMDS accountable on fraud, waste, and abuse. In cases where criteria for PDMS is not met, a transition policy will be implemented to assist individuals in accessing services outlined in the service agreement.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

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

**Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

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

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

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

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

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

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

Specify these living arrangements:

Participant directed and managed services are available to all individuals with the exception of those in congregate service arrangements or programs where individuals, families, or guardians do not have the opportunity to direct and manage the services [as defined in State Administrative rule He-M 525] and the approved funding.

In addition, individuals who present with high risk behaviors may be subject to review prior to the development of a participant directed and managed service plan in order to determine if direction and management by the individual could result in risk of serious harm to the individual or the community.

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

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

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

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

**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery**

methods are available for participants who decide not to direct their services or do not meet the criteria.

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Individuals and/or their guardians interested in the Acquired Brain Disorder (ABD) Waiver are provided information regarding Participant Directed and Managed Services (PDMS) method of service delivery upon initial eligibility for the ABD waiver and annually thereafter. Information provided to individuals/guardians by the area agency (when new to service, prior to service planning) or the service coordinator (if already participating in services) include:

- The services that can be participated in through a PDMS;
- Requirements and expectations for service planning and monitoring;
- Provider qualification requirements and roles in parties responsible to complete background checks and other requirements;
- The responsibilities of the area agency, service coordinator, providers and individuals/guardians in the participation in and provision of services and supports;
- The flexibility available to individuals/guardians to have budget and employer authority.
- Expectations and protections when having providers come into the home environment.
- Expectations and requirements if the individual is taking medication as well as the supports available to administer the medication safely.

A PDMS long term supports and services committee has been developed with broad stakeholder participation.

The goal(s) of the committee include the:

- 1.) Identification of a self-assessment tool to assist individuals/guardians to determine if PDMS is an option for them.
- 2.) Development a PDMS Participant Handbook

The handbook will include all relevant information for an individual/guardian to understand the use of Medicaid funds. The handbook will include the rights and responsibilities associated with the management of Medicaid funds, onboarding staff including the recruitment, training, supervision and necessary background checks, as well as covered services in the approved waiver.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

**The state does not provide for the direction of waiver services by a representative.**

**The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

**Waiver services may be directed by a legal representative of the participant.**

**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Non-Medical Transportation		
Residential Habilitation		
Individual Goods and Services		
Environmental and Vehicle Modification Services		
Crisis Response Services		
Assistive Technology		
Supported Independent Living Services		
Community Participation Services		
Supported Employment		
Wellness Coaching		
Personal Emergency Response Services		
Specialty Services		
Respite		
Service Coordination		
Community Integration Services		

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

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

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

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

**Governmental entities**

**Private entities**

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

**Appendix E: Participant Direction of Services**

**E-1: Overview (8 of 13)**

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

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

**The waiver service entitled:**

**FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

State designated area agencies are the only types of entities in New Hampshire that will be allowed to furnish financial management services (FMS) as an Medicaid administrative activity.

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

Costs related to FMS are a Medicaid administrative billing activity.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

**Assist participant in verifying support worker citizenship status**

**Collect and process timesheets of support workers**

**Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

**Other**

*Specify:*

Assists with processing criminal background checks on prospective workers

Supports furnished when the participant exercises budget authority:

**Maintain a separate account for each participant's participant-directed budget**

**Track and report participant funds, disbursements and the balance of participant funds**

**Process and pay invoices for goods and services approved in the service plan**

**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

**Other services and supports**

Specify:

---

Additional functions/activities:

---

**Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

**Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

**Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

**Other**

Specify:

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

BDS conducts a post payment review of PDMS services.

The post payment review starts with a self-assessment process conducted by the area agency and then verified by BDS on-site monitoring. Post payment review includes:

- verification that receipts/invoices are available to support all expenditures charged to the individual;
- expenditures that have been paid are supported by the individual's service agreement;
- reimbursement for wages paid include details regarding who was paid, on what dates, hours and rate of pay per hour;
- verification of detailed accounting records payroll records; timesheets or similar payroll documents signed by the employee and approved by their supervisor;
- that all expenditures are ABD Waiver allowable expenses;
- review of utilization within the service authorization to confirm that individuals/guardians are provided with regular reports of actual spending versus allocated funding amount.

## Appendix E: Participant Direction of Services

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### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

**Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Non-Medical Transportation	
Residential Habilitation	
Individual Goods and Services	
Environmental and Vehicle Modification Services	
Removable Prosthodontic Services	
Crisis Response Services	
Assistive Technology	
Supported Independent Living Services	
Community Participation Services	
Supported Employment	
Wellness Coaching	
Personal Emergency Response Services	
Specialty Services	
Respite	
Service Coordination	
Community Integration Services	

**Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

#### k. Independent Advocacy (*select one*).

**No. Arrangements have not been made for independent advocacy.**

**Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

People First of New Hampshire (PFNH):

Since 1992, BDS has assisted with funding for PFNH, a statewide independent self-advocacy organization. Currently, there are 14 recognized self-advocacy chapters and a total of 17 groups located throughout NH. Individuals with disabilities are members of local self-advocacy chapters and each chapter elects two representatives to serve on the board of directors of PFNH. PFNH is a non-profit entity run and governed completely by individuals with disabilities.

People First of New Hampshire's mission is to assist individuals to take control of their lives through learning how to make decisions and choices which increase their level of independence as well as becoming aware of both their rights and responsibilities. People First exists to help individuals speak up and speak out about their beliefs and needs and believe in a more accessible future, where disability is just another form of diversity. In 2017, they changed their mission statement to read as follows: "We are multi-cultural champions of equality who advocate for people with disabilities to achieve their full potential".

Self-Advocacy Leadership Team (SALT):

SALT began as a task force of the New Hampshire Council on Developmental Disabilities and has since taken on a life of its own. The group consists of more than 10 adults with disabilities who are committed to ensuring that disability does not prevent them or anyone else from living life to the fullest. The mission of SALT is to support people who have disabilities to ensure they have the ability to live quality lives in the community.

New Hampshire's system allows individuals to hire an independent service coordinator; the individual/guardian can secure service coordination from independent case management organizations or hire someone of their choosing to act as an independent advocate.

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

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

An individual or guardian may withdraw voluntarily from any service(s) at any time or from participant direction of any service. Likewise, an individual or guardian may withdraw voluntarily from the Acquired Brain Disorder (ABD) waiver.

The ABD waiver is designed to support individuals to be involved with Participant Directed and Managed Services to the extent they wish, and this may be altered at any time. This waiver allows individuals to direct and manage their services along a continuum; if they no longer have any interest in directing and managing their services, they would be supported to transition to traditional services available through the Acquired Brain Disorder Waiver with the support of their service coordinator.

Specific attention to the individual's health and welfare is provided through ongoing contacts with the individual by the service coordinator such as home visits, monthly contact and quarterly discussions around satisfaction of service participation and provision.

The state assures continuity of services and participant health and safety during the transition to increased delegation to a third entity, if applicable. Specific attention to the individual's health and welfare is provided through ongoing contacts with the individual or guardian by the service coordinator. Ongoing contact includes:

-Quarterly visits are required for all individuals receiving a waiver service.

-For individuals receiving Residential Habilitation, the quarterly visits must take place in the individual's residence.

-Service Coordinators must contact the individual and guardian at least monthly for individual's receiving Residential Habilitation, Community Participation Services, Supported Independent Living Services, and Supported Employment and at least quarterly for individual's receiving all other services unless additional contacts are outlined in the individual service agreement.

-Quarterly satisfaction surveys are completed by the Service Coordinator with the individual and guardian for all individuals receiving waiver services.

## Appendix E: Participant Direction of Services

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### E-1: Overview (12 of 13)

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

Individuals may be disallowed or terminated from managing and directing their services under the following circumstances:

A formal risk assessment conducted within the past year by a N.H. licensed psychologist or psychiatrist that finds the individual to pose a moderate or high risk to community safety and includes recommendations on the level of security, services, and treatment necessary for the individual; and

Recommendation from the area agency's human rights committee, established pursuant to RSA 171-A:17, I, that services under He-M 525 would not provide the degree of security, services, or treatment needed by the individual.

In the cases identified above, the individual may obtain a second opinion from a New Hampshire licensed psychologist or psychiatrist.

The human rights committee shall consider the findings of the assessment conducted as noted above;

If a human rights committee convenes, the committee shall meet, if requested, with the individual and the individual's representative to explain its decision.

Individuals who are not permitted to direct or manage their services are assisted to access traditional ABD Waiver services.

Individuals and their guardians have the right to appeal a decision to disallow or terminate participant direction and management.

The NH Developmental Services system focuses on prevention of circumstances that may require termination of participant direction.

He-M 525 elaborates on the process of educating families relative to participant direction.

The person-centered service planning process is ongoing, in order to meet the changing needs of an individual. If a change is identified, the service agreement may be modified at any time by the family, service providers, service coordinator, and others involved in the care of the individual through joint discussion, written revision, and consent.

Ultimately, if issues arise that cannot be resolved and if these are such that the State believes that Participant Directed and Managed Services is no longer in the best interest of the individual, steps would be taken to transition Participant Directed Services to an alternative service delivery method or assist the family to delegate service provision to a provider agency.

Individuals would be assisted by the Service Coordinator with resources to find an alternate provider during the person centered service planning process should involuntary termination occur.

The state assures continuity of services and participant health and safety during the transition to increased delegation to a third entity, if applicable. Specific attention to the individual's health and welfare is provided through ongoing contacts with the individual or guardian by the service coordinator. Ongoing contact includes:

-Quarterly visits are required for all individuals receiving a waiver service.

-For individuals receiving Residential Habilitation, the quarterly visits must take place in the individual's residence.

-Service Coordinators must contact the individual and guardian at least monthly for individual's receiving Residential Habilitation, Community Participation Services, Supported Independent Living Services, and Supported Employment and at least quarterly for individual's receiving all other services unless additional contacts are outlined in the individual service agreement.

-Quarterly satisfaction surveys are completed by the Service Coordinator with the individual and guardian for all individuals receiving waiver services

## Appendix E: Participant Direction of Services

**n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="31"/>
Year 2	<input type="text"/>	<input type="text" value="31"/>
Year 3	<input type="text"/>	<input type="text" value="31"/>
Year 4	<input type="text"/>	<input type="text" value="31"/>
Year 5	<input type="text"/>	<input type="text" value="31"/>

**Appendix E: Participant Direction of Services**

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

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

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

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

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

Both strategies are supported.

The individual/guardian retains ultimate authority over delivery of services when participating in a co-employer or a participant common law arrangement in that payment for services to the employee, provider, or the employing agency is contingent upon signature verification of the individual/guardian that the services have been provided as agreed by all parties.

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

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

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**

**Verify staff qualifications**

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

Specify how the costs of such investigations are compensated:

The Bureau of Developmental Services has an arrangement with the NH Department of Safety for reduced fee criminal records checks. In addition, BDS participates directly in paying half the cost of the reduced fee; the remaining cost is paid by the area agency as part of its administrative responsibilities.

**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state's method to conduct background checks does not vary from as described in C-2-a

**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

**Determine staff wages and benefits subject to state limits**

**Schedule staff**

**Orient and instruct staff in duties**

**Supervise staff**

**Evaluate staff performance**

**Verify time worked by staff and approve time sheets**

**Discharge staff (common law employer)**

**Discharge staff from providing services (co-employer)**

**Other**

Specify:

**Appendix E: Participant Direction of Services**

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

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

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

**Reallocate funds among services included in the budget**

**Determine the amount paid for services within the state's established limits**

**Substitute service providers**

**Schedule the provision of services**

**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

**Identify service providers and refer for provider enrollment**

**Authorize payment for waiver goods and services**

**Review and approve provider invoices for services rendered**

**Other**

Specify:

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

The method for establishing the amount of the Participant Directed and Managed Services budget is as follows:

The Service Coordinator conducts person-centered service planning with the individual to identify the assessed needs of the individual and the services needed. Service needs are determined with consideration of the individual's goals and aspirations as well as information and evaluations shared by the individual and/or guardian that may have been previously conducted through the participant's school or from a private practitioner, evaluations conducted as part of the eligibility determination process, and results from the Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST) and any other relevant evaluations. Selected services are outlined in the individual service agreement and an individualized budget for services is developed. Individual budget proposals are submitted to the Bureau of Developmental Services (BDS), which makes all final budget determinations based on the cost effectiveness of proposed services.

The method that BDS uses to consistently apply budget development to each participant is based on the average cost for services within this waiver. Budgets are adjusted either up or down to match the individual's needs.

While residential habilitation services are the primary service within PDMS, individuals have the flexibility to reallocate among the approved services within the service agreement, including increasing or decreasing the hourly wage of direct service providers to meet specific needs of the individual. A strength of this approach is that individuals/guardians can negotiate different payment levels for staff and providers, based on provider skill set and the individual's needs.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individualized budgeting process starts with identification of the individual's service needs as part of the person-centered service planning process. Information gathered through the eligibility process, the guardian and/or legal representative (which may include existing evaluations through the participant's school or private practitioner), the supports intensity scale (SIS), HRST, and any other relevant evaluations needed to determine appropriate services and support level needed.

The individual service agreement (ISA) is developed jointly using the information outlined in the above paragraph with the individual/guardian and the service coordinator. Service needs identified drive the development of an individualized budget request which is submitted to BDS for review/approval/denial/renegotiation.

Once the individualized budget is approved by BDS, the communication of final budget approval to the individual/guardian is done through the service coordinator.

If an individual's service needs change as demonstrated by assessments, adjustments are made to his/her service agreement via an amendment. If additional service funding is needed, subsequent requests follow the same process as an initial funding request in that the service coordinator develops with the individual/guardian the revised service agreement based on changes in needs and this is costed out in the individualized budget and submitted to BDS for approval.

Individuals/guardians have the right to appeal BDS' decisions.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

##### iv. Participant Exercise of Budget Flexibility. *Select one:*

**Modifications to the participant directed budget must be preceded by a change in the service plan.**

**The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The service coordinator communicates with the individual/guardian or representative regarding available funds remaining in the individual's budget. Monthly reports of the status of each individual's budget and expenditures are provided to the individual/guardian. Discrepancies relative to planned spending versus actual spending are addressed by the service coordinator and individual/guardian jointly. Utilization is carefully monitored by the service coordinator.

If additional funds are needed as a result of increased service needs, the service agreement is modified and a request for additional funding is submitted to BDS.

Conversely, when funds are projected to be underutilized on a short term basis, the underutilized funding amount may be reallocated to another waiver eligible individual for one time needs (such as an Environmental Modification).

Flexibility in this regard plays a significant role in the Participant Directed and Managed Services model. If significant changes are desired, for example, ending one service and adding a new service not previously included in the service agreement, a modification of the service agreement would be required. As long as these changes are budget neutral, meet the requirements for the Acquired Brain Disorder Waiver, and do not exceed service limits, there may be no need for BDS to review/approve such changes. All budgets and service arrangements are reviewed on at least an annual basis.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The service coordinator communicates with the individual/guardian relative to available funds. Monthly reports of the status of each individual's budget and expenditures are provided and discussed with the individual. Utilization is carefully monitored.

If a participant/guardian appear to be utilizing the funding at a higher/lower rate than the monthly average, the service coordinator monitors the spending and works with the individual/guardian to understand if the overspending or underspending in any given quarter is related to changes in service needs.

If additional funds are needed as a result of increased service needs, the service agreement is modified (based on updated assessments) and a request for additional funding is submitted to the Bureau of Developmental Services. All requests for increased funds must be accompanied by appropriate justifications to support the change. This includes information from recent or updated assessments/evaluations/screenings such Supports Intensity Scale, Health Risk Screening Tool, risk assessment, and/or any other relevant evaluation.

Conversely, when funds are projected to be underutilized on a short-term basis, the underutilized funding amount may be reallocated to another waiver eligible individual for one time needs (such as an Environmental Modification).

The service coordinator ensures that the funds budgeted for an individual are appropriately and fully utilized by the individual. Discrepancies relative to planned spending vs. actual spending are addressed by the service coordinator and individual jointly on an on-going basis.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not

given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Pursuant to He-M 517, anyone who has been denied waiver services because the Department determines they do not meet the eligibility criteria for waiver services may appeal the decision within 30 working days of receipt of the decision. Such appeal request shall be made by forwarding the request to the bureau administrator, in writing, in care of the department's office of client and legal services, and shall then be forward to the department's administrative appeals unit, which will schedule and conduct the hearing. If a fair hearing is requested, the following actions occur: For current waiver services recipients, services and payments continue as a consequence of an appeal for a fair hearing until a decision has been made; and If BDS' decision is upheld, benefits will cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later. Copies of the Department's denial would be located in the Medicaid Management Information System (MMIS) system under the applicant's name

Pursuant to administrative rule He-M 522, any determination, action, or inaction by an area agency or provider agency may be appealed by an individual, guardian, or representative, and can be appealed by forwarding an appeal request in writing to the bureau administrator in care of the department's office of client and legal services. Once received, the appeal request will be forwarded to the department's administrative appeals unit, which will schedule and conduct the hearing. The following actions are subject to the notification requirements:

- (1) Adverse eligibility actions under He-M 522;
- (2) A determination to terminate services under He-M 522

The area agency shall provide written and verbal notice to the applicant and representative of the specified actions, including:

- (1) The specific rules that support, or the federal or state law that requires, the action;
- (2) Notice of the individual's right to appeal in accordance with He-C 200 within 30 days and the process for filing an appeal, including the contact information to initiate the appeal with the bureau administrator;
- (3) Notice of the individual's continued right to services pending appeal, when applicable,
- (4) Notice of the right to have representation with an appeal by: a. Legal counsel; b. A relative; c. A friend; or d. Another spokesperson;
- (5) Notice that neither the area agency nor the bureau is responsible for the cost of representation;
- (6) Notice of organizations with their addresses and phone numbers that might be available to provide legal assistance and advocacy, including the Disabilities Rights Center and pro bono or reduced fee assistance. If a hearing is requested, the following shall occur:

- 1) For current recipients, services and payments shall be continued as a consequence of an appeal for a hearing until a decision has been made, and if the decision is upheld, benefits shall cease 60 days from the date of the denial letter, or 30 days from the hearing decision, whichever is later, or
- 2) In the instance of termination of services, services shall cease one year after the initial decision to terminate services or 30 days from the hearing decision, whichever is later.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Prepaid Ambulatory Health Plan (PAHP) operates a member grievance and appeal process, which are specific to Removable Prosthodontic Services only, as this is the only service in this waiver that is delivered by the PAHP. The PAHP grievance and appeal processes do not supplant the waiver participant's ability to request State a fair hearing.

#### PAHP Grievance Process

The PAHP shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the PAHP either orally or in writing at any time. [42 CFR 438.402(c)(1)(i-ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

- The quality of care or services provided;
- Aspects of interpersonal relationships such as rudeness of a Provider or employee;
- Failure to respect the Member's rights;
- Dispute of an extension of time proposed by the PAHP to make an authorization decision;

The PAHP shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the PAHP receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the PAHP does not have all the information necessary to make the decision. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

The PAHP may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

- If the Member requests the extension; or
- If the PAHP shows that there is need for additional information and that the delay is in the Member's interest (upon State request). [42 CFR 438.408(c)(1)(i-ii); 438.408(b)(1)]

If the PAHP extends the timeline for a grievance not at the request of the Member, the PAHP shall:

- Make reasonable efforts to give the Member prompt oral notice of the delay; and
- Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.408(c)(2)(i-ii); 42 CFR 438.408(b)(1)]

The PAHP shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

#### PAHP Appeal Process

The PAHP shall permit a Member, or the Member's authorized representative, or a Provider acting on behalf of the Member and with the Member's written consent, to request an appeal orally or in writing of any PAHP action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

The PAHP shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's State. [42 CFR 438.406(b)(6)]

The PAHP shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the PAHP's notice of action. [42 CFR 438.402(c)(2)(ii)]

The PAHP shall ensure that oral inquiries seeking to appeal an action are treated as appeals. [42 CFR 438.406(b)(3)]

If the Department receives a request to appeal an action of the PAHP, the Department shall forward relevant information to the PAHP and the PAHP shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

The PAHP shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

The PAHP shall permit the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing [42 CFR 438.406(b)(4)]. The PAHP shall inform the Member of the limited time available for this in the case of expedited resolution.

The PAHP shall provide the Member and the Member's representative an opportunity to receive the Member's case file, including medical records, and any other documents and records considered during the Appeal Process free of charge prior to the resolution. [42 CFR 438.406(b)(5); 438.408(b-c)]

The PAHP may offer peer-to-peer review support, with a like clinician, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should occur in a timely manner.

The PAHP shall resolve standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the PAHP. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

The date of filing shall be considered either the date of receipt of an oral request for appeal or a written request for appeal from either the Member or Provider, whichever date is the earliest.

If the PAHP fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the PAHP's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

The PAHP shall permit the appeal of any action taken by the PAHP. Actions shall include, but are not limited to the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service. [42 CFR 438.400(b)(3)];
- Failure to provide services in a timely manner, as defined by this Agreement;
- Untimely service authorizations;
- Failure of the PAHP to act within the timeframes outlined in the PAHP Agreement; and
- At such times, if any, that the Department has an Agreement with fewer than two (2) PAHPs, for a rural area resident with only one (1) PAHP, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

#### Expedited Appeal

For appeals when the PAHP determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

The PAHP shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals. [42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)]

The PAHP shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the PAHP receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

The PAHP may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the PAHP justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] The PAHP shall also make reasonable efforts to provide oral notice.

The date of filing of an expedited appeal shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest.

If the PAHP extends the timeframes not at the request of the Member, it shall:

- Make reasonable efforts to give the Member prompt oral notice of the delay by providing a minimum of three (3) oral attempts to contact the Member at various times of the day, on different days within two (2) calendar days of the PAHP's decision to extend the timeframe as detailed in He-W 506.08(j);
- Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision;
- Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i-iii); 42 CFR 438.408(b)(2)-(3)]

The PAHP shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

If the PAHP denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

The Member has a right to file a grievance regarding the PAHPs denial of a request for expedited resolution. The PAHP shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

#### a. Operation of Grievance/Complaint System. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Pursuant to He-M 310 and He-M 202 the NH Department of Health and Human Services has established a Client and Legal Services Section; its functions and responsibilities include but are not limited to:

- Assisting the Commissioner in responding to inquiries and complaints by or on behalf of mentally ill or developmentally disabled persons;
- Assisting the Commissioner in securing needed services and information for mentally ill persons, developmentally disabled persons, or their respective families; and
- Assisting the Commissioner in assuring that the human rights of mentally ill persons and of developmentally disabled clients in the service delivery system are protected.

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Office of Client and Legal Services (OCLS) administers and directly implements the complaint system outlined in He-M 202. OCLS maintains a 24-hour hotline to receive complaints. User friendly brochures are shared with all participants, guardians, area agency staff, providers, and stakeholders on an on-going basis to ensure awareness of the process and numbers to call.

Complaints are generally reported when there is an allegation, assertion, or indication that the following have occurred with respect to an individual: abuse, neglect, exploitation, or a rights violation pursuant to He-M 310 by an employee of, or contractor, consultant, or volunteer for an area agency or program; DHHS, the area agency, or any other program.

The OCLS has 3 people designated as complaint investigators at all times. Additional investigators are hired if more are needed to carry out all the duties of the complaint investigation process within the timelines required by He-M 202.

OCLS assigns each complaint to a complaint investigator as soon as possible but not later than one business day following receipt of the complaint.

Complaints involving abuse, neglect, or exploitation are investigated prior to any other complaints and the complaint is also shared with Adult Protective Services or the Division for Children, Youth and Families depending on the age of the participant. Other complaints are investigated in the order in which they are received.

In any complaint, area agencies are required to assure participants are protected pending completion of any investigation.

The complaint investigator investigates and attempts to resolve the complaint to the satisfaction of the individual or his or her guardian or representative within 15 business days following the process outlined in He-M 202.07. A formal report must be issued within the 15 business day timeline. The timeline may be extended by an additional 10 business days if any of the following factors makes it impossible to issue a report as required:

- (1) The number of allegations to be investigated;
- (2) The number or availability of witnesses to be contacted;
- (3) The availability of evidence; or
- (4) Other similar complicating circumstances.

The full report is provided to the individual or their guardian, the area agency executive director, and the program involved, if any. If the report includes recommendations for resolution that require area agency or program action, the action must be taken within 20 business days of the date of the final report, unless a shorter timeline is specified. The area agency or program must send written documentation of such actions to the complaint investigator. If implementation of the action will take longer than 20 days, the area agency or program shall send documentation to the complaint investigator of the planned action within 20 business days from the date of the report, and shall send written documentation demonstrating implementation of the action to the complaint investigator upon completion.

As part of the overall complaint investigation process, the following is also required in He-M 202 and He-M 522:

Each area agency must annually share information to all programs, participants, families, and stakeholders the procedures and contact information for filing a complaint. Additionally, each area agency must have this information posted internally within their offices and to their website. This information includes that if an individual elects to file a grievance or make a complaint, doing so is not a pre-requisite or substitute for a Fair Hearing. Additionally, at each participant's annual service planning meeting, the service coordinator must provide this information to the participant, guardian, and family.

At a minimum, the service coordinator must discuss and provide information in writing, to the individual, guardian, and/or family the procedures and contact information for filing a complaint during the annual person-centered planning meeting.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in

the waiver program.*Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Pursuant to State Administrative Rule He-M 202, any agency staff who suspects a participant has been the victim of abuse, neglect or exploitation must call in a complaint to the Office of Client and Legal Services (OCLS).

The Department of Health and Human Services (DHHS) has a policy regarding critical events, referred to as the Bureau of Program Quality (BPQ) PO.1003 Sentinel Event Reporting and Review Policy, as part of a comprehensive quality assurance program with BPQ that establishes the reporting and review requirements of sentinel events involving individuals served by the Department. Both community providers and DHHS divisions or bureaus that provide direct care services shall report sentinel events as directed by this policy. Statutory authority for reviews of sentinel events is set forth in NH RSA 126-A:4, IV.

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. The Bureau of Quality Assurance and Improvement (BQAI) has adopted the following categories of reportable sentinel events.

Client-centered sentinel events, in which the individual is either a victim and/or perpetrator, include:

1. Any sudden, unanticipated, or accidental death, not including homicide or suicide, and not related to the natural course of an individual's illness or underlying condition.
2. Permanent loss of function, not related to the natural course of an individual's illness or underlying condition, resulting from such causes including but not limited to:
  - A medication error, and/or
  - An unauthorized departure or abduction from a facility providing care, and/or
  - A delay or failure to provide requested and/or medically necessary services due to waitlists, availability, insurance coverage, or resource limits.
3. Homicide.
4. Suicide.
5. Suicide attempt, such as self-injurious behavior with a non-fatal outcome, with explicit or implicit evidence that the person intended to die, and medical intervention was needed.
6. Rape or any other sexual assault.
7. Serious physical injury to or by a client.
8. Serious psychological injury that jeopardizes the person's health that is associated with the planning and delivery of care.
9. Injuries due to physical or mechanical restraints.
10. High profile event, such as:
  - media coverage;
  - police involvement when the involvement is related to a crime or suspected crime; and/or,
  - an issue that may present significant risk to DHHS staff or operations.

All providers of services through DHHS and the Bureau of Developmental Services (BDS) are required to report sentinel events that involve an individual who:

- Are receiving Department funded services,
- Have received Department funded services within the preceding 30 days; or
- Are the subject of a Child or Adult Protective Services report.

Notification shall be provided to the BDS Bureau Administrator or designee in accordance with the timeframes and methods outlined in the Sentinel Event Reporting and Review Policy.

Bureau of Quality Assurance and Improvement (BQAI) PO.1003 Sentinel Event Reporting and Review Policy:  
<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/bpq-hsa-sentinel-event-policy.pdf>

Upon the discovery of a sentinel event by a community provider or by a DHHS Division or Bureau (whether by direct report by a provider, other mandatory reporting mechanisms, or a more general discovery), that person or entity shall

provide verbal notification to the appropriate DHHS Bureau Administrator or designee within 24 hours. Written notification of the sentinel event shall be provided by the reporting person or designated agency staff to the appropriate DHHS Office within 72 hours of the event.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The rights of all individuals with acquired brain disorder to be free from abuse, neglect, and exploitation are detailed in NH State Administrative Rule He-M 310. In accordance with He-M 310, provider agencies are required to notify individuals and guardians or representatives of individuals' rights in accordance with He-M 310 upon initial participation in any service, upon any change in provider agency or community residence, and at least once a year after initial participation. The required notification also includes informing individuals, their guardian or representative, of the process for filing a complaint pursuant to State Administrative rule He-M 202.

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

The Office of Client and Legal Services (OCLS) receives complaints of abuse, neglect, and exploitation. OCLS maintains a 24 hour hotline to receive such complaints. The OCLS has 3 people designated as complaint investigators at all times. Additional investigators are hired if more are needed to carry out all the duties of the complaint investigation process within the timelines required by He-M 202.

OCLS assigns each complaint to a complaint investigator as soon as possible but not later than one business day following receipt of the complaint.

The complaint investigator investigates and attempts to resolve the complaint to the satisfaction of the individual or his or her guardian or representative within 15 business days following the process outlined in He-M 202.07. The timeline may be extended by an additional 10 business days if any of the following factors makes it impossible to issue a report as required:

- (1) The number of allegations to be investigated;
- (2) The number or availability of witnesses to be contacted;
- (3) The availability of evidence; or
- (4) Other similar complicating circumstances.

At the conclusion of the investigation, the complaint investigator prepares a report that includes:

- (1) A summary of the issues presented, including any issues that arose during the investigation;
- (2) The names of persons interviewed during the investigation;
- (3) A list of all documents and other evidence reviewed;
- (4) The dates of any reports made to BAAS or DCYF, if applicable;
- (5) Investigatory findings of fact;
- (6) A discussion of the investigatory findings of fact, a determination of whether the allegations are founded or unfounded, and an explanation of why such determination was made;
- (7) A discussion of systemic factors that caused, contributed to, or exacerbated the violation; and
- (8) The proposed resolution and, as applicable, the proposed corrective action by the area agency, program, or bureau.

The full report is provided to the individual or their guardian, the area agency executive director, and the executive director of the program involved, if any. If the report includes recommendations for resolution that require area agency or program action, the action must be taken within 20 business days of the date of the final report, unless a shorter timeline is specified. The area agency or program must send written documentation of such actions to the complaint investigator. If implementation of the action will take longer than 20 days, the area agency or program shall send documentation to the complaint investigator of the planned action within 20 business days from the date of the report, and shall send written documentation demonstrating implementation of the action to the complaint investigator upon completion.

The BQAI policy for reporting Sentinel Events requires the community agencies (Area Agencies) to make verbal notification to the State within 24 hours of the discovery of a sentinel event, and to provide written notification to the State on the required Sentinel Event form within 72 hours of the Sentinel Event. For sentinel events reported to BDS that do not require a complaint investigation in accordance with He-M 202, the BDS clinical administrator will review the sentinel event and assure it is provided to the appropriate BDS staff for follow up with the area agency and/or program.

Each agency is expected to complete its own review of a reportable sentinel event consistent with the applicable DHHS administrative rules and its agency policies regarding incidents and events that are consistent with the BQAI definition of a sentinel event. The review of the event shall identify recommendations for follow-up activity to address identified systemic issues, if any and shall be reported to BDS on a quarterly basis.

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

If complaint investigation reports issued by the Office of Client and Legal Services (OCLS) contain recommendations for remedial action, the agency is required to provide a response to the plan, and documentation to demonstrate the actions to comply with the remedial action. The OCLS maintains a database that includes whether agencies provide the required documentation to support the remedial action.

During the redesignation process, the Bureau of Developmental Services reviews area agency compliance with certification requirements. If the area agency is determined to not be in compliance with providing documentation to support compliance, BDS will note this and require remedial action.

During annual governance audits, BDS staff require area agencies to provide their policy to demonstrate compliance with the BQAI Sentinel Event Reporting and Review Policy. In addition, BQAI maintains a database of all reported sentinel events.

In the individual complaint investigation reports, the OCLS complaint investigators note any systemic factors that contributed to the complaint and include recommendations to prevent similar occurrences in the future.

## Appendix G: Participant Safeguards

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

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

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

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

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

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Pursuant to He-M 310, individuals are assured the right to freedom from restraint including:

- a. For individuals under the age of 18, the right to limitations on the use of restraint and seclusion pursuant to RSA 126-U; and
- b. The right to be free from seclusion and physical, mechanical, or pharmacological restraint except that in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:

1. Such means of restraint as are authorized by a prescribing practitioner and approved by a human rights committee pursuant to RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and

2. The minimum necessary degree of restraint may also be used:

- (i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
- (ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
- (iii) When the person is involuntarily admitted in accordance with RSA 171-B.

RSA 171:A requires that each area agency have a Human Rights Committee (HRC) of 5 or more people, the majority of the members are people who represent the interests of individuals with developmental disabilities and who are not employees of the department.

The duties of the HRC include, but are not limited to:

- Evaluating the treatment and habilitation provided;
- Regularly monitoring the implementation of individual service agreements;
- Monitoring the use of restrictive or intrusive interventions designed to address challenging behavior;
- Fostering the capacity of individuals served by the area agency to exercise more choice and control in their lives; and
- Promoting advocacy programs on behalf of the clients.

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

The Bureau of Developmental Services (BDS) monitors the authorized and unauthorized use of restraints through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committee (HRC) within each area agency that identifies monitoring and review of any use of authorized restraints and unauthorized restraints broken down by waiver. The report must identify follow-up action if an unauthorized restraint was used.

Complaint Investigations are conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS waiver participants. Reports indicate if an unauthorized use of restraint was used and recommendations for corrective action are made.

As described in section G-1(b), if a restraint occurred that falls under the definition of the BQAI Sentinel Event Reporting and Review Policy, BDS would be immediately notified. BDS will review the written report and make recommendations or engage in appropriate follow-up, if necessary.

Health information is reviewed and updated at least annually (by the area agency) using the Health Risk Screening Tool that includes utilization of psychotropic medications. BDS runs quarterly reports to monitor changes in health risk screening levels.

As part of service review audits, service agreements are reviewed along with progress notes, approved behavior plans, documentation of approval from the HRC, satisfaction surveys, and data from all relevant evaluations, assessments and screenings including the Supports Intensity Scale, Health Risk Screening Tool, Risk Assessment (if applicable) and any other relevant evaluations.

## Appendix G: Participant Safeguards

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

#### b. Use of Restrictive Interventions. *(Select one):*

##### **The state does not permit or prohibits the use of restrictive interventions**

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

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Pursuant to He-M 310, individuals are assured the right to freedom from restraint including:

- a. For individuals under the age of 18, the right to limitations on the use of restraint and seclusion pursuant to RSA 126-U; and
- b. The right to be free from seclusion and physical, mechanical, or pharmacological restraint except that in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:

1. Such means of restraint as are authorized by a prescribing practitioner and approved by a human rights committee pursuant to RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and

2. The minimum necessary degree of restraint may also be used:

- (i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
- (ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
- (iii) When the person is involuntarily admitted in accordance with RSA 171-B.

RSA 171:A requires that each area agency have a Human Rights Committee of 5 or more people, the majority of the members are people who represent the interests of people with developmental disabilities and who are not employees of the department.

The duties of the HRC include, but are not limited to:

- Evaluating the treatment and habilitation provided;
- Regularly monitoring the implementation of individual service agreements;
- Monitoring the use of restrictive or intrusive interventions designed to address challenging behavior;
- Fostering the capacity of individuals served by the area agency to exercise more choice and control in their lives; and
- Promoting advocacy programs on behalf of the clients.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

BDS monitors the authorized and authorized use of restrictive interventions through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committees (HRCs) within each area agency that identifies monitoring and review of any use of authorized restrictive intervention and unauthorized restrictive intervention broken down by waiver. The report must identify follow-up action if an unauthorized restrictive intervention was used.

Complaint Investigations conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS waiver participants. Reports indicate if an unauthorized use of restrictive intervention was used and recommendations for corrective action are made.

As described in section G-1(b), if an incident occurred that falls under the definition of the BQAI sentinel event process, BDS would be immediately notified. The outcome of the sentinel event review would indicate corrective actions necessary.

## Appendix G: Participant Safeguards

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

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

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

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

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

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

Pursuant to He-M 310, individuals are assured the right to freedom from seclusion including:

- a. For individuals under the age of 18, the right to limitations on the use of restraint and seclusion pursuant to RSA 126-U; and
- b. The right to be free from seclusion and physical, mechanical, or pharmacological restraint except that in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:

1. Such means of restraint as are authorized by a prescribing practitioner and approved by a human rights committee pursuant to RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and
2. The minimum necessary degree of restraint may also be used:
  - (i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
  - (ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
  - (iii) When the person is involuntarily admitted in accordance with RSA 171-B.

RSA 171:A requires that each area agency have a Human Rights Committee (HRC) of 5 or more people, the majority of the members are people who represent the interests of individuals with developmental disabilities and who are not employees of the department.

The duties of the HRC include, but are not limited to:

- Evaluating the treatment and habilitation provided;
- Regularly monitoring the implementation of individual service agreements;
- Monitoring the use of restrictive or intrusive interventions designed to address challenging behavior;
- Fostering the capacity of individuals served by the area agency to exercise more choice and control in their lives; and
- Promoting advocacy programs on behalf of the clients.

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

BDS monitors the authorized limited use of seclusion through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committees (HRC) within each area agency that identifies monitoring and review of any use of seclusion broken down by waiver. The report must identify follow-up action if seclusion was used.

Complaint investigations conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS waiver recipients. Reports indicate if unauthorized use of seclusion was used and recommendations for corrective action are made.

As described in section G-1(b), if an incident occurred that falls under the definition of the BQAI Sentinel Event process, BDS would be immediately notified. The outcome of the Sentinel Event Review would indicate corrective actions necessary.

## Appendix G: Participant Safeguards

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

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

**a. Applicability.** Select one:

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

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

- **Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

In the event that a waiver participant opts for staff that is employed directly by a provider agency, and is expected to administer medication, staff must be He-M 1201 trained for medication administration.

The employer of the medication authorized staff is responsible for the ongoing monitoring of participant medication regimens. Training, medication monitoring and oversight is conducted by a Registered Nurse trainer who is employed or contracted with the associated area agency in accordance with He-M 1201.

All authorized medication providers must have a review of competency and a direct observation of a medication pass by a Registered Nurse Trainer completed annually. The Registered Nurse Trainer completes a quality review no less than every six months in accordance with He-M 1201.

All medication errors must be reported in accordance with He-M 1201. Each provider agency submits a six month nurse trainer report and each area agency submits a six month agency report to the Medication Committee. These reports address all medication errors within a specific six month time frame, identify trends within the region and inform the Medication Committee of the number of individuals within that region who are receiving 4 or more psychotropic and/or antipsychotic medications.

When any behavior modifying medication is being used (pharmaceutical restraint) the Human Rights Committee (HRC) at the area agency must review and approve the use of the medication. The Registered Nurse Trainer must develop a PRN protocol consistent with the physician's order that outlines the perimeters and indications for when that medication can be administered. All staff who are authorized to administer those PRN medications must receive training on the PRN protocol and instruction, specific to the individual receiving the medication, from the Registered Nurse Trainer.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Semi-annual medication administration reports are submitted by the area agencies and reviewed by the statewide medication committee and co-facilitated by the BDS Nurse Administrator and the BDS Medical Director.

All medication errors must be reported in accordance with He-M 1201. Each provider agency submits a six month nurse trainer report and each area agency submits a six month agency report to the Medication Committee. On a scheduled semiannual basis, representatives from each area agency meet with the Medication Committee to review their submitted reports and collaborate on recommendations, concerns or corrective action if applicable.

The Medication Committee may request additional follow up, unannounced visits to a specific setting or interim reporting be completed as a quality assurance measure.

## Appendix G: Participant Safeguards

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

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Area agencies and vendor agencies through their State designated nurse trainers in conjunction with State Administrative Rule He-M 1201: Healthcare Coordination and Administration of Medications or under certain circumstances, State Administrative Rule NUR 404, Delegation of Medication Administration.

Nurse Trainers are required to have 2 years of licensed nursing experience within the past 5 years, at least one of which was as a registered nurse and to have completed a 6-hour orientation program conducted by the Bureau of Developmental Services.

The scope of monitoring is specific to timely and accurate administration of medications.

Medication administration practices that are potentially harmful identified and managed in the quality review process noted below.

All medications not administered by family members must be administered in conjunction with He-M 1201 which requires a number of overlapping protective practices.

- **Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

The Bureau of Developmental Services has appointed a Medication Committee to review information regarding medication errors. This committee is co-chaired by the medical director of the Bureau, the nurse administrator of the Bureau, two registered nurses from provider agencies and two non-nurse representatives from provider agencies. NH He-M 1201.11 governs the Medication Committee and the oversight of the Committee.

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

A medication error is defined as any deviation in the administration of a medication as prescribed or in the documentation of such administration, with the exception of an individual's refusal. This includes: wrong medication, wrong time, wrong dose, wrong person, wrong route, omission of a medication and documentation errors involving a medication. All such errors must be reported to a nurse trainer and recorded as such.

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

In accordance with He-M 1201, specific forms are provided for medication error reporting to the medication committee. The type of errors that must be reported to the state on these forms are: wrong medication, wrong time, wrong dose, wrong person, wrong route, omission of medication and documentation error involving a medication. Each error type has a required field on the provided forms that must be completed. Accompanying information is required if any adverse effects or outcomes occurred as a result of a medication error. Additionally, patterns of non-compliance and identified negative trends with medication administration are also required to be reported to the medication committee.

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

He-M 1201 requires a Quality Review including:

(a) A registered nurse shall review the following for all individuals whose medications are administered by authorized providers:

- (1) Documentation that the provider administering the medication(s) holds a current authorization;
  - (2) Medication orders and PRN protocols;
  - (3) Medication labels and medications listed on the medication log to ensure that they match the prescribing practitioner's orders;
  - (4) Medication logs to ensure that documentation indicates:
    - a. That medication was administered as prescribed;
    - b. Refusal by the individual to take medication, if applicable;
    - c. Any medication occurrences; and
    - d. The full signatures of all authorized providers who initial the log; and
  - (5) Medication storage to ensure compliance with He-M 1201.07.
- (b) Reviews pursuant to (a) above shall be performed according to the following timeframes:
- (1) For family residences with 3 or fewer individuals and services provided pursuant to He-M 521, reviews shall occur at least semiannually; and
  - (2) For all other settings in which authorized providers administer medications, reviews shall occur at least monthly.
- (c) The review pursuant to He-M 1201.08(a) shall be documented, dated, and signed by the registered nurse and retained for at least 6 years by the provider agency.

He-M 1201.10 outlines the requirement for a State Medication Committee:

- (a) The Director shall appoint a medication committee
- (b) The committee shall be composed of at least the following:
  - (1) The medical director of the division or physician designee who shall serve as chairperson of the committee;
  - (2) Two registered nurses from provider agencies;
  - (3) Two non-nurse representatives from provider agencies; and
  - (4) A representative of the Division.
- (c) Each provider agency shall complete and submit semiannually to the area agency Form 1201-a according to table 12.1.1 for each service in which authorized providers administer medications.
- (d) Form 1201-a required by (c) above shall include the following:
  - (1) The name of the provider agency;
  - (2) The name and type of service;
  - (3) The dates during which information was collected;
  - (4) The number of individuals receiving medications from authorized providers;
  - (5) The total number of doses administered;
  - (6) The total number of providers authorized;
  - (7) The average number of hours of supervision provided by the nurse trainer per month;
  - (8) The number and type of department-issued He-M 1201 certification deficiencies pursuant to He-M 1001.14 and He-M 507.03;
  - (9) The total number of medication occurrences listed by specific medication(s) involved, type of occurrence, and the immediate corrective action taken;
  - (10) A narrative summary of systemic trends, if any, associated with occurrences within the setting;
  - (11) A corrective action plan that identifies specific steps to be taken to prevent future occurrences;
  - (12) The signature of the nurse trainer completing the form; and
  - (13) The signature of the provider agency director or designee and the date on which the report is submitted.
- (e) Using Form 1201-b, an area agency shall report on each provider agency's performance regarding medication administration based on the information submitted through 1201-a forms. The area agency shall submit Forms 1201-a and 1201-b to the medication committee semiannually, according to table 12.1.1.
- (f) The Form 1201-b required by (e) above shall include the following:
  - (1) The name of the area agency and the provider agency;
  - (2) The type of service;
  - (3) The dates during which information was collected;
  - (4) The total number of doses administered;
  - (5) The total number of providers authorized;
  - (6) A summary of the number and type of medication occurrences for each provider agency;

- (7) A summary of the provider agency's corrective action plan;  
 (8) The area agency's plan for monitoring, oversight and quality improvement; and  
 (9) The signature of the area agency director or designee.

The Statewide Medication Committee is responsible to identify areas of non-compliance and recommend to the Bureau Nurse Administrator and BDS Medical Director that corrective action be taken by those provider agencies that, as demonstrated by the reports, have failed to comply with the provisions of He-M 1201.

(j) For those provider agencies for which areas of non-compliance have been identified, the medication committee shall make recommendations regarding the area agency's plan for monitoring, oversight and quality improvement.

(k) The Director shall review all recommendations for corrective action made pursuant to (i)(3) and (j) above. For those provider agencies for which corrective action has been identified, the Director shall require such action to be taken if he or she determines that the action is necessary for the provider agency to be in compliance with the provisions of He-M 1201.

(l) An agency which is in receipt of a requirement for corrective action from the Director pursuant to (k) above shall, within 30 days of such receipt, forward a corrective action plan to the medication committee and begin implementation of such a plan.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

#### a. Methods for Discovery: Health and Welfare

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*

##### i. Sub-Assurances:

- a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

##### Performance Measures

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

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

##### Performance Measure:

**The number and percent of participants' records reflecting documentation of an annual discussion about rights, including how to report a complaint regarding abuse, neglect and exploitation. N: Number of participants' records reflecting documentation of an annual discussion about rights, including how to report a complaint regarding abuse, neglect and exploitation. D: Number of records reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with a +/- 5% margin of error.                     </div>
<b>Other</b> Specify:  <input style="width: 100px; height: 20px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100px; height: 20px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100px; height: 20px;" type="text"/>
	<b>Other</b> Specify:  <input style="width: 100px; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
Specify: <input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**The number and percent of complaint investigations in which documentation of implementation of recommendations were received. Numerator: Number of complaint investigations in which documentation of implementation of recommendations were received. Denominator: Total number of complaint investigations with recommendations.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Implementation plan(s) received from the Area Agency**

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

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The number and percent of abuse, neglect, exploitation and unexplained death complaints that were investigated within the required timelines. Numerator: Number of abuse, neglect, exploitation and unexplained death complaints that were investigated within the required timelines. Denominator: Total number of abuse, neglect, exploitation and unexplained death complaints.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Abuse, neglect, exploitation and unexplained death complaints.**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of sentinel events regarding ANE and unexplained death that were referred to investigative entities, if applicable. N: Number of sentinel events regarding ANE and unexplained death that were referred to investigative entities, if applicable. D: Number of sentinel events regarding ANE and unexplained death that needed to be referred to investigative entities.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Supplemental information provided with submission of sentinel event forms**

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

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	<b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

The number and percent of sentinel event trends where recommendation of intervention was necessary and provided. Numerator: The number of sentinel event trends where recommendation of intervention was necessary and provided. Denominator: Number of sentinel event trends where recommendation of intervention was necessary.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Bureau of Developmental Services (BDS) sentinel event data**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1061 1264 1144" type="text"/>
Other Specify: <input data-bbox="408 1285 647 1368" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1285 1264 1368" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1509 1264 1592" type="text"/>
	Other Specify: <input data-bbox="718 1733 954 1816" type="text"/>	

Data Aggregation and Analysis:

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

The number and percent of sentinel events that are analyzed to identify trends.

**Numerator:** The number of sentinel events that are analyzed to identify trends.

**Denominator:** Number of sentinel events.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Bureau of Developmental Services (BDS) sentinel event data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>
Other	Annually	Stratified

Specify:  <input type="text"/>		Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

*c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

**Performance Measures**

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

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

**Performance Measure:**

**The number and percent of instances of restrictive interventions (including restraint and seclusion) in which agency policies and procedures were followed. N: The number of instances of restrictive interventions (including restraint and seclusion) in which agency policies and procedures were followed. D: Total number of restrictive interventions (including restraint and seclusion).**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Quarterly data submission from area agency**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

The number and percent of area agencies with documentation that policies are in place regarding the use of restraint and seclusion. Numerator: The number of area agencies with documentation that policies are in place regarding the use of restraint and seclusion. Denominator: Total number of area agencies.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

The agencies will provide the above policies to the Bureau of Developmental Services during the governance audit.

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

		<input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

**Performance Measures**

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

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

**Performance Measure:**

**The number and percent of participants who have a current Health Risk Screening Tool (HRST) completed. Numerator: The number of participants who have a current Health Risk Screening Tool (HRST) completed. Denominator: Total number of participants reviewed receiving Acquired Brain Disorder waiver services.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  95% confidence level with a +/- 5% margin of error.
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

The number and percent of administered medication doses with no medication errors. Numerator: The number of administered medication doses with no medication errors. Denominator: The total number of medication doses that were administered.

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**The number and percent of participants who have a current Supports Intensity Scale (SIS) completed. Numerator: The number of participants who have a current Supports Intensity Scale (SIS) completed. Denominator: Total number of participants reviewed receiving Acquired Brain Disorder waiver services.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with a +/- 5% margin of error.                     </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Continuously and Ongoing	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

Individual complaint investigation reports contain recommendations for remedial action when appropriate.

If complaint investigation reports issued by the Office of Client and Legal Services (OCLS) contain recommendations for remedial action, the agency is required to provide a response to the plan, and documentation to demonstrate the actions to comply with the remedial action. The OCLS maintains a database that includes whether agencies provide the required documentation to support the remedial action. During the redesignation process, the Bureau of Developmental Services reviews area agency compliance with all rules, including He-M 202. If the area agency is determined to not be in compliance with providing documentation to support compliance, BDS will note this and require remedial action.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 30px;"></div>

**c. Timelines**

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

**No**

**Yes**

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

**Appendix H: Quality Improvement Strategy (1 of 3)**

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Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

**Quality Improvement Strategy: Minimum Components**

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the

assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

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### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Acquired Brain Disorder waiver was created to help people with acquired brain disorders live independently in their homes or within their communities as an alternative to institutional care.

NH has adopted Administrative Rule He-M 522 which defines the eligibility criteria, covered services, the planning process and service agreement, the quality review oversight process, qualified providers, rights of the participants and the appeal process. In accordance with He-M 522, each eligible individual has the coordination of an initial, and thereafter annual, person-centered planning process resulting in an individual service agreement. The service agreement is a fluid document that is amended as needed based on assessments or a change in the individual's needs. The content ensures that each eligible individual has goals that are identified specific to their interests, needs and preferences. ABD waiver individuals select a service coordinator who is responsible to advocate on their behalf, assist in navigating the service delivery system, coordinate a team approach for planning services, and provide quality oversight to ensure the satisfaction of services.

New Hampshire uses two assessments to assist in the planning of services: the Health Risk Screening Tool (HRST) and the Supports Intensity Scale (SIS).

The Health Risk Screening Tool (HRST) ensures each individual's risk has been assessed and provides a health care level (HCL) resulting in a clinical review by a nurse if the score exceeds a HCL3 (on a scale of HCL 1-6). The tool identifies service and training considerations which has assisted individuals, families and teams to ensure providers receive appropriate, individualized training. The HRST assists with the identification of health and safety risks and can assist in the determination of the appropriate supervision requirements in various settings. The service agreements are populated with results of the assessments to further ensure planning is based on assessments as well as the individual and team's preferences. The on-going HRST trainings for nurses and family managed employees has been a source of significant discussions relative to NH specific data and the quality of our services.

The Supports Intensity Scale, (SIS) is a national assessment that is used to identify what supports and services may benefit an individual. Individuals ages sixteen and older participate in this assessment every five years, or more frequently based on the needs of the individual and family.

The state implements an annual service file review audit to ensure services are being planned and delivered in accordance with the intent of He-M 522 regarding the type, scope and duration of services as identified in the individual service agreement (ISA). In addition, the service file review is used to measure compliance with the six major waiver assurances. Remediation activities are followed to correct individual problems in the implementation of each of the assurances.

On an annual basis the ten regional area agencies submit evidence of the governance of their agency. Additionally, pursuant to He-M 505, the area agencies must submit an area plan every 5 years to coincide with the redesignation process, and they are required to review it every 2 years, and modify it as needed. The evidence is expected to include wide stakeholder engagement in the planning process resulting in a regional strategic plan per RSA 171-A (the area agency plan). The area agency plan is required to incorporate the perceptions and experiences from individuals served, family, staff, Board of Directors, community and survey results.

In addition to the annual governance audit, Area Agencies and provider agencies undergo an annual service file review. BDS uses three tools to assess compliance with regulation, administrative rule and waiver guidelines, which have the waiver sub-assurances incorporated into them. This includes a service file review tool, provider qualifications tool and a post-payment review tool. Area agencies and provider agencies are provided with a random sample and complete a self-assessment using the review tools. BDS then completes an on-site review of the random sample. Findings from this audit are compiled and shared with the agencies to identify remediation for areas they were non-compliant.

Service Coordinators assess satisfaction and quality of services with individuals and families on a quarterly basis with the Quality Satisfaction Survey in HRST. Feedback from these surveys help to identify unmet needs.

Pursuant to RSA 171-A and He-M 505, each Area Agency must undergo redesignation every five years to maintain their status as a designated Area Agency. The redesignation process and final report issued as a result includes a review of the following items:

- Area Agency Financial Condition with Five-Year Trend Analysis
  - Compliance with Rights, Health and Safety Requirements, and Complaint Investigation Quality Review
  - Compliance with DHHS Program Certification Requirements
  - Compliance with Family Centered Early Supports and Services Requirements
  - Compliance with Medication Administration and Health Care Coordination Requirements
  - Compliance with Employment Supports for Individuals Requirements
  - In Home Supports, Developmental Disabilities and Acquired Brain Disorder Waiver Service File Review Findings
  - Summary of the Family Support Council Questionnaire
  - Summary of the Individuals and Self Advocates Redesignation Forum / Survey
  - Summary of the Family and Guardian Redesignation Forum / Survey
  - Summary of the Provider Redesignation Forum / Survey
- In addition, pursuant to Administrative Rule He-M 504, all provider agencies must be a Medicaid enrolled provider and are subject to monitoring by the department. Provider agencies must complete the enrollment process, and re-enrollment process in order to provide services to individuals under the ABD waiver.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Other</b> Specify: <input style="width: 100%; height: 20px; border: 1px solid black;" type="text" value="Ongoing"/>

**b. System Design Changes**

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

As indicated in section a. System Improvements above, a systematic and standardized approach for reviewing Key Indicator data is reviewed by internal DHHS staff, area agency staff and stakeholders at the frequency outlined. The data is reviewed as part of regularly scheduled meetings to engage all levels of the system to better understand performance data and the importance of remediation, as necessary, to ensure a meaningful and timely quality improvement process.

BDS will remain engaged with all of its stakeholders in its efforts to continuously monitor and improve the quality of and satisfaction with services. The new approach will also be subject to continuous evaluation and refinement as we learn lessons from implementation.

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

At least annually, the BDS Waiver Manager will review the information needed to assess waiver quality and whether aspects of the quality improvement system require revision. The analysis and any recommendations, if necessary, will be shared with the BDS Management Team and staff for initial review and then broadly shared with area agencies and stakeholders.

**Appendix H: Quality Improvement Strategy (3 of 3)**

**H-2: Use of a Patient Experience of Care/Quality of Life Survey**

**a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):**

**No**

**Yes** (*Complete item H.2b*)

**b. Specify the type of survey tool the state uses:**

**HCBS CAHPS Survey :**

**NCI Survey :**

**NCI AD Survey :**

**Other** (*Please provide a description of the survey tool used*):

**Appendix I: Financial Accountability**

***I-1: Financial Integrity and Accountability***

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

*New Hampshire has a layered approach to ensuring the integrity of payments for Medicaid services. This approach includes regulatory governance of provider agencies, contractual and regulatory governance of area agencies, operational oversight of area agencies and provider agencies, post payment audits, and area agency-supported system oversight and monitoring.*

*Area agencies and direct service providers are enrolled Medicaid providers within the NH MMIS. Area agencies and direct service providers must have a current BDS approved and issued Prior Authorization to bill for HCBS-ABD. Payment for claims without an appropriate Prior Authorization will be denied by MMIS, NH's fiscal intermediary for Medicaid payments. New Hampshire's administrative rule He-M 504, effective July 1, 2023, outlines when suspension and termination may be appropriate due to provider mismanagement of Medicaid funds. This rule operationalizes the oversight authority of BDS to collaborate with Program Integrity and temporarily or permanently revoke a provider's enrollment ID, suspend payment, and initiate processes for recoupment.*

*There are multiple steps in the approval of a Prior Authorization for HCBS-ABD waiver services. BDS utilizes databases that contain budget and service information for every NH HCBS-ABD participant. This information is maintained and verified by BDS staff for each request for a Prior Authorization.*

*In addition to multiple programmatic tasks, BDS staff also have responsibilities including:*

- Approving requests for Prior Authorizations of HCBS-ABD services from the standpoint of available funds and appropriateness of proposed services;*
- Ensuring alignment of service agreement and funding requested;*
- Approval of proposals for changes in amount, scope, duration, and/or frequency of services for which changes in funding are requested.*

*So that BDS staff can complete their prior authorization review, service coordinators are responsible for submitting a four-part service authorization request to the bureau. The four parts include a service authorization screen in the state's IT system, a copy of the ISA, a copy of the budget which includes rendering provider rate and scope information, and a provider attestation verifying the services to be rendered. These electronic file submissions enable BDS staff to confirm that services have been planned for and will be delivered in a Medicaid compliant way. BDS staff review includes but is not limited to, verification that services have not been requested outside of established service limitations, that appropriate rates for services have been requested, and that no unauthorized services have been requested.*

*In conjunction with their financial responsibilities, BDS conducts an annual representative sample review utilizing a 95% confidence level with a 5% margin of error (unless otherwise indicated, such as a 100% review) of enrolled provider agency billing to assure Medicaid payments align with attendance/service provision records indicating date(s) of service, units of service, service provider, and that the required contact notes/progress notes are complete. An enrolled provider agency may neither exceed the authorization on any given Prior Authorization for any given individual nor the aggregate amount of services as defined in the waiver.*

*BDS staff collaborate with area agencies to complete annual service file reviews for all enrolled providers. New Hampshire's ten area agencies, as the designated area agency system, will provide quality oversight of provider agencies. The area agencies will review a BDS selected sample of Medicaid HCBS-ABD service authorizations as part of the annual service file review. The area agencies will also review and monitor waiver services to ensure compliance with waiver requirements, along with contact notes/progress notes to ensure they are complete and align with attendance/service provision records. A provider agency may not exceed the authorization on any given Prior Authorization for any given individual. On those occasions where Medicaid payment has been made but service records are not adequate upon review/audit, recoupments are made.*

*-The State Office of Program Integrity is the lead office for auditing HCBS service providers. This office ensures that annual audits are conducted in accordance with the provisions of the Single Audit required under OMB Circular A-133 for state agencies. Program Integrity (PI) provides oversight and monitoring of Medicaid providers for fraud, waste and abuse. PI does queries on services and looks for anomalies on all Medicaid services, including Home and Community Based Care Services. If PI finds anomalies, they follow up with the provider to do an audit. In addition, PI audits providers if they get referrals or complaints.*

*The State requires that non-federal entities that expend \$750,000 or more in total federal grant funds in a fiscal year must have a single audit conducted by an independent auditor, on a fiscal year basis.*

*The waiver unit operates as the BDS' contact for Medicaid Management Information System (MMIS), NH's Medicaid*

financial intermediary. This role requires that the waiver unit be able to address provider billing issues relative to procedure codes, Medicaid, HCBS-ABD eligibility, Medicaid eligibility determination, and claims processing interfaces.

Finally, area agencies are BDS' partners in ensuring Medicaid fidelity. As a part of their Medicaid Administrative responsibilities area agencies must provide guidance to provider in their catchment region about appropriate use of Medicaid funds. Important to this process are area agency business managers who possess Medicaid finance subject matter expertise. BDS disseminates information to business managers about the states expectations. Business Managers representing all 10 area agencies meet with members of the BDS Management Team each month to explore system, program, financial management and accountability issues in an effort to enhance statewide consistency in methodology and operations related to Medicaid. Topics addressed include:

-Review of Key Financial Indicator Reports: Monthly Medicaid Utilization Report and Monthly/Quarterly AA Fiscal Health Reports;

-Budget development;

-Other financial monitoring;

-Documentation requirements to support Medicaid billing;

-System modification requests;

-Implementation of legislative and legal initiatives;

-Fiscal intermediary operations; and

-Prior Authorization Process.

-NH sought a good faith exemption to delay implementation of Electronic Visit Verification (EVV) until January 1, 2023. Services that are subject to EVV include Personal Care and Respite. An approved EVV system was not implemented by January 1, 2023. The State has been paying the penalty for Personal Care and Respite services since January 1, 2023.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

#### a. Methods for Discovery: Financial Accountability Assurance:

**The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.**

##### i. Sub-Assurances:

**a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

##### **Performance Measures**

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

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

##### **Performance Measure:**

**The number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator: Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator: Number of claims.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Medicaid Management Information System (MMIS)**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i>	<i>Annually</i>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of coded claims paid for individuals that are enrolled and eligible for services. Numerator: Number of coded claims paid for individuals that are enrolled and eligible for services. Denominator: Number of coded claims.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Medicaid Management Information System (MMIS)**

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

		<input type="checkbox"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<p><b>Other</b> Specify:</p> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<p><b>Other</b> Specify:</p> <input type="text"/>

**Performance Measure:**

*The number and percent of participants with a financial record review with sufficient documentation that services paid were actually rendered. Numerator: The number of participants with a financial record review with sufficient documentation that services paid were actually rendered. Denominator: Number of records reviewed.*

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>

<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i>  <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <i>95% confidence level with a +/- 5% margin of error.</i> </div>
<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>	<i>Annually</i>	<i>Stratified Describe Group:</i>  <input style="width: 100%; height: 20px;" type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>
	<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	<input type="text"/>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

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

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

**Performance Measure:**

**The number and percent of waiver rates that follow the approved methodology.**

**Numerator: The number and percent of waiver rates that follow the approved methodology. Denominator: Number of waiver rates.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Medicaid Management Information System (MMIS)**

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

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**The number and percent of participant records reviewed that document waiver service claims paid correspond to those specified in the service agreement. Numerator: The number of participant records reviewed that document waiver service claims paid correspond to those specified in the service agreement. Denominator: Number of participant records reviewed.**

**Data Source (Select one):**

**Record reviews, off-site**

*If 'Other' is selected, specify:*

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

<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i>  <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <i>95% confidence level with a +/- 5% margin of error.</i> </div>
<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>	<i>Annually</i>	<i>Stratified Describe Group:</i>  <input style="width: 100%; height: 20px;" type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>
	<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

If payment errors are noted, the State requires that payments be recouped through the Medicaid Management Information System (MMIS).

Staff in the Bureau of Improvement and Integrity monitor financial claims for NH's Medicaid plan including waiver services. They review all provider claims for fraud, waste or abuse. The unit also recovers overpayments. If there appears to be a case of fraud, it is referred to the Attorney General's office for further review. They also conduct reviews to determine if recipients are inappropriately using certain types of medications.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

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

No

Yes

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

**Appendix I: Financial Accountability**

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

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

*The rate methodology is the methodology as developed and approved in the ABD Waiver for FY2011-2015. NH's current rate methodology is based on a common rate schedule which is used by all Medicaid enrolled providers.*

*BDS is unable to locate detailed information documenting the current rate methodology. It is presumed that the fee schedule was derived using standard rate setting methodology that identifies labor and other costs associated with the provision of services. This rate methodology has been continued, in relationship to funds appropriated by the General Assembly, in the development of Individual Budgets.*

*BDS has contracted with a rate setting vendor to assist in the development of a rate build up methodology. The new methodology will be based on: labor, other direct care costs, program support, productivity and program administration. The waiver reimbursement rate redesign will include provider cost reports and rate methodology. A robust stakeholder engagement structure is part of the vendor's work.*

*There are service limits for specific categories of covered services outlined in Appendix C-1. ABD rates are independently determined based on individual's needs using the prevailing costs within their region, except for Service Coordination, Specialty Services, Supported Independent Living Services, and Crisis Response Services. Reimbursement is approved and reviewed in alignment with individuals assessed needs in alignment with similar services across the waiver population. The prevailing rates are determined by reviewing the annual 372 reports to determine the average cost spent per unit of service. Once a service agreement for a waiver participant is established, the service coordinator prepares a budget based on provider(s) costs to provide the services identified in the individual's service agreement. The service coordinator is responsible for submitting the individual service agreement, a budget template, provider agreements, and a prior service authorization request to BDS for review. The individual participates in the development of their budget at the time of the person-centered service planning meeting.*

*Each service agreement identifies the waiver services selected through a person-centered service planning process and each budget contains projected costs for each identified service. As noted previously, these estimates are based on the prevailing costs for the services being requested.*

*NH is broken down into 10 catchment areas. Some areas of NH are more rural while some are more densely populated which impacts service costs.*

*This information identifies the proposed total waiver payments for the child's/individual's services. Based on the prior authorization issued and actual provision of services, the authorized provider submits claims and may be reimbursed, for actual services provided.*

*Payment rates are located on the MMIS website by visiting MMIS at <https://nhmmis.nh.gov>: To view, from the Main MMIS screen click on Documentation, Documents & Forms and Scroll down to Fee Schedules or using this direct link: <https://nhmmis.nh.gov/portals/wps/wcm/connect/254bab90-ee57-4f0e-bf2b-02680076e057/2024+Fee+Schedule+-+ABD+Waiver+Fee+Schedule+as+of+01-01-2024.pdf?MOD=AJPERES&CVID=oPZTnMY>.*

*The service rates for Service Coordination, Specialty Services, Supported Independent Living Services, and Crisis Response Services do not vary geographically, nor by provider agency. Provider agencies bill for services using the state's uniform rate schedule.*

*The state reviews its rate schedule on a periodic basis. Every biennium the rate schedule is reviewed in preparation for State budget development and appropriations. The review of rates ensures payments are consistent with economy, efficiency, and quality of care and are sufficient to enlist enough providers. The most recent biennium review was completed in late summer/early fall 2024.*

*NH DHHS is being responsible for rate determination. In addition, the NH DHHS is responsible for oversight which includes utilization of cost reports and claims data, service review and definitions, public engagement, statutory framework, and joint administration work to ensure rate parity.*

*Individuals whom select to self-direct services use the same individual budget development process as those accessing "traditional" service modality types. Self-directed services utilize standard and customary rates – i.e. the same rates in the uniform rate table.*

Moving forward, NH is moving to a rate build up methodology that will have, as its foundation, wages and other staffing costs of the direct support professionals to better promote market rates that are sufficient for the different regions within the State and support a strong workforce.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Area agencies and service providers must have a current BDS approved and issued Prior Authorization and documentation that services were provided, in order to bill for any individual receiving HCBS-ABD services.

Enrolled providers will have a Medicaid Provider Agreement with the NH State Medicaid Agency and be enrolled in MMIS. Enrolled Medicaid providers are offered three methods to bill. They may bill into the state claims payment system directly for services rendered, work with a third-party vendor, or software to bill on their behalf.

Medicaid billing is implemented on a fee for service basis utilizing a set of service rates and Medicaid Administrative rate(s). Supporting documentation for every claim/invoice submitted must be maintained and available for review by the State Medicaid Agency.

The 10 area agencies will serve as the state's OHCDs in order to provide FMS and "pass-through" billing. Pass-through services include Assistive Technology, Environmental and Vehicle Modification Services, Individual Goods & Services, Non-Medical Transportation, Personal Emergency Response System (PERS), Community Integration Services, Respite, Wellness Coaching, and Specialty Services for assessments, consultations, and evaluations. In these cases, the area agency will hold a contract with a provider who is not enrolled with Medicaid to provide a service. The area agency will submit a claim for billing and ensure timely payment to the rendering provider.

## Appendix I: Financial Accountability

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

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

**No. state or local government agencies do not certify expenditures for waiver services.**

**Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

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

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

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

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

## Appendix I: Financial Accountability

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

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

All HCBS billing is processed through the NH Medicaid Management Information System (MMIS). All billing for HCBS-ABD services requires a Prior Authorization be open and current in MMIS. Prior Authorizations includes only the services outlined in the individual's service agreement. If an individual's Medicaid status changes, claims are not paid until or unless the individual has open Medicaid status for the time period included on the claim(s).

Provider agencies are not authorized to bill for services without documentation that the services have been provided. As part of the service file reviews, BDS conducts a sample of post-payment reviews each year to ensure that for paid claims there is documentation that services were actually provided. The state will utilize a 95% confidence level with a 5% margin of error. The post payment review report lists any recoupments needed and BDS ensures the recoupments are made.

Recoupments are made through MMIS, which goes through the Department's Public Assistance Cost Allocation Plan (PACAP) and then reflected on the CMS-64.

EVV is not currently part of the pre-payment review process. The State has been paying the penalty for Personal Care and Respite services since January 1, 2021.

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

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

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

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

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

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

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on

the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

**Appendix I: Financial Accountability**

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**I-3: Payment (2 of 7)**

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

**Appendix I: Financial Accountability**

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**I-3: Payment (3 of 7)**

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

**No. The state does not make supplemental or enhanced payments for waiver services.**

**Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

**d. Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

**No.** State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

**Yes.** State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

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**The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**

**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

**Appendix I: Financial Accountability****I-3: Payment (6 of 7)**

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

**Appendix I: Financial Accountability****I-3: Payment (7 of 7)****g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** Select one:

**No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** Select one:

**No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

*In accordance with RSA 171-A and He-M 505, BDS contracts with 10 private, non-profit community 501(c)(3) providers known as area agencies. He-M 504, effective 7/1/23, authorizes area agencies to act as the state's organized health care delivery system (OHCDS). Further, it outlines requirements for completing billing as an OHCDS entity. To be granted OHCDS authority, an area agency must be designated pursuant to He-M 505.*

*The 10 area agencies will be able to provide billing as the OHCDS for certain services, known as "pass-through", in accordance with NH administrative rule He-M 504. These arrangements must be voluntary, and rendering providers will have the opportunity to enroll to bill Medicaid directly at any time. If an individual, guardian, or representative elects to receive a service from a provider who is not currently associated with an area agency, the area agency will assist the provider with establishing a contract or other agreement. The area agency will submit a claim for billing and ensure timely payment to the rendering provider. The area agency will be responsible for ensuring the provider of the service meets the provider qualifications as outlined in the waiver for the service being provided.*

*Pursuant to He-M 505 all designated area agencies are:*

- Locally Controlled: Governed by independent Boards of Directors made up of volunteer families and community business professionals.*
- Family Driven: Advised by Regional Family Support Councils.*
- Regionally Based: Responsible for providing services to individuals with acquired brain disorders and their families within their catchment area.*
- Overseen by the Bureau of Developmental Services.*
- Redesignated every 5 years.*

*Area agencies are considered successful, operating efficiently and eligible for redesignation when:*

- There is a high level of involvement of those who use and depend on services in all aspects of system planning, design, and development*
- The area agency demonstrates through its coordination of services and supports a commitment to a mission which embraces community membership for persons with acquired brain disorders*
- Ongoing inquiry regarding individual/guardian satisfaction is a common practice*
- Recipients of services and supports are satisfied*
- The area agency is fiscally sound and manages resources effectively to support its mission*
- The area agency board of directors demonstrates effective governance of the agency management and functions*
- Supports and services are flexible and represent the needs, preferences, and capacities of individuals/guardians*
- The area agency promotes preventative services and supports which reduce the need or the intensity of long-term care*
- The area agency, through multiple means, demonstrates its commitment to individual rights and safeguards*
- The area agency seeks to achieve continuous quality improvement in managing its operations and services*
- There is adherence to state and federal requirements.*

*Approval of an area agency's request for redesignation is granted if, based on the following information, the area agency is found to be in compliance with He-M 505:*

- Public comments regarding the area agency's demonstrated ability to provide local services and supports to people with acquired brain disorders and their families*
- A comprehensive self-assessment of the area agency's current abilities and past performance*
- Input from a wide range of individuals, agencies, or groups who are either recipients, providers, or people who collaborate in the provision of services and supports*
- Documentation pertaining to area agency operations available regionally and at the department*
- Input from department staff who have direct contact with and knowledge of area agency operations.*

**iii. Contracts with MCOs, PIHPs or PAHPs.**

***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

*The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.*

*Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

*The Acquired Brain Disorder Waiver utilizes a Prepaid Ambulatory Health Plan (PAHP) for the delivery of Removable Prosthodontic Services only. No other services in this waiver, as outlined in Appendix C, are delivered by the PAHP. The PAHP operates statewide for Removable Prosthodontic Service delivery and payment for this service is included in the PAHP agreement. The PAHP does not perform any waiver operational functions nor administrative functions on behalf of the State Medicaid Agency for this waiver.*

*This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.*

*This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.*

*If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

*In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

## ***Appendix I: Financial Accountability***

### ***I-4: Non-Federal Matching Funds (1 of 3)***

***a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

***Appropriation of State Tax Revenues to the State Medicaid Agency***

***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

[Empty rectangular box]

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

[Empty rectangular box]

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (2 of 3)**

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

*Not Applicable.* There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

Check each that applies:

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

[Empty rectangular box]

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

[Empty rectangular box]

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (3 of 3)**

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

*None of the specified sources of funds contribute to the non-federal share of computable waiver costs*

*The following source(s) are used*

Check each that applies:

*Health care-related taxes or fees*

*Provider-related donations*

*Federal funds*

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings. Select one:**

*No services under this waiver are furnished in residential settings other than the private residence of the individual.*

*As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.*

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

*Room and board are not allowable budget items and BDS ensures that Medicaid waiver funds are not used for Room and Board by requiring that a budget is submitted for each individual clearly delineating non-Medicaid revenues which are used to pay for Room and Board, typically, Social Security income. The Room and Board amount is clearly reflected in each individual's budget, and it is subtracted from the amount total prior to the Medicaid funding amount being expressed.*

*Room and Board payments are made from individual's income by the individual or guardian directly to the agency or entity providing residential services.*

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:**

*No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*

*Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

**No.** The state does not impose a co-payment or similar charge upon participants for waiver services.

**Yes.** The state imposes a co-payment or similar charge upon participants for one or more waiver services.

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

**Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

Specify:

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

**b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

**No.** The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

**Yes.** The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	153444.12	12238.00	165682.12	251211.00	17484.00	268695.00	103012.88
2	158784.89	12519.00	171303.89	261791.00	18221.00	280012.00	108708.11
3	164288.08	12807.00	177095.08	272817.00	18988.00	291805.00	114709.92
4	169975.97	13102.00	183077.97	284307.00	19788.00	304095.00	121017.03
5	175863.95	13403.00	189266.95	296282.00	20621.00	316903.00	127636.05

**Appendix J: Cost Neutrality Demonstration**

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

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

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
Year 1	238	Nursing Facility	
			238

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 2	238		238
Year 3	238		238
Year 4	238		238
Year 5	238		238

**Appendix J: Cost Neutrality Demonstration**

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

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The state used the actual average length of stay (ALOS) as submitted on 372's for waiver years 2019-2025. These actual ALOS were used to calculate an average annual trend for waiver year 2019-2025 of 0.30%, which was used to calculate a projected ALOS for waiver year 2026 and 2027-2031.

The updated yearly ALOS are as follows:

WY	Projected ALOS J-2-b
1	341.0
2	342.1
3	343.1
4	344.1
5	345.1

The 0.30% was calculated using an average annual trend formula in Microsoft Excel, rounded to 3 decimal places, as follows: =ROUND((WY25/WY19)^(1/6)-1,3).

**Appendix J: Cost Neutrality Demonstration**

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

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

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

*Factor D equals the grand total divided by the total estimated unduplicated participants for each waiver year as recorded in J-2-d-i. Five (5) tables were created to populate the WY templates in J-2-d-i.*

*Table 1 (Unduplicated Count of Participants): The projected number of unduplicated participants for each waiver year 2027-2031 was based on 372's prepared for the waiver years 2019-2025 in addition to the Bureau of Developmental Services (BDS) experience with this waiver to date and expectations for growth. Actual waiver year 2019-2025 unduplicated counts of ABD participants were used to estimate an annual growth trend, which was then used to forecast an unduplicated count for waiver years 2026 and 2027-2031. BDS experience informed variable trend factors for waiver services where programmatic factors are expected to impact the global trend.*

*Table 2 (Total Units):*

- a. 2025: Actual units billed in waiver year 2025 were queried in MMIS for each waiver service.*
- b. 2026-31: A forecast for the volume of billable units was calculated over waiver years 2026-2031 as the product of values in Table 1 [Unduplicated Count] and Table 3 [Avg. Units Per User] for each waiver service and waiver year.*

*Table 3 (Avg. Units Per User):*

- a. 2025: The average volume of units per user was calculated as the quotient of Table 2 [Total Units] and Table 1 [Unduplicated Count of Participants].*
- b. 2026-31: Per BDS experience and expectations, the projected average volume of services rendered per user is assumed to remain constant across all waiver services. Calculated values for waiver year 2025 average units were used to form a Waiver Year 1 (2027) baseline projection.*

*Table 4 (Avg. Cost Per Unit):*

- a. 2025: The average cost per unit was calculated as the quotient of Table 5 [Total Cost] and Table 2 [Total Units].*
- b. 2026-31: An annual trend of 3.9%—based on the Medical Consumer Price Index 12-month value ending Jan. 2026—was used to forecast waiver year 2026 and 2027-2031 values for average cost per unit from a baseline of the estimated waiver year 2025 average cost per unit value. A trend value of 0.0% was assumed for the following services for which rate changes only take place through a formal rate increase that is not currently planned: Service Coordination and Community Integration Services.*

*Table 5 (Total Cost): A forecast for total cost was calculated over waiver years 2026-2031 as the product of values in Table 1 [Unduplicated Count of Participants], Table 3 [Average Units Per User], and Table 4 [Average Cost Per Unit] for each waiver service and year.*

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

*Factor D' derivation was based on the actual payments for the most recent (waiver year 2025) 372 Report. The state used the actual Factor D' values as submitted on 372's for waiver year 2019-2025 to calculate an average annual trend for waiver years 2019-2025 of 2.3%. This annual trend was used to calculate a projected Factor D' for 2026 and 2027-2031.*

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

*Factor G Derivation was based on actual cost per person estimates from a state-run long-term care facility for developmentally disabled and/or mentally ill adult population. The 2027-2031 per person annual cost was based on SFY2026 projected daily rate, adjusted for inflation and annualized using ALOS estimates (see J-2-b).*

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

Factor G' includes the cost of all other Medicaid services furnished while the individual is institutionalized. Factor G' was based on the Factor G' values on the 372 report for the most recent waiver year and trended forward 2026-2031 using expected ALOS (see J-2-b) and an annual growth in the daily rate of 3.5%, the Medical Consumer Price Index 12-month value ending Jan. 2026.

**Appendix J: Cost Neutrality Demonstration**

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

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

Waiver Services	
Community Participation Services	
Residential Habilitation	
Respite	
Service Coordination	
Supported Employment	
Assistive Technology	
Community Integration Services	
Crisis Response Services	
Environmental and Vehicle Modification Services	
Individual Goods and Services	
Non-Medical Transportation	
Personal Emergency Response Services	
Removable Prosthodontic Services	
Specialty Services	
Supported Independent Living Services	
Wellness Coaching	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<p><b>GRAND TOTAL: 36519701.61</b></p> <p>Total: Services included in capitation: 1661.29</p> <p>Total: Services not included in capitation: 36518040.32</p> <p><b>Total Estimated Unduplicated Participants: 238</b></p> <p><b>Factor D (Divide total by number of participants): 153444.12</b></p> <p>Services included in capitation: 6.98</p> <p>Services not included in capitation: 153437.14</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">341</span></p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Participation Services Total:</b>							3384511.36
Community Participation Services		15 Minutes	92	2504.30	14.69	3384511.36	
<b>Residential Habilitation Total:</b>							31501678.21
Residential Habilitation		Day	206	272.80	560.56	31501678.21	
<b>Respite Total:</b>							74842.94
Respite		15 Mintues	11	6.40	1063.11	74842.94	
<b>Service Coordination Total:</b>							737544.60
Service Coordination		Month	234	10.00	315.19	737544.60	
<b>Supported Employment Total:</b>							44259.76
Supported Employment		15 Minutes	5	608.80	14.54	44259.76	
<b>Assistive Technology Total:</b>							86740.50
Assistive Technology		Item	10	15.00	578.27	86740.50	
<b>Community Integration Services Total:</b>							38136.30
Community Integration Services		Each	20	6.90	276.35	38136.30	
<b>Crisis Response Services Total:</b>							119267.64
Crisis Response Services		15 Minutes	6	2358.00	8.43	119267.64	
<b>Environmental and Vehicle Modification Services Total:</b>							126149.57
Environmental and Vehicle Modification Services		Each	16	1.20	6570.29	126149.57	
<b>Individual Goods and Services Total:</b>							21290.08
<p><b>GRAND TOTAL: 36519701.61</b></p> <p>Total: Services included in capitation: 1661.29</p> <p>Total: Services not included in capitation: 36518040.32</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 153444.12</p> <p>Services included in capitation: 6.98</p> <p>Services not included in capitation: 153437.14</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">341</span></p>							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services		Each	7	1.60	1900.90	21290.08	
<b>Non-Medical Transportation Total:</b>							12469.92
Non-Medical Transportation		Each	8	187.80	8.30	12469.92	
<b>Personal Emergency Response Services Total:</b>							1537.85
Personal Emergency Response Services		Each	8	5.30	36.27	1537.85	
<b>Removable Prosthodontic Services Total:</b>							1661.29
Removable Prosthodontic Services		Each	233	1.00	7.13	1661.29	
<b>Specialty Services Total:</b>							214531.95
Specialty Services		Each	147	32.70	44.63	214531.95	
<b>Supported Independent Living Services Total:</b>							139096.96
Supported Independent Living Services		15 Minutes	13	1031.80	10.37	139096.96	
<b>Wellness Coaching Total:</b>							15982.68
Wellness Coaching		Hour	7	3.00	761.08	15982.68	
<p><b>GRAND TOTAL: 36519701.61</b></p> <p>Total: Services included in capitation: 1661.29</p> <p>Total: Services not included in capitation: 36518040.32</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 153444.12</p> <p>Services included in capitation: 6.98</p> <p>Services not included in capitation: 153437.14</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">341</span></p>							

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

04/16/2026

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Participation Services Total:</b>							3502013.12
Community Participation Services		15 Minutes	92	2504.30	15.20	3502013.12	
<b>Residential Habilitation Total:</b>							32604259.42
Residential Habilitation		Day	206	272.80	580.18	32604259.42	
<b>Respite Total:</b>							77462.53
Respite		15 Mintues	11	6.40	1100.32	77462.53	
<b>Service Coordination Total:</b>							747000.30
Service Coordination		Month	237	10.00	315.19	747000.30	
<b>Supported Employment Total:</b>							45812.20
Supported Employment		15 Minutes	5	608.80	15.05	45812.20	
<b>Assistive Technology Total:</b>							89776.50
Assistive Technology		Item	10	15.00	598.51	89776.50	
<b>Community Integration Services Total:</b>							47364.91
Community Integration Services		Each	24	6.90	286.02	47364.91	
<b>Crisis Response Services Total:</b>							123370.56
Crisis Response Services		15 Minutes	6	2358.00	8.72	123370.56	
<b>Environmental and Vehicle Modification Services Total:</b>							138725.10
Environmental and Vehicle Modification Services		Each	17	1.20	6800.25	138725.10	
<b>Individual Goods and Services Total:</b>							22035.22
<p><b>GRAND TOTAL: 37790803.85</b></p> <p>Total: Services included in capitation: 1719.54</p> <p>Total: Services not included in capitation: 37789084.31</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 158784.89</p> <p>Services included in capitation: 7.22</p> <p>Services not included in capitation: 158777.67</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">342</span></p>							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services		Each	7	1.60	1967.43	22035.22	
<b>Non-Medical Transportation Total:</b>							12920.64
Non-Medical Transportation		Each	8	187.80	8.60	12920.64	
<b>Personal Emergency Response Services Total:</b>							1989.62
Personal Emergency Response Services		Each	10	5.30	37.54	1989.62	
<b>Removable Prosthodontic Services Total:</b>							1719.54
Removable Prosthodontic Services		Each	233	1.00	7.38	1719.54	
<b>Specialty Services Total:</b>							215989.06
Specialty Services		Each	143	32.70	46.19	215989.06	
<b>Supported Independent Living Services Total:</b>							139096.96
Supported Independent Living Services		15 Minutes	13	1031.80	10.37	139096.96	
<b>Wellness Coaching Total:</b>							21268.17
Wellness Coaching		Hour	9	3.00	787.71	21268.17	
<p><b>GRAND TOTAL: 37790803.85</b></p> <p>Total: Services included in capitation: 1719.54</p> <p>Total: Services not included in capitation: 37789084.31</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 158784.89</p> <p>Services included in capitation: 7.22</p> <p>Services not included in capitation: 158777.67</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">342</span></p>							

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Participation Services Total:</b>							3624122.79
Community Participation Services		15 Minutes	92	2504.30	15.73	3624122.79	
<b>Residential Habilitation Total:</b>							33745054.46
Residential Habilitation		Day	206	272.80	600.48	33745054.46	
<b>Respite Total:</b>							80173.63
Respite		15 Mintues	11	6.40	1138.83	80173.63	
<b>Service Coordination Total:</b>							750152.20
Service Coordination		Month	238	10.00	315.19	750152.20	
<b>Supported Employment Total:</b>							47425.52
Supported Employment		15 Minutes	5	608.80	15.58	47425.52	
<b>Assistive Technology Total:</b>							92919.00
Assistive Technology		Item	10	15.00	619.46	92919.00	
<b>Community Integration Services Total:</b>							57193.00
Community Integration Services		Each	28	6.90	296.03	57193.00	
<b>Crisis Response Services Total:</b>							127756.44
Crisis Response Services		15 Minutes	6	2358.00	9.03	127756.44	
<b>Environmental and Vehicle Modification Services Total:</b>							152026.42
Environmental and Vehicle Modification Services		Each	18	1.20	7038.26	152026.42	
<b>Individual Goods and Services Total:</b>							22806.45
<p><b>GRAND TOTAL: 39100562.54</b></p> <p>Total: Services included in capitation: 1777.79</p> <p>Total: Services not included in capitation: 39098784.75</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 164288.08</p> <p>Services included in capitation: 7.47</p> <p>Services not included in capitation: 164280.61</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">343</span></p>							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services		Each	7	1.60	2036.29	22806.45	
<b>Non-Medical Transportation Total:</b>							13371.36
Non-Medical Transportation		Each	8	187.80	8.90	13371.36	
<b>Personal Emergency Response Services Total:</b>							2471.50
Personal Emergency Response Services		Each	12	5.30	38.86	2471.50	
<b>Removable Prosthodontic Services Total:</b>							1777.79
Removable Prosthodontic Services		Each	233	1.00	7.63	1777.79	
<b>Specialty Services Total:</b>							217310.79
Specialty Services		Each	139	32.70	47.81	217310.79	
<b>Supported Independent Living Services Total:</b>							139096.96
Supported Independent Living Services		15 Minutes	13	1031.80	10.37	139096.96	
<b>Wellness Coaching Total:</b>							26904.24
Wellness Coaching		Hour	11	3.00	815.28	26904.24	
<p><b>GRAND TOTAL: 39100562.54</b></p> <p>Total: Services included in capitation: 1777.79</p> <p>Total: Services not included in capitation: 39098784.75</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 164288.08</p> <p>Services included in capitation: 7.47</p> <p>Services not included in capitation: 164280.61</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">343</span></p>							

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Participation Services Total:</b>							3750840.37
Community Participation Services		15 Minutes	92	2504.30	16.28	3750840.37	
<b>Residential Habilitation Total:</b>							34926311.20
Residential Habilitation		Day	206	272.80	621.50	34926311.20	
<b>Respite Total:</b>							82979.78
Respite		15 Mintues	11	6.40	1178.69	82979.78	
<b>Service Coordination Total:</b>							750152.20
Service Coordination		Month	238	10.00	315.19	750152.20	
<b>Supported Employment Total:</b>							49099.72
Supported Employment		15 Minutes	5	608.80	16.13	49099.72	
<b>Assistive Technology Total:</b>							96171.00
Assistive Technology		Item	10	15.00	641.14	96171.00	
<b>Community Integration Services Total:</b>							67650.91
Community Integration Services		Each	32	6.90	306.39	67650.91	
<b>Crisis Response Services Total:</b>							132283.80
Crisis Response Services		15 Minutes	6	2358.00	9.35	132283.80	
<b>Environmental and Vehicle Modification Services Total:</b>							166088.88
Environmental and Vehicle Modification Services		Each	19	1.20	7284.60	166088.88	
<b>Individual Goods and Services Total:</b>							23604.67
<p><b>GRAND TOTAL: 40454280.05</b></p> <p>Total: Services included in capitation: 1840.70</p> <p>Total: Services not included in capitation: 40452439.35</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 169975.97</p> <p>Services included in capitation: 7.73</p> <p>Services not included in capitation: 169968.23</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">344</span></p>							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services		Each	7	1.60	2107.56	23604.67	
<b>Non-Medical Transportation Total:</b>							13837.10
Non-Medical Transportation		Each	8	187.80	9.21	13837.10	
<b>Personal Emergency Response Services Total:</b>							2984.32
Personal Emergency Response Services		Each	14	5.30	40.22	2984.32	
<b>Removable Prosthodontic Services Total:</b>							1840.70
Removable Prosthodontic Services		Each	233	1.00	7.90	1840.70	
<b>Specialty Services Total:</b>							218429.46
Specialty Services		Each	135	32.70	49.48	218429.46	
<b>Supported Independent Living Services Total:</b>							139096.96
Supported Independent Living Services		15 Minutes	13	1031.80	10.37	139096.96	
<b>Wellness Coaching Total:</b>							32908.98
Wellness Coaching		Hour	13	3.00	843.82	32908.98	
<p><b>GRAND TOTAL: 40454280.05</b></p> <p>Total: Services included in capitation: 1840.70</p> <p>Total: Services not included in capitation: 40452439.35</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 169975.97</p> <p>Services included in capitation: 7.73</p> <p>Services not included in capitation: 169968.23</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">344</span></p>							

**Appendix J: Cost Neutrality Demonstration**

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

**d. Estimate of Factor D.**

**ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Participation Services Total:</b>							3882165.86
Community Participation Services		15 Minutes	92	2504.30	16.85	3882165.86	
<b>Residential Habilitation Total:</b>							36148591.60
Residential Habilitation		Day	206	272.80	643.25	36148591.60	
<b>Respite Total:</b>							85884.48
Respite		15 Mintues	11	6.40	1219.95	85884.48	
<b>Service Coordination Total:</b>							750152.20
Service Coordination		Month	238	10.00	315.19	750152.20	
<b>Supported Employment Total:</b>							50804.36
Supported Employment		15 Minutes	5	608.80	16.69	50804.36	
<b>Assistive Technology Total:</b>							99537.00
Assistive Technology		Item	10	15.00	663.58	99537.00	
<b>Community Integration Services Total:</b>							78772.61
Community Integration Services		Each	36	6.90	317.12	78772.61	
<b>Crisis Response Services Total:</b>							136811.16
Crisis Response Services		15 Minutes	6	2358.00	9.67	136811.16	
<b>Environmental and Vehicle Modification Services Total:</b>							180949.44
Environmental and Vehicle Modification Services		Each	20	1.20	7539.56	180949.44	
<b>Individual Goods and Services Total:</b>							24430.90
<p><b>GRAND TOTAL: 41855619.62</b></p> <p>Total: Services included in capitation: 1905.94</p> <p>Total: Services not included in capitation: 41853713.69</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 175863.95</p> <p>Services included in capitation: 8.01</p> <p>Services not included in capitation: 175855.94</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">345</span></p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services		Each	7	1.60	2181.33	24430.90	
<b>Non-Medical Transportation Total:</b>							14317.87
Non-Medical Transportation		Each	8	187.80	9.53	14317.87	
<b>Personal Emergency Response Services Total:</b>							3530.22
Personal Emergency Response Services		Each	16	5.30	41.63	3530.22	
<b>Removable Prosthodontic Services Total:</b>							1905.94
Removable Prosthodontic Services		Each	233	1.00	8.18	1905.94	
<b>Specialty Services Total:</b>							219368.28
Specialty Services		Each	131	32.70	51.21	219368.28	
<b>Supported Independent Living Services Total:</b>							139096.96
Supported Independent Living Services		15 Minutes	13	1031.80	10.37	139096.96	
<b>Wellness Coaching Total:</b>							39300.75
Wellness Coaching		Hour	15	3.00	873.35	39300.75	
<p><b>GRAND TOTAL: 41855619.62</b></p> <p>Total: Services included in capitation: 1905.94</p> <p>Total: Services not included in capitation: 41853713.69</p> <p>Total Estimated Unduplicated Participants: 238</p> <p>Factor D (Divide total by number of participants): 175863.95</p> <p>Services included in capitation: 8.01</p> <p>Services not included in capitation: 175855.94</p> <p>Average Length of Stay on the Waiver: <span style="border: 1px solid black; padding: 2px;">345</span></p>							