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 §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:
Significant changes include:

Content demonstrating compliance with CMS regulations governing Home and Community Based Care Services (HCBS) published in January 2014

An overview of Rate Setting Methodology

Modifications to Quality Measures and Reporting to comply with CMS Expectations published in March 2014

Addition of new services/service definitions including Participant Directed Services, Supported Employment and Financial Management Services

Information about the State's HCBS Statewide Transition Plan

Additional Level of Care Instruments

Requirements for Participant Centered Planning and Service Delivery

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 §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*):
Choices for Independence Waiver Renewal: 2017--->2022

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**

Waiver Number:NH.0060.R07.00
Draft ID: NH.001.07.00

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

Regular Waiver

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

07/01/17

Approved Effective Date: 07/01/17

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 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:

○ **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 §1915(a)(1)(a) of the Act and described in Appendix I**

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

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

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §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 §1915(i) of the Act.**

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The goal of the Choices for Independence (CFI) Waiver, administered by the NH Department of Health and Human Services (NH DHHS), is to support elders and adults with disabilities to live independently in the community.

The CFI Waiver provides supports and services to individuals who are Medicaid eligible and meet nursing facility level of care through a network of community based provider agencies who are directly enrolled as NH Medicaid Providers.

Individuals living in the Community who wish to apply for CFI Waiver services can access support for the application process through the NH Care Path/ServiceLink, New Hampshire's Aging and Disability Resource Center: http://www.servicelink.nh.gov/index.htm. NH CarePath/ServiceLink is administered by NH DHHS.

Individuals living in a nursing facility who wish to access CFI Waiver services as an alternative to nursing facility care are made aware of this opportunity during the completion of the Minimum Data Set (MDS) clinical assessment process used by all federally certified nursing homes. Section Q of the MDS (version 3.0) actively engages nursing facility residents in exploring community living options as an alternative to nursing facility care.

When a nursing facility resident indicates an interest in community based services and supports, the nursing facility completes and submits a Section Q referral to the local NH CarePath/Service Link office. ServiceLink staff provide the resident with information regarding home and community based supports and, if requested by the individual, assists with the CFI Waiver Application Process.

Applications for CFI Waiver services are submitted to and processed by the NH DHHS which provides, for eligible individuals, an initial service authorization and access to independent case management services. The Independent Case Management agency selected by the individual provides the supports necessary for development of the supports outlined in the person centered plan and provides ongoing monitoring and support to ensure services are provided as outlined in the plan.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §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 §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside

in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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:
In November and December of 2016, DHHS hosted a series of informal "Listening Sessions" to elicit input from CFI Waiver stakeholders. Information elicited in the Listening Sessions was used in the development of the draft Waiver renewal document.

5 Listening Sessions were conducted
Approx.58 attendees provided input

Themes from the Listening Sessions: Concerns regarding workforce capacity and its impact on services. A suggestion was made to allow flexibility so that different services could be substituted when there is a workforce shortage of providers for a specific service category;

Recommendations for streamlining the eligibility and redetermination processes, consideration of a 3 month retroactive service coverage to address timeliness of initial eligibility and redeterminations and implementation of presumptive eligibility;

Feedback supporting the revision of services offered on the waiver, including participant directed services, transportation and PT, OT and Speech Therapy in excess of state plan limits;

Recommendation to implement components of the NH DD and NH ABD waivers in the CFI waiver: for example participant managed and directed services and support to individuals who wish to self-direct their services;

Suggestions regarding increased access to Adult Medical Day Services including when someone lives in Adult Family Care or Kinship Care; and,

Recommendations for aligning the provision of personal care services and non-medical transportation services.

DHHS developed a web page for the CFI Waiver renewal at:http://www.dhhs.nh.gov/ombp/medicaid/cfi-waiver.htm.

As part of the formal public notice process DHHS provided formal public notice of opportunities for public input in two statewide newspapers on 1/27/17 [the Manchester Union Leader and the Nashua Telegraph], via email and via web posting.

The notice included the following:
Pursuant to 42 C.F.R. §441.301(c)(6)(iii) notice is hereby given that the New Hampshire Department of Health and Human Services, as the single state Medicaid agency, intends to submit a renewal of its Section 1915(c) Choices for Independence (CFI) Waiver to the Centers for Medicare and Medicaid Services (CMS).

This renewal reflects changes including, but not limited to:
• Content demonstrating compliance with CMS regulations governing Home and Community Based Care Services (HCBS) published in January 2014
• An overview of Rate Setting Methodology
• Modifications to Quality Measures and Reporting to comply with CMS Expectations published in March 2014
• Addition of new services/service definitions
• Information about the State’s HCBS Statewide Transition Plan

• Addition of Participant Direction of Services
• Additional Level of Care Instruments
• Requirements for Participant Centered Planning and Service Delivery

This notice contains a link to the draft 1915(c) waiver renewal document, as well as dates, times, and locations of opportunities for public input related to this renewal.

Opportunity for Public Input

The draft waiver renewal document was made available for public review on January 30, 2017 on the Department's website at: http://www.dhhs.nh.gov/ombp/medicaid/cfi-waiver.htm

The draft waiver renewal document was available for viewing in hard copy from 8:00 AM – 4:30 PM Monday through Friday at the NH Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301-3857.

Public comments were accepted until midnight on February 28, 2017 by: email to nhcfiwaiverrenewalinput@dhhs.nh.gov or by United States Postal Service to Lorene Reagan, NH Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301-3857.

The State scheduled three public hearings. One hearing was cancelled due to inclement weather.

There were opportunities to attend [see schedule below] in person, by phone or by Zoom web conference.

February 8, 2017 from 10am-12noon
Brown Auditorium
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

February 9, 2017 from 1pm-3pm: CANCELLED
Brown Auditorium
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

February 15, 2017 from 5:30pm-7:30pm
Brown Auditorium
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Public Hearing attendance: a total of 26 people participated either in person, online or through phone participation.

Written input: 9 individuals/stakeholder groups submitted written input

Public Input: Themes

The majority of those commenting applauded the addition of Participant Directed and Managed Supports [PDMS] with the exception of one entity which strongly recommended the Department not include PDMS in the final Waiver renewal application.

A number of commenters expressed concern regarding the Department's timeframe for State Plan Medicaid eligibility and CFI Waiver eligibility.

Several commenters endorsed the expansion of additional assessment tools/instruments for determining Waiver eligibility/level of care.

Several commenters requested that new/additional services be added to the Waiver renewal; others requested that

service caps be reduced or eliminated.

Several commenters suggested that the Department conduct rate setting activities on an annual basis.

Concerns regarding provider adequacy and direct support workforce capacity.

Several commenters requested that the Department re-evaluate its approach to having a cost limit lower than institutional costs and requested that additional detail be added re: the state's approach to the individual cost limit.

Implementation of Presumptive Eligibility was strongly recommended as a strategy for streamlining CFI Waiver eligibility.

A summary of public input received can be found at: https://www.dhhs.nh.gov/ombp/medicaid/cfi-waiver.htm

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

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

7. Contact Person(s)

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

Last Name: Jeffrey

First Name: Meyers

Title: Commissioner

Agency: New Hampshire Department of Health and Human Services

Address: 129 Pleasant Street

Address 2:

City: Concord

State: **New Hampshire**

Zip: 03301

Phone: (603) 271-9446 **Ext:** ☐ **TTY**

Fax:

(603) 271-4912

E-mail:

Jeffrey.Meyers@dhhs.nh.gov

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

Last Name:

Reagan

First Name:

Lorene

Title:

Medicaid Senior Health Systems Administrator

Agency:

NH Department of Health and Human Services

Address:

129 Pleasant Street

Address 2:

City:

Concord

State: **New Hampshire**

Zip:

03301

Phone:

(603) 271-9180 **Ext:** ☐ **TTY**

Fax:

(603) 271-7100

E-mail:

lorene.reagan@dhhs.nh.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §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: Christine Santaniello

State Medicaid Director or Designee

Submission Date: Jun 21, 2017

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

Last Name: Lorene

First Name: Reagan

Title: Medicaid Senior Health Systems Administrator

Agency: New Hampshire Department of Health and Human Services

Address: 129 Pleasant Street

Address 2:

City: Concord

State: **New Hampshire**

Zip: 03301

Phone: (603) 271-9180 **Ext:** ☐ **TTY**

Fax: (603) 271-7100

E-mail: lorene.reagan@dhhs.nh.gov

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:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The information contained in this waiver renewal regarding New Hampshire's Statewide Transition Plan [STP] has been developed in accordance with the HCBS 1915c regulations and is consistent with the most updated version of the State's STP submitted to CMS on May 30, 2016 and amended [and resubmitted to CMS] on June 28, 2016.

At the time of the public notice for this waiver renewal [January 2017], New Hampshire's Statewide Transition Plan is currently under review at CMS and the state is awaiting notification of approval.

The state's STP is broken down into three phases:

The first phase is to focus on systemic efforts designed to educate providers, participants and stakeholders.

The second phase is to identify systems, practices and policies that can be enhanced, updated and/or implemented.

The third phase is an assessment of the state's status toward full compliance, including a self-assessment, additional site visits, and data analysis relevant to the topic areas identified by the HCBS rule. The three phases will occur simultaneously in many cases.
While New Hampshire has many pockets of excellence, the focus of the Transition Plan is to identify how to enhance the current systems, ultimately having a consistent approach and implementation strategy to Home and Community Based Services.

The transition process is being led by the state's designated Waiver Transition Team and a sixteen member Advisory Task Force of stakeholders. New Hampshire will begin implementation of its Statewide Transition Plan upon CMS approval.

Both the Transition Framework, submitted to CMS in March 2015, outlining the process the state would implement to develop its Transition Plan, and the Statewide Transition Plan submitted to CMS can be found at:
http://www.dhhs.nh.gov/ombp/medicaid/draft-transition-framework.htm

Focus areas of the Statewide Transition Plan will enhance the services provided to participants under the CFI waiver and implement new strategies to ensure both improved quality of services, and CMS compliance. The state has begun implementing educational opportunities for providers, participants and stakeholders while awaiting feedback from CMS.

The state assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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.
   DHHS Office of Medicaid 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:
   The NH Department of Health and Human Services (DHHS) is the single state Medicaid agency. As required by RSA 151-E, DHHS has adopted administrative rules, He-E 801 (Choices for Independence), and He-E 805 (Targeted Case Management) which direct the Department's administration of the waiver program. He-E 801 describes clinical eligibility standards, the eligibility process, service definitions and requirements, and provider requirements. It also includes the requirement of a comprehensive person

centered plan developed by the case manager and participant using a person-centered planning process. He-E 805 outlines the requirements for Targeted Case Management provided to waiver participants.

The DHHS Office of Medicaid Services is responsible for CFI waiver operations, including waiver program monitoring.The Commissioner of Health and Human Service retains the ultimate authority over all of NH's HCBS waivers.

Online References:

State Statute: RSA 151-E: http://www.gencourt.state.nh.us/rsa/html/xi/151-e/151-e-mrg.htm

He-E 800 Administrative Rules:http://www.gencourt.state.nh.us/rules/state_agencies/he-e800.html

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

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.:*
   DHHS contracts with Xerox/Conduent to screen and enroll Medicaid Providers and to manage the state's MMIS.

   DHHS contracts with Service Link Resource Centers, New Hampshire's Aging and Disabilities Resource Centers, to provide information, referral, application support and options counseling for CFI Waiver Applicants. NH CarePath, a resource within Service Link provides specific resources regarding community based long term supports and services.

   DHHS utilizes, in addition to DHHS state staff, a contracted agency (KEPRO) to complete state approved clinical assessment tools and level of care determinations per RSA –E:3 II. Evaluators must meet criteria for skilled professional medical personnel, in accordance with 42 C.F.R section 432.50(d)(1)(ii).

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

Appendix A: Waiver Administration and Operation

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

   ○ **Not applicable**

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

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

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

The Department of Health and Human Services utilizes enrolled Medicaid Providers whose personnel meet the definition of skilled professional medical personnel in accordance with 42 C.F.R section 432.50(d)(1)(ii) to complete state approved clinical assessment tools for initial and annual clinical redetermination assessments. These entities do not make the level of care determination.

☑ **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:

The Department of Health and Human Services utilizes personnel who are employed by NH Medicaid enrolled hospitals and nursing facilities and who meet the criteria for skilled professional medical personnel, in accordance with 42 C.F.R section 432.50(d)(1)(ii), to complete state approved clinical assessment tools for initial and annual clinical redetermination assessments. These entities do not make the level of care determination.

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 DHHS Medicaid Unit utilizes the Department's Office of Improvement and Integrity to assess the performance of NH Medicaid Enrolled Providers and to monitor for fraud, waste and abuse.

The DHHS Office of Quality Assurance and Improvement (OQAI) monitors the performance of contracted entities conducting waiver operational and administrative functions.

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:
NH DHHS employs state staff who are specifically designated to oversee the performance of each entity performing waiver operational and administrative functions. Designated state staff work in partnership with the Department's Office of Improvement and Integrity and Office of Quality Assurance and Improvement to assess the qualifications of and performance of non-state entities. The DHHS Provider Relations director is also instrumental in communicating with non-state entities regarding waiver performance expectations.

Methods used to assess performance include execution and monitoring of Medicaid Provider agreements, annual contract review, licensing and certification reviews and quality assurance activities such as record reviews and performance reviews of provider agencies according to the performance measures included in this waiver.

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.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of CFI Waiver Providers with a standardized, state approved Medicaid Provider Agreement in place. N: Number of CFI Waiver Providers with a

standardized state approved Medicaid Provider Agreement in place D: Number of CFI Waiver Providers

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of CFI Waiver Providers with policies and procedures in place reflecting updated HCBS Settings Requirements N: Number of CFI Waiver Providers with policies and procedures in place reflecting updated HCBS Settings Requirements D: Number of CFI Waiver Providers reviewed

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When individual problems are discovered, they are remediated through discussions with the enrolled Medicaid Provider by the NH DHHS Provider Relations staff or the CFI Waiver Administrator. Documentation is via email communications.

When problematic trends are suspected or confirmed, the NH DHHS Office of Quality Assurance and Improvement is engaged to conduct a QI review; the results of the QI review are documented and suggested remediation strategies are shared within the Department and with involved providers/provider groups. Follow up is conducted to evaluate the effectiveness of the strategies implemented.

ii. **Remediation Data Aggregation**

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☑	**Disabled (Other)**	18	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

Individuals must meet clinical eligibility requirements established in RSA 151-E:3 I. Individuals who would otherwise require the services of an IMD, and are of the age of 21 through 64 (per 1905 (a) 28 (B) of the Act), or who would otherwise require the services of a psychiatric residential treatment facility as defined in 42 CFR 483.352, are not eligible.

RSA 151-E:3 states the following:
I. A person is medicaid eligible for nursing facility services if the person is:
(a) Clinically eligible for nursing facility care because the person requires 24-hour care for one or more of the following purposes, as determined by registered nurses appropriately trained to use an assessment tool and employed by the department, or a designee acting on behalf of the department:
(1) Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;
(2) Restorative nursing or rehabilitative care with patient-specific goals;
(3) Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous

feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or
(4) Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence; and
(b) Financially eligible as either:
(1) Categorically needy, as calculated pursuant to rules adopted by the department under RSA 541-A; or
(2) Medically needy, as calculated pursuant to rules adopted by the department under RSA 541-A.

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:

The age limits stated pertain to Medicaid eligibility for the disabled category of assistance. That category of Medicaid eligibility serves individuals who are at least age 18 years and no older than 64 years. When a waiver participant reaches 65 years of age, s/he becomes eligible through the Old Age Assistance category of assistance. Waiver participation is not affected by the category of assistance for which the participant is eligible.

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.

According to NH State Statute RSA 151-E:11:

No person whose costs would be in excess of 80 percent of the average annual cost for the provision of services to a person in a nursing facility shall be approved for home-based or mid-level services without the prior approval of the commissioner of health and human services. The prior approval shall include a comparison of the mid-level or home-based care costs of the person with the costs of a facility qualified to provide any specialized services necessary for the proper care and treatment of the individual.

The average annual cost for the provision of services to persons in the mid-level of care shall not exceed 60 percent of the average annual cost for the provision of services in a nursing facility.

The average annual cost for the provision of services in home-based care shall not exceed 50 percent of the average annual cost for the provision of services to persons in a nursing facility.

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: 80

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Each prospective participant is clinically evaluated by skilled professional medical personnel contracted or trained by the State, using a standardized state approved assessment instrument, to determine if s/he is clinically eligible and to identify the individual's needs. Skilled professional medical personnel shall have the same meaning as in 42 C.F.R. section 432.50(d)(1)(ii).

The resulting standardized state approved assessment form is provided to DHHS. A skilled medical professional

employed or contracted by DHHS approves a set of preliminary services that address the participant's identified needs. Using the service rates in use at the time, the skilled medical professional estimates the cost of the preliminary list of services, and this cost is compared to the cost of facility care. The skilled medical professional uses the results of this comparison to determine whether the individual's needs can be met through the Program within the cost limit.

The state's procedures take into account the full range of supports a person requires in the community. If enrollment is denied, NH issues a notice, which outlines the process for an appeal through NH's Administrative Appeals Unit (AAU) in accordance with He-C 200, the rule established to govern the process regarding Administrative Appeals in accordance with the following State Laws: RSA 541-A:16 I and RSA 126-A:5, VII.

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:

If a Participant's condition or circumstances change after being accepted to the Program, a skilled medical professional, contracted or trained by the State conducts a clinical reassessment of his/her functional needs.

The Independent Case Manager works with the participant using a person centered planning approach to update the individual's plan of care according to the clinical reassessment.

Additional Program services may be authorized if they are required to maintain the participant's health and safety. There is no standard amount of additional services that may be authorized. Rather, an authorization is made after consideration of other supports available to the individual and the period of time when the additional services are needed, such as if additional services are needed until the Participant moves to another living arrangement. Additional services are considered for authorization based on the Participant's clinical needs and living environment, with the foremost goal of preserving health and safety.

☑ **Other safeguard(s)**

Specify:

If the Participant requires services than are greater than what can be provided, the case manager and Participant discuss how his/her needs can be met. If the Participant lives in his/her own home or apartment, receiving services through alternative settings, such as Residential Care and Adult Family Care, is considered. Placement in a nursing facility is offered if none of the other alternatives meet the Participant's needs or preferences.

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	3619
Year 2	3656
Year 3	3692
Year 4	

Waiver Year	Unduplicated Number of Participants
	3729
Year 5	3766

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

The waiver provides for the entrance of applicants who are found eligible though the eligibility requirements identified in RSA 151-E:3 and in State Administrative Rule He-E 801. Enrollment is effective as soon as the eligibility process is completed and the applicant is found eligible. The requirements for the waiver program are as follows:

An individual shall be eligible to receive CFI services if he or she meets all of the following requirements:
Submits a signed and dated application to the department;

Is at least 18 years of age;

Has been determined financially eligible as either categorically needy or medically needy;

Meets the clinical eligibility requirements for nursing facility care in RSA 151-E:3, I(a), namely, the person requires 24-hour care for one or more of the following purposes, as determined by registered nurses appropriately trained to use an assessment instrument and employed by the department, or a designee acting on behalf of the department:
a. Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;
b. Restorative nursing or rehabilitative care with patient-specific goals;
c. Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or
d. Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence;

Requires the provision of at least one CFI waiver service, as documented in the identified needs list, and receives at least one CFI waiver service at least monthly;

Is determined by a qualified medical professional employed or designated by the department to require CFI waiver services that can be provided at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services; and

Has chosen, or whose legal representative has chosen, by signing the application in (1) above, CFI services as an alternative to institutional care.

Pursuant to 42 CFR 441.301 (b)(1)(iii) and (b)(6), eligibility shall be restricted to individuals who meet the target population criteria approved by CMS for this program and who, without the services provided by the program, would otherwise require institutional placement in a long term care nursing facility as described in He-E 802, and not services provided in a hospital, an institution for mental diseases (IMD) as defined in 42 CFR 435.1010, or an intermediate care facility for the mentally retarded (ICF/MR) as defined in 42 CFR 440.150.

While receiving care as a resident in a nursing facility, an individual shall not be eligible for coverage of CFI Waiver services

An individual shall not be considered to be a resident of a nursing facility if he or she is a CFI participant who is admitted to a nursing facility on a temporary basis for treatment or care for an acute episode.

For those CFI participants who are receiving short-term inpatient care in a hospital or nursing facility, the following shall apply:

CFI Waiver services shall not be provided while the participant is in the facility, except for services that have been prior authorized for the purpose of enabling the participant to transition back to his or her community; and

The participant's clinical eligibility shall be maintained until such time that an eligibility redetermination is conducted in accordance with He-E 801 and the participant is determined ineligible.

Eligibility Determination.
(a) The department shall make the clinical eligibility determination of the applicant as follows:

(1) A qualified medical professional employed or designated by the department shall:
a. Conduct an on-site, face-to-face visit with the applicant;
b. Perform a clinical assessment of the applicant; and
c. Develop a list of identified needs with the applicant;

(2) The applicant shall sign the following:

a. The identified needs section of the assessment, indicating his or her agreement or disagreement with the identified needs;

b. A consent for participation in the CFI program, including whether or not he or she has a preference of a case management agency;

c. An authorization for release of information; and

d. An authorization for release of protected health information;

(3) Pursuant to RSA 151-E:3, IV, if the department is unable to determine an applicant clinically eligible based on the assessment in (a) above, the department shall send notice to the applicant and the applicant's licensed practitioner(s), as applicable, requesting additional medical information within 30 calendar days of the notice and stating that the failure to submit the requested information will impede processing of the application and delay service delivery;

(4) Within the 30 day period in (3) above, if the requested information is not received, the department shall send a second notice to the applicable licensed practitioner(s), with a copy to the applicant, as a reminder to provide the requested information by the original deadline;

(5) Upon request from the treating licensed practitioner within the 30 day period in (3) above, the department shall extend the deadline in (3) above for a maximum of 30 days if the practitioner states that he or she has documentation that supports eligibility and will provide it within that time period; and

(6) If the information required by (3) above is not received by the date specified in the notice, or as extended by the department in accordance with (5) above, the applicant shall be determined to be clinically ineligible.

(b) For each applicant who meets the clinical eligibility requirements, a qualified medical professional employed or designated by the department shall estimate the costs of the provision of home-based services by identifying medical and other services, including units, frequencies, and costs, that would meet the needs identified in the assessment in (a)(1) above in order to determine if services that meet the applicant's needs can be provided at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services, pursuant to He-E 801.03(a)(6), and does not exceed the cost limits described in this waiver.

(c) The applicant shall be determined eligible for the CFI program if it is determined that the applicant meets the financial eligibility requirements described in He-W 600, the clinical eligibility requirements of He-E 801, and the other eligibility requirements in He-E 801

(d) Upon a determination of eligibility, the applicant or his or her legal representative shall be sent an approval notice, including:

(1) The name and contact information of the case management agency and case manager chosen by the applicant or assigned to the applicant by the department, if available at the time of the notice; and

(2) The eligibility start date.

(e) Upon a determination of ineligibility, because the applicant does not meet eligibility requirements or because required information is not received pursuant to (a)(6) above, the applicant or his or her legal representative shall be sent a notice of denial, including:

(1) A statement regarding the reason and legal basis for the denial;

(2) Information concerning the applicant's right of appeal pursuant to He-C 200, including the requirement that the applicant has 30 calendar days from the date of the notice of denial to file such an appeal; and

(3) An explanation that an applicant who is denied services and who chooses to appeal this denial pursuant to He-C 200 shall not be entitled to Medicaid payments for CFI services pending the appeal hearing decision.

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)*:
   - ○ **§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)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **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 §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §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 §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 §1902(e)(3) of the Act)**
- [x] **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)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Eligibility groups covered by NH's Medicaid State Plan.

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

- [x] **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: [ ]

- [x] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [x] **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:

Medically needy with spend down to or below the medically needy income standard using the state average monthly Medicaid rate for residents of nursing facilities and other incurred expenses to reduce an individual's income.

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 five-year period beginning January 1, 2014, 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 §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 §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §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 periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

○ **Spousal impoverishment rules under §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 §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 (SSI 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 §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 periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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 periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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:

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 435.726:

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

Select one:

- (●) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §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 §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.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

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 (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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:

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 435.726:

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

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
The State does not establish reasonable limits.
The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §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:

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:

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: 1

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

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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:

Skilled professional medical personnel employed by or designated to act on behalf of the department shall determine clinical eligibility for home and community based services.

The eligibility determination shall be based upon an assessment tool, approved by the department, performed by skilled professional medical personnel employed by the department, or by an individual with equivalent training

designated by the department.

Skilled professional medical personnel shall have the same meaning as in 42 C.F.R. section 432.50(d)(1)(ii). Specifically: Skilled professional medical personnel have professional education and training in the field of medical care or appropriate medical practice. “Professional education and training” means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care. The skilled professional medical personnel are in positions that have duties and responsibilities that require those professional medical knowledge and skills.

The state ensures that all evaluators are appropriately trained in the use of approved assessment tools.

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.

Individuals must meet the eligibility requirements established in RSA 151-E:3 I, which are: To be clinically eligible for Medicaid coverage of long term care, a person must require 24-hour care for one or more of the following purposes: medical monitoring and nursing care; restorative nursing or rehabilitative care; medication administration requiring medical or nursing intervention; or assistance with two or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence.

The Medical Eligibility Assessment (MEA) instrument, current Minimum Data Set (MDS) or current Outcome and Assessment Information Set (OASIS) are the approved tools for determining clinical eligibility and Waiver level of care.

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

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

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

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

For Initial Level of Care Evaluations:

The qualified medical professional evaluates the applicant in person and completes the Medical Eligibility Evaluation [MEA]instrument or reviews the information in the current MDS or OASIS.

The completed MEA, MDS or OASIS is transmitted to DHHS and reviewed by a qualified medical professional employed or under contract by the Medicaid Agency, who determines clinical eligibility and level of care for admission to the waiver program.

For Re-evaluation of Level of Care:

The Qualified medical professional evaluates the participant in person and completes the sections of the Medical

Eligibility Evaluation [MEA]tool or reviews the sections of the MDS or OASIS that are necessary to demonstrate that the participant continues to meet the criteria outlined in State Statute RSA 151-E:3 I: the need for 24-hour care for one or more of the following purposes: medical monitoring and nursing care; restorative nursing or rehabilitative care; medication administration requiring medical or nursing intervention; or assistance with two or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence.

The MEA, MDS or OASIS is transmitted to DHHS and reviewed by qualified medical personnel employed or contracted by the Medicaid Agency, who determine continued clinical eligibility and level of care for continued participation in the waiver program.

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):*

NH DHHS maintains qualified medical personnel directly employed by or under contract with the department to complete reevaluations of level of care.

NH DHHS contracts with an outside entity to assist with reevaluations.

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:

NH DHHS maintains all written and/or electronic documentation of evaluations and re-evaluations for a minimum of 3 years by scanning and uploading clinical documentation into the New Heights information system, maintenance of electronic records in the Options information system and through maintenance of paper files at DHHS.

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:
The Number and Percentage of CFI Waiver Enrollees whose LOC was determined prior to receipt of services. N = The number of new enrollees whose LOC was determined prior to receipt of services. D = The Number of new enrollees reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of initial CFI Waiver level of care determinations made by professionals who meet the definition of skilled professional medical personnel per 42 C.F.R section 432.50(d)(1)(ii). N: Number of initial CFI Waiver LOC determinations made by professionals who meet the definition of skilled professional medical personnel D: Number of initial CFI Waiver LOC determinations reviewed

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

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

		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of CFI Waiver level of care Re-determinations made by professionals who meet the definition of skilled professional medical personnel per 42 C.F.R section 432.50(d)(1)(ii). N: Number of CFI Waiver LOC Re-determinations made by professionals who meet the definition of skilled professional medical personnel D: Number of CFI Waiver LOC Re-determinations reviewed

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

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

Data Aggregation and Analysis:

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

Performance Measure:

N: Number of CFI Waiver LOC Re-determinations completed at least annually;
D: Number of CFI Waiver LOCs reviewed.

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

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

Data Aggregation and Analysis:

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

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

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 initial level of care determinations made using a state approved assessment tool. N = Number of initial LOC determinations made using a state approved assessment tool D = Number of initial LOC determinations reviewed

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of level of care Re-determinations made using a state approved assessment tool. N = Number of LOC Re-determinations made using a state approved assessment tool D = Number of LOC Re-determinations reviewed

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of CFI Waiver Service Authorization requests responded to by DHHS within 30 days. N: Number of CFI Waiver Service Authorization requests responded to by DHHS within 30 days; D: Number of CFI Waiver Service Authorization requests reviewed.

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

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

		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When individual problems are discovered, they are remediated through discussions with the enrolled Medicaid Provider by the NH DHHS Provider Relations staff, Office of Quality Assurance and Improvement or the CFI Waiver Administrator. Documentation is via email communications.

When problematic trends are suspected or confirmed, the NH DHHS Office of Quality Assurance and Improvement is engaged to conduct a formal QI review; the results of the QI review are documented and suggested remediation strategies are shared within the Department and with involved providers/provider groups. When necessary, corrective action is required, including the submission of a corrective action plan by the provider. Follow up is conducted to ensure corrective action(s) have been taken and to evaluate the effectiveness of the strategies implemented.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Eligible individuals are informed of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services in the following ways:

Through information provided by NH's Aging and Disability Resource Center [ADRC], ServiceLink/NH Carepath whose counselors receive comprehensive training and supervision by DHHS concerning the importance of each applicant being accurately informed about his/her ability to choose either institutional or community based care.

Service Link Resource Center Counselors conduct standardized education of each applicant concerning:
1. Availability of CFI Waiver services as an alternative to institutional care.
2. The range of available long term care services.
3. The appeal process if the application is denied.

In addition, case managers ensure this information is made clear to enrollees and documentation is maintained in each applicant's record of his/her choice of community based services instead of institutional services. This documentation is updated annually.

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.

Forms are developed and retained by the Department in electronic and written format.

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):
DHHS provides meaningful access to Limited English Proficient (LEP) applicants and participants through the following means:

1. At each NH DHHS District Office (DO) and at each ServiceLink Resource Center (SLRC), at least one of which is accessed by every applicant in the application and redetermination processes, there is a large poster that is prominently displayed. It shows a symbol for sign language, low vision, hard of hearing, and speaking impairment and announces in large print that assistance is available at no cost to the individual. The individual indicates his/her needs by pointing to the appropriate block.2. Every DO and SLRC has equipment available for use by applicants and participants during the application and redetermination process. This includes:

a. Pocket-talker: These small, battery-operated devices are used by people who are hard of hearing and make it possible for them to hear the person with whom they are speaking.

b. CCTV device: This enables magnification of documents for reading by people with low vision. (not all SLRCs have a CCTV)

c. Videophones: The State Office and the SLRCs have videophones that provide access to video relay services for sign language.

d. Language Line: The Language Line is available at all DOs and SLRCs and provides translation of all languages for people whose primary language is not English.

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	

Service Type	Service		
Statutory Service	Adult Medical Day Services		
Statutory Service	Home Health Aide		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Supports for Participant Direction	Financial Management Services		
Other Service	Adult Family Care		
Other Service	Adult In-Home Services		
Other Service	Community transition services		
Other Service	Environmental accessibility services		
Other Service	Home-Delivered Meals		
Other Service	Non Medical Transportation		
Other Service	Participant Directed and Managed Services		
Other Service	Personal Emergency Response System		
Other Service	Residential Care Facility Services		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Equipment Services		
Other Service	Supportive Housing Services		

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:

Adult Day Health

Alternate Service Title (if any):

Adult Medical Day 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):*
Adult medical day programs provide a protective environment individuals with cognitive impairments or who are at risk for isolation or institutionalization. Services include an array of social and health care services and provides day-time respite for primary caregivers. Services are furnished on a regularly scheduled basis, for one or more days per week.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Medical Day
Individual	Adult Medical Day Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Medical Day Services

Provider Category:
Agency
Provider Type:
Adult Medical Day
Provider Qualifications
License *(specify):*
Adult Medical Day, RSA 151:2
Certificate *(specify):*
Other Standard *(specify):*
NH Enrolled Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
NH Bureau of Licensing and Certification
Frequency of Verification:
Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Medical Day Services

Provider Category:
Individual

Provider Type:
Adult Medical Day Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
When Participant Directed and Managed: the individual or his/her representative.

Frequency of Verification:
Prior to service delivery and periodically thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Home Health Aide

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):*
Services defined in 42 CFR 440.70 that are provided in addition to home health aide services furnished under the approved State Plan. Home Health aide services under the waiver differ in nature, scope, supervision arrangements or provider type from home health aide services in the State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Home Health Aide
Agency	Agency licensed by the State under RSA 151:2, for home care services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:
Individual
Provider Type:
Home Health Aide
Provider Qualifications
License *(specify):*
Home Health Aides are individually licensed by the NH Board of Nursing under State Statute RSA 326:B; qualifications, supervision requirements and scope of practice are outlined in RSA 326: B.

Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
When Participant Directed and Managed: the individual or his/her representative.

Frequency of Verification:
Prior to service delivery and periodically thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:
Agency

Provider Type:
Agency licensed by the State under RSA 151:2, for home care services

Provider Qualifications

License *(specify):*
RSA 151:2-b

Certificate *(specify):*

Other Standard *(specify):*
Home Health Aides are individually licensed by the NH Board of Nursing under State Statute RSA 326:B; qualifications, supervision requirements and scope of practice are outlined in RSA 326: B.

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
NH Bureau of Licensing and Certification

Frequency of Verification:
Annual

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:

Homemaker

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):*
Non hands-on general household services, such as light cleaning or meal preparation.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Homemaker
Agency	Agency licensed by the State under RSA 151:2, for home care services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual
Provider Type:
Homemaker
Provider Qualifications
License *(specify):*
Home Health, RSA 151
Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

NH Enrolled Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
When Participant Directed and Managed: the individual or his/her representative.
Frequency of Verification:
Prior to service delivery and periodically therafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Agency licensed by the State under RSA 151:2, for home care services
Provider Qualifications
License *(specify):*
Home Health, RSA 151:2-b
Certificate *(specify):*

Other Standard *(specify):*
NH Enrolled Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
NH Bureau of Licensing and Certification
Frequency of Verification:
Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
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):*

Personal Care Services includes a range of individually tailored supports to assist with activities of daily living such as meal preparation, eating, bathing, dressing, personal hygiene, medication management, community inclusion, the transportation necessary to access the services outlined in the person centered plan and social and leisure skills to assist the individual to reside in the setting most appropriate to his/her needs. Supports may include hands-on assistance, cueing, personal care, protective oversight, and supervision as necessary for the health and welfare of the individual. Services and supports may be furnished in the home or outside the home.

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Care Provider
Agency	Agencies licensed by the State under RSA 151:2 for home care
Agency	Other Qualified Agencies (OQA)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual
Provider Type:
Personal Care Provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
When Participant Directed: the individual or his/her representative
Frequency of Verification:
Prior to service delivery and ongoing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Agencies licensed by the State under RSA 151:2 for home care
Provider Qualifications

License *(specify):*
RSA 151:2
Certificate *(specify):*

Other Standard *(specify):*
NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
NH Bureau of Licensing and Certification

Frequency of Verification:
Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
Other Qualified Agencies (OQA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
OQA: RSA 161 (OQA certification)

Other Standard *(specify):*
NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS certifies OQAs

Frequency of Verification:
Annual

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):*
Respite Services: Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of the caregiver normally providing the care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are limited to the equivalent of 30, 24 hour days of care per state fiscal year/participant. Services are provided in units of time that are determined appropriate by the caregiver and case manager.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Facilities licensed by the State to provide Residential Care Services
Agency	Agencies licensed by the State under RSA 151:2 for home care
Agency	Facilities licensed by the State as Nursing Facilities
Individual	Respite Provider
Agency	Agencies certified by the State as Other Qualified Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:
Facilities licensed by the State to provide Residential Care Services
Provider Qualifications
License *(specify):*
Residential care, RSA 151:2
Certificate *(specify):*

Other Standard *(specify):*
NH Enrolled Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
Bureau of Health Facilities Licensing
Frequency of Verification:
Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Agencies licensed by the State under RSA 151:2 for home care
Provider Qualifications
License *(specify):*
RSA 151:2-b, He-P 809 and He-P 822
Certificate *(specify):*

Other Standard *(specify):*
NH Enrolled Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
Bureaus of Health Facilities Licensing
Frequency of Verification:
Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Facilities licensed by the State as Nursing Facilities
Provider Qualifications
License *(specify):*
Nursing Facilities, RSA 151:2

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of Health Facilities Licensing
Frequency of Verification:
Annual

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):*

Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
When Participant Directed: the individual or his/her representative
Frequency of Verification:
Prior to service delivery and ongoing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Agencies certified by the State as Other Qualified Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*
OQA, RSA 161:I
Other Standard *(specify):*
NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Office of Quality Improvement
Frequency of Verification:
Annual

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):*
Individual Employment Services are the ongoing supports to individuals who, because of their disabilities, need intensive on-going supports to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage.

Supported employment services are individualized and may include any combination of the following services: vocational/job related discovery or assessment, person centered employment planning, job placement, job development, negotiation with prospective employers, job incentives planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 USC 1401 et seq.). FFP is not claimed for incentive payments, subsidies or unrelated vocational training expenses.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Employment Services Provider
Individual	Employment Services Provider

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 Services Provider
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Employment Services Providers must ensure that Employment Counselors meet one of the following criteria:

Have completed, or complete within the first 6 months of becoming an employment professional, training that meets the national competencies for job development and job coaching, as established by the Association of People Supporting Employment First (APSE) in “APSE Supported Employment Competencies” (Revision 2010)or

Have obtained the designation as a Certified Employment Services Professional through the Employment Services Professional Certification Commission (ESPCC), an affiliate of APSE; and

Obtain 12 hours of continuing education annually in subject areas pertinent to employment professionals including, at a minimum:

Employment;

Customized employment;

Task analysis/systematic instruction;

Marketing and job development;

Discovery;

Person-centered employment planning;

Work incentives for individuals and employers;

Job accommodations;

Assistive technology;

Vocational evaluation;

Personal career profile development;

Situational assessments;

Writing meaningful vocational objectives;

Writing effective resumes and cover letters;

Understanding workplace culture;

Job carving;

Understanding laws, rules, and regulations;

Developing effective on the job training and supports;

Developing a fading plan and natural supports;

Self-employment; and

School to work transition.

At a minimum, job coaching staff shall be trained on all of the following prior to supporting an individual in employment:

Understanding and respecting the business culture and business needs;

Task analysis;

Systematic instruction;

How to build natural supports;

Implementation of the fading plan;

Effective communication with all involved; and

Methods to maximize the independence of the individual on the job site.

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Office of Quality Improvement

Frequency of Verification:
Annually

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 Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Employment professionals shall:

Meet one of the following criteria:

Have completed, or complete within the first 6 months of becoming an employment professional, training that meets the national competencies for job development and job coaching, as established by the Association of People Supporting Employment First (APSE) in “APSE Supported Employment Competencies” (Revision 2010)or

Have obtained the designation as a Certified Employment Services Professional through the Employment Services Professional Certification Commission (ESPCC), an affiliate of APSE; and

Obtain 12 hours of continuing education annually in subject areas pertinent to employment professionals including, at a minimum:

Employment;

Customized employment;

Task analysis/systematic instruction;

Marketing and job development;

Discovery;

Person-centered employment planning;

Work incentives for individuals and employers;

Job accommodations;

Assistive technology;

Vocational evaluation;

Personal career profile development;

Situational assessments;

Writing meaningful vocational objectives;

Writing effective resumes and cover letters;

Understanding workplace culture;

Job carving;

Understanding laws, rules, and regulations;

Developing effective on the job training and supports;

Developing a fading plan and natural supports;

Self-employment; and

School to work transition.

At a minimum, job coaching staff shall be trained on all of the following prior to supporting an individual in employment:

Understanding and respecting the business culture and business needs;

Task analysis;

Systematic instruction;

How to build natural supports;

Implementation of the fading plan;

Effective communication with all involved; and

Methods to maximize the independence of the individual on the job site.

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When Participant Directed and Managed: the individual or his/her representative.

Frequency of Verification:
Prior to service delivery and periodically thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

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):*
Service/function that assists the family or participant to: manage and direct the disbursement of funds contained in the participant-directed budget; facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding Federal, state and local tax and making tax payments to appropriate tax authorities; and performing fiscal accounting and making expenditure reports to the participant or family and state authorities.

Financial management services include employer functions such as assisting the participant to verify worker citizenship status, ensure criminal record and/or state or federal registry status is checked and confirmed, and

process payroll. Budget management services include maintaining a separate account for each participant's 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.

FMS also includes furnishing orientation/skills training to participants about their responsibilities when they function as the co-employer of their direct support workers.

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services Provider
Individual	Financial Management Services Provider

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Financial Management Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrollment as a NH Medicaid FMS Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS

Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Financial Management Services Provider
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Enrollment as a NH Medicaid FMS Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
When participant directed and managed: the individual or his/her representative
Frequency of Verification:
Prior to service delivery and ongoing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Adult Family Care

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):*
Personal care and services, homemaker, attendant care and companion services, and medication oversight (to the extent permitted by State law) provided in a licensed or certified (as required by law) private home by a principal care provider who lives in the home. Adult Family Care (AFC) services are provided to participants who receive them in conjunction with residing in the home. There shall be no more than 2 unrelated individuals living in the home, including participants in the Program. Separate payment shall not be made for homemaker services to participants receiving AFC, as those services are integral to and inherent in the provision of AFC.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	DHHS approves providers to provide caregiver oversight. AFC homes meet the requirements established in law.
Individual	Adult Family Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Care

Provider Category:
Agency
Provider Type:
DHHS approves providers to provide caregiver oversight. AFC homes meet the requirements established in law.
Provider Qualifications
License *(specify):*
RESIDENTIAL CARE AND HEALTH FACILITY LICENSING laws:
RSA 151:2 as follows:
II. This chapter shall not be construed to require licensing of the following:
(b) Facilities maintained or operated for the sole benefit of persons related to the owner or manager by blood or marriage within the third degree of consanguinity.
151:9 as follows:
VIII. The commissioner of the department of health and human services shall establish a program, by rule, to certify facilities that provide services to fewer than 3 individuals, beyond room and board

care, in a residential setting, as an alternative to nursing facility care, which offers residents a home-like living arrangement, social, health, or medical services, including, but not limited to, medical or nursing supervision, medical care or treatment by appropriately trained or licensed individuals, assistance in daily living, or protective care.

Certificate *(specify):*

RESIDENTIAL CARE AND HEALTH FACILITY LICENSING laws:
151:9 as follows:
VIII. The commissioner of the department of health and human services shall establish a program, by rule, to certify facilities that provide services to fewer than 3 individuals, beyond room and board care, in a residential setting, as an alternative to nursing facility care, which offers residents a home-like living arrangement, social, health, or medical services, including, but not limited to, medical or nursing supervision, medical care or treatment by appropriately trained or licensed individuals, assistance in daily living, or protective care.

Other Standard *(specify):*

These private homes are certified, based on their size, as required by law and serve no more than two unrelated persons.

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS approves the caregiver oversight agencies if they are licensed or certified to provide personal care and homemaking services, and have expertise in arranging home placements for adults. The NH Bureau of Licensing and Certification certifies the homes as required by state law.

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Care

Provider Category:

Individual

Provider Type:

Adult Family Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When participant directed: the individual of his/her representative

Frequency of Verification:

Prior to service delivery and ongoing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult In-Home 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):*

Non-medical care, supervision and socialization provided to isolated individuals to prevent institutionalization. When specified in the comprehensive care plan, this may include meal preparation, light housekeeping, laundry and shopping which are essential to the health and welfare of the participant. In-home services do not include hands-on care. Home health agencies that provide this service are not required to be certified to provide Medicare services.

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Adult in Home Care Provider
Agency	Agency licensed by the State under RSA 151:2, for home care services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult In-Home Services

Provider Category:
Individual
Provider Type:
Adult in Home Care Provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
When Participant Directed and Managed: the individual or his/her representative.
Frequency of Verification:
Prior to service delivery and periodically thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult In-Home Services

Provider Category:
Agency
Provider Type:
Agency licensed by the State under RSA 151:2, for home care services
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home Health or Homemaker RSA 151:2-b
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Bureau of Health Facilities Licensing
Frequency of Verification:
Annually

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 transition 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):*
Non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: security deposits that are required to obtain a lease on an apartment or home, essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, household appliances and utensils necessary for basic food preparation and not for diversionary or recreational purposes; bed/bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy. Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community transition services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Services must be prior authorized by DHHS and are limited to $1,500/person per transition. This limit is independent of other service limits. This service does not include payment for rent. The payment of a security deposit is not considered rent.

Community Transition Services are one time services and represent one time costs; in the event that costs related to this service negatively impact the cost effectiveness of an individual's budget, Commissioner approval should be sought to eliminate any potential barrier to an individual transitioning from an institutional or other provider operated living arrangement.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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 Transition Services
Agency	CFI Waiver Medicaid Enrolled Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community transition services

Provider Category:

Individual

Provider Type:

Community Transition Services

Provider Qualifications

License *(specify):*

When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

NH Enrolled Medicaid Provider

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
When Participant Directed: the individual or his/her representative

Frequency of Verification:
Prior to service delivery and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community transition services

Provider Category:
Agency

Provider Type:
CFI Waiver Medicaid Enrolled Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled CFI Waiver Medicaid Providers

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Office of Quality Improvement

Frequency of Verification:
Annually

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 accessibility 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):*
Physical adaptations to the Participant's home or vehicle, articulated in the person centered plan, which are necessary to ensure the health, welfare and safety of the Participant or which will enable the Participant to function with greater independence and, without which, the Participant would require institutionalization. Services may include the installation of grab-bars, widening of doorways, modification of bathroom facilities, installation of a ramp or other adaptations to allow an individual to be safely transported in a vehicle, or installation of specialized electric equipment or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the health and welfare of the Participant. Adaptations or improvements that are of general utility, add to the square footage of the home, or are not of direct medical or remedial benefit to the Participant, such as carpeting, roof repair, or air conditioning, are not included in this service. Does not include the purchase of a vehicle.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services must be prior authorized by DHHS, and are limited to $15,000 per Participant per five year period. This limitation is applied to this service independently of specified limits on other services (e.g.: Specialized Medical Equipment Services).

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Environmental Accessibility provider
Agency	Environmental Accessibility Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental accessibility services

Provider Category:
Individual

Provider Type:
Environmental Accessibility provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Potential providers must be:
(1.) Licensed if the work to be completed requires licensure;
(2.) Registered with the NH secretary of state to do business in the state of NH;
(3.) Insured with general liability insurance for person and property for a minimum amount of $50,000; and
(4.) Have submitted documentation of (1)-(3) above to the department's fiscal agent and be a NH Medicaid enrolled provider

Verification of Provider Qualifications

Entity Responsible for Verification:
When Participant Directed and Managed: the individual or his/her representative.

Frequency of Verification:
Prior to service delivery and periodically thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental accessibility services

Provider Category:
Agency

Provider Type:
Environmental Accessibility Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Potential providers must be:
(1.) Licensed if the work to be completed requires licensure;
(2.) Registered with the NH secretary of state to do business in the state of NH;
(3.) Insured with general liability insurance for person and property for a minimum amount of $50,000; and

(4.) Have submitted documentation of (1)-(3) above to the department's fiscal agent and be a NH Medicaid enrolled provider

Verification of Provider Qualifications

Entity Responsible for Verification:
NH Enrolled Medicaid Provider

1. Prior to enrollment:
i. The Medicaid Fiscal Agent receives the documentation required above and informs DHHS that an EAA provider has applied for enrollment;
ii. The Fiscal Agent confirms that the provider meets the standards above and, if they do meet the standards;
iii. Enrolls the provider in the MMIS and informs DHHS of the enrollment; and
iv. DHHS enters the provider information in the DHHS database so that DHHS nurses and case managers can see that this provider is available to participants.

2. Post-enrollment: DHHS performs annual reviews to determine whether providers continue to meet the requirements.

Frequency of Verification:
The verification process described above is used prior to enrollment, with a post-enrollment verification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Home-Delivered Meals

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 provides the delivery of a nutritionally balanced meal to the Participant's home, that provides at least one-third of the recommended dietary allowances established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, as well as the Dietary Guidelines for Americans issued by the Secretary of the US Department of Health and Human Services and Agriculture. Further, emergencies or potentially harmful situations encountered during the delivery are reported to the appropriate manager.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	All qualified nutrition providers

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
All qualified nutrition providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
a dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutritional services

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Office of Quality Improvement

Frequency of Verification:

Annual

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):*

Non medical transportation is provided to enable participants to access the personal care services services articulated in the person centered plan.

Transportation services provided under this waiver are non-medical transportation services and do not duplicate the medical transportation provided under the Medicaid State Plan.

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

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

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

☑ **Provider managed**

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 Staff
Agency	Non Medical Transportation Provider

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 Staff
Provider Qualifications
License *(specify):*
Must be at least 18 years of age and have a valid and current driver's license
Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

NH Enrolled Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
When participant directed, the individual or his/her designee
Frequency of Verification:
Prior to service delivery and ongoing thereafter

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:
Non Medical Transportation Provider
Provider Qualifications
License *(specify):*
All drivers must be at least 18 years of age and have a valid and current driver's license.

Certificate *(specify):*

Other Standard *(specify):*
The following providers may provide Non-Medical Transportation: NH Medicaid enrolled providers:
1. NH Licensed Home Health Care Agencies enrolled as NH Medicaid Providers
2. NH Licensed Home Care Service Agencies enrolled as NH Medicaid Providers
3. Other Qualified Agencies [OQA'a}enrolled as NH Medicaid Providers and certified according to NH State statute and administrative rule;
4. Agencies under contract with the Department to provide community based services, which include the provision of transportation, funded by the Older American's Act or the Social Services Block Grant.

Providers of non medical transportation services must develop policies and procedures outlining requirements for individual license verification, insurance requirements and driver record checks for staff providing non medical transportation

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Office of Quality Improvement
Frequency of Verification:
Upon initial enrollment and periodically thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Participant Directed and Managed 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):*
PDMS assist waiver participants to avoid institutionalization and function in the community by affording the option to exercise choice and control over a menu of waiver services and utilization of DHHS authorized funding.

This service category includes an individually tailored and personalized combination of services and supports for individuals in order to meet the individual's need for transportation, opportunities and experiences in living, working, socializing, personal growth, safety and health.

Authorized services that are directed and managed by the individual who is actively involved in all aspects of the service arrangement include: Designing the services; Selecting the service providers; Deciding how the authorized funding is to be spent based on the needs identified in the person centered plan; and performing ongoing oversight of the services provided.

The participant may engage a legal representative to assist with participant direction and management.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Participant Directed and Managed Services
Agency	Participant Directed and Managed Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Directed and Managed Services

Provider Category:
Individual
Provider Type:
Participant Directed and Managed Services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
When participant directed and managed: the individual or his/her representative

Frequency of Verification:
Prior to service delivery and ongoing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Directed and Managed Services

Provider Category:
Agency

Provider Type:
Participant Directed and Managed Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
When participant directed and managed: the individual or his/her representative

Frequency of Verification:
Prior to service delivery and ongoing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

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):*

An electronic device that enables participants at high risk of institutionalization and who are alone for periods of time to summon help in an emergency. The Participant may also wear a portable "help" button to allow for mobility. The system is connected to the Participant's telephone and programmed to signal a response center when activated. The response center is staffed by trained professionals 24 hours/day, seven days/week.

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

Services are limited to participants who live alone or who are alone for significant parts of the day who would otherwise require extensive supervision.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency response system providers

Provider Category	Provider Type Title
Individual	Emergency response system providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:
Emergency response system providers
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
NH Medicaid Enrolled Provider of Emergency Response Services
Verification of Provider Qualifications
Entity Responsible for Verification:
When Participant Directed and Managed: the individual or his/her representative.
Frequency of Verification:
Prior to service delivery and periodically thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Individual
Provider Type:
Emergency response system providers
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
When Participant Directed and Managed: the individual or his/her representative.

Frequency of Verification:
Prior to service delivery and periodically thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Residential Care Facility 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):*
Supportive services provided in a licensed facility, including: Assistance with activities of daily living and incidental activities of daily living; Personal care; 24 hour supervision; Incontinence management; Dietary planning; Non-medical transportation to community based services and supports necessary to access the home and community based supports outlined in the person centered plan; and any other activities that promote and support health and wellness, dignity and autonomy within a community setting. Shared bedrooms do not accommodate more than two people. Personal care services listed above as part of this service are included in the rate paid to the provider and are not separately billed.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Residential Care Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Care Facility Services

Provider Category:
Agency
Provider Type:
Residential Care Facility
Provider Qualifications
License *(specify):*
Residential Care, RSA 151:2
Certificate *(specify):*

Other Standard *(specify):*
Enrolled NH Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
NH Bureau of Licensing and Certification
Frequency of Verification:
Annual

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:
Skilled Nursing

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 listed in the comprehensive plan of care that are within the scope of the state's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. This service provides intermittent skilled nursing services on a long term basis.

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Skilled Nursing
Agency	Home Care Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:
Skilled Nursing
Provider Qualifications
License *(specify):*
Registered Nurse or Licensed Practical nurse under the supervision of a registered nurse, licensed to practice in the State of NH.
Certificate *(specify):*
Other Standard *(specify):*
Be an Enrolled NH Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
When participant directed: the individual or his/her representative
Frequency of Verification:
Prior to service delivery and ongoing

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency
Provider Type:
Home Care Service Provider
Provider Qualifications
License *(specify):*
Agency licensed by the State under RSA 151:2, for home care services

Registered Nurse or Licensed Practical nurse under the supervision of a registered nurse, licensed to practice in the State of NH.
Certificate *(specify):*
Other Standard *(specify):*
Enrolled NH Medicaid Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
NH Bureau of Licensing and Certification
Frequency of Verification:
Annual

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:

Specialized Medical Equipment 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):*

Specialized Medical Equipment and Supplies include: (a) devices, controls or appliances that are specified in the comprehensive care plan which enable participants to increase their ability to perform activities of daily living; (b) devices, controls or appliances that are specified in the comprehensive care plan to perceive, control or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. The participant is included throughout the evaluation and selection process, and has a choice of provider when more than one provider is available.

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

Purchases must be prior authorized by the DHHS, and are limited to $15,000 per participant for every five year period. This limit is applied to this service independently of specified limits on other services.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Durable medical equipment and supply providers enrolled as NH Medicaid Providers
Individual	Durable medical equipment and supply providers enrolled as NH Medicaid Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment Services

Provider Category:

Agency

Provider Type:

Durable medical equipment and supply providers enrolled as NH Medicaid Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled in the NH Medicaid Program to provide medical equipment or supplies.

Verification of Provider Qualifications

Entity Responsible for Verification:

When Participant Directed and Managed: the individual or his/her representative.

Frequency of Verification:

Prior to service delivery and periodically thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment Services

Provider Category:

Individual

Provider Type:

Durable medical equipment and supply providers enrolled as NH Medicaid Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing

or certification requirements.

NH Enrolled Medicaid Provider
Enrolled in the NH Medicaid Program to provide medical equipment or supplies.

Verification of Provider Qualifications

Entity Responsible for Verification:
When Participant Directed and Managed: the individual or his/her representative.

Frequency of Verification:
Prior to service delivery and periodically thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Supportive Housing 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):*
Services provided by a licensed agency in apartments located in publicly funded apartment buildings that include: Personal care services, including assistance with activities of daily living and instrumental activities of daily living; Supervision; Medication reminders; and other supportive activities as specified in the comprehensive care plan or which promote and support health and wellness, dignity and autonomy within a

community setting. Personal care, medication reminders and other services identified as part of this service are included in the rate paid to the provider and can not be separately billed.

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Agency licensed by the State under RSA 151:2, for home health care services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supportive Housing Services

Provider Category:
Agency

Provider Type:
Agency licensed by the State under RSA 151:2, for home health care services

Provider Qualifications

License *(specify):*
RSA 151:2-b

Certificate *(specify):*

Other Standard *(specify):*
NH Medicaid Enrolled Provider

Verification of Provider Qualifications

Entity Responsible for Verification:
NH Bureau of Licensing and Certification

Frequency of Verification:
Annual

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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *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:

NH enrolls private agencies that are licensed as case management providers and enrolled to provide targeted case management services in accordance with the approved State Plan and NH administrative rules. They support the individual in the development, implementation and monitoring of the person centered plan.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal background checks at the State level are required as part of the licensing and certification process for personal care service workers, adult family care providers, residential care providers, adult day providers, home health providers, homemaking providers, and shared housing providers, and is ensured by the Bureau of Health Facilities Licensing. *** Home delivered meals providers are required by their contract with the Department to screen workers, and compliance is checked through contract compliance reviews conducted by the Department.

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; and, (c) the process for ensuring that mandatory screenings have been conducted. 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):

DHHS is responsible for maintaining the state-wide abuse registry. The first tier of enforcement is the law, RSA 161-F:49, which states that "All employers of programs which are licensed, certified, or funded by the department to provide services to individuals shall be required before hiring a prospective employee, consultant, contractor, or volunteer who may have contact with individuals to submit his or her name, for review against the registry to determine whether the person is on the registry." This law also directs the Department in what actions it must take to investigate and then notify the potential employer.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Residential Care Facilities	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

NH has undertaken, as part of its Statewide Transition Plan [STP], an assessment of settings to ensure that services provided to CFI Waiver participants are provided in a home and community based setting, including those where four or more participants are served. The state's review highlighted the need for technical assistance, training and continued monitoring to ensure that all settings maintain a home and community character, consistent with the character of the of others who are not receiving waiver services to the greatest extent possible; provide opportunities for activities, community participation and community integration in order to prevent isolation; locks on bedroom doors and other strategies to ensure privacy and ensuring choice and control of daily activities.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Specialized Medical Equipment Services	☐
Personal Emergency Response System	☐
Non Medical Transportation	☐
Adult Medical Day Services	☐
Homemaker	☐
Respite	☑
Home-Delivered Meals	☐
Residential Care Facility Services	☑
Skilled Nursing	☐
Supported Employment	☐
Adult Family Care	☐

Waiver Service	Provided in Facility
Financial Management Services	☐
Participant Directed and Managed Services	☐
Environmental accessibility services	☐
Adult In-Home Services	☐
Supportive Housing Services	☐
Community transition services	☐
Home Health Aide	☐
Personal Care	☐

Facility Capacity Limit:

Each facility is individually licensed for the capacity allowed by its structure. Greater details are provided in the service description.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

N/A

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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar

services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

  The State makes payment to legally responsible persons for the provision of personal care and similar services as delineated in Appendix C-1 when the individual is Directing his/her services under Participant Direction and has indicated this arrangement as their choice for the provision of services.

  The State also makes payment to legally responsible persons for personal care and similar services as delineated in Appendix C-1 when:

  An individual requires extraordinary care, as demonstrated by a state approved assessment tool, which exceeds the ordinary care that would be provided to a person without a disability of the same age;

  An individual is unable to access non-legally responsible personal care providers because of geographic, cultural or other factors limiting availability of care providers;

  In order to ensure that the provision of personal care or other services is in the best interest of the individual, the Case Manager will discuss with the individual the benefits and challenges associated with this arrangement.

  The decision to make payment to legally responsible individuals for furnishing personal care or other services as delineated in Appendix C will be documented in the Person Centered Plan and re-evaluated by the Case Manager during routine case management contacts and at least annually when the Person Centered Plan is updated.

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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.

Payment is made through enrolled providers and not directly to relatives/legal guardians. The enrolled provider ensures that employees are qualified and that payment is made only for services rendered.

Service Review Audits of selected records are conducted by DHHS to ensure payments are made only for services rendered.

Documentation requirements are the same for family, legally responsible persons and non-family providers.

Case managers are in regular contact with the participant to ensure that services are rendered in keeping with the Person Centered Plan.

○ **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:

All willing and qualified providers have the opportunity to enroll as waiver service providers. Provider enrollment is managed by the State's Medicaid fiscal agent [Xerox]. All providers must meet the requirements articulated in the NH Medicaid Provider Agreement [https://nhmmis.nh.gov/portals/wps/portal/EnterpriseHome].

Specifically providers agree to the following:

I agree that my charges for services or items delivered to NH Title XIX Program recipients will not exceed my fees or charges for similar services or items delivered to persons not entitled to receive benefits under the NH Title XIX Program. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to NH Title XIX Program recipients are not greater than charges for services to non-NH Title XIX Program individuals, the New Hampshire Department of Health and Human Services, hereinafter referred to as the Department, or its authorized representatives will make such determination.

I agree to accept payments made by NH Title XIX Program as payments in full for the services or items I may provide, and to retain records supporting each claim on which NH Title XIX Program makes any payment (including crossover claims) for a period of not less than six years.

I agree that in any case or cases where it becomes necessary for State or Federal representatives to ascertain the appropriateness and necessity of care or services, the Department, or its authorized representatives, will determine the appropriateness and necessity of care or services.

I agree to keep such records as are necessary to fully disclose the extent of the care or services provided to individuals under the NH Title XIX Program and to furnish the Department with such information (original or photocopied) regarding any payment claimed, as may be requested. I recognize that, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulation at 45 CFR 164:512(d), such information is a permitted disclosure of personal health information without authorization for oversight of the NH Title XIX Program.

I agree that as a condition of NH Title XIX Program participation, I will disclose, within 35 days of the date on a request by the Secretary or the Department, ownership information including full and complete information about the ownership of any subcontractor or wholly-owned supplier with whom I have had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request, ownership information and any significant business transactions between myself and any wholly owned supplier, or between myself and any contractor, during the 5-year period ending on the date of the request.

I acknowledge that I have an obligation to regularly screen all employees and contractors (utilizing the List of Excluded Individuals/Entities-LEIE-website at http://www.oig.hhs.gov/fraud/exclusions.asp and/or any other exclusion lists or instructions provided by NH Title XIX Program) to determine whether any of them have been excluded from participation in Federal health care programs, to report to Title XIX any exclusion information

discovered, and I agree to comply with these obligations.

I agree to maintain current required permits, licenses, certifications, or other documentation that allows me to continue in my practice.

I agree that I will comply with the requirements of Section 1902(a)(68) of the Social Security Act regarding Employee Education About False Claims Recovery and that I have a responsibility to self identify if I qualify as an "entity" and if I have met the $5,000,000 annual threshold amount, as described in the Act.

I agree to disclose to the Department the name of any owners, officers, directors, agents, and managing employees of my business who have been or who are convicted of fraud against any programs under Titles XVIII, XIX, or XX of the Social Security Act.

I acknowledge that I may be suspended or terminated from participation in the NH Title XIX Program if convicted of a criminal offense under the Medicare or Title XIX Program, or if the Department administratively determines that fraud exists, or for failure to disclose ownership information as required. Moreover, I agree that in the event my license is revoked or I am disqualified through state action, or federal or Department administrative action this Agreement is automatically terminated. All of the above are considered to be adverse actions. Claims cannot be submitted for any dates of service that occur while an adverse action is in effect.

I acknowledge and agree that either party may terminate this agreement without cause with a 60 day written notice to the other party.

I agree not to sell or provide my accounts receivable for NH Title XIX Program recipients to bill collection agencies, similar entities, or any other third party.

I agree to abide by all rules, regulations, billing manuals, bulletins and notices promulgated by the US Department of Health and Human Services, the State of NH, or the NH Department of Health and Human Services pertaining to the provision of care or services under NH Title XIX and the claiming of payments for those services.

I agree that I may be required to refund, or have payment recouped by the NH Title XIX program for both the state and federal share of any overpayments, including erroneous payments, erroneously claimed payments, payments made for non-compliant claims, payments in excess of the amount allowed, fraudulent claims or claims identified in accordance with the exclusion provisions of 42 CFR 1001.1901(b).
I agree that payment may be withheld because of a non-conforming claim for whatever cause until such non-conforming claim can be remedied.

I agree to take no action or adopt any procedure that would circumvent or deny the Title XIX recipient’s freedom to choose any willing Title XIX provider in accordance with the Freedom of Choice provisions of 42 CFR 431.51.

I 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.

I agree that the US Department of Health and Human Services, its authorized representatives, and the Medicaid Fraud Control Unit of the NH Attorney General's Office will have access to the same records and information as does the NH Department of Health and Human Services.

In the event I select electronic direct deposit transfer payments for claims reimbursement, I agree to sign and submit the NH Title XIX Program Electronic Funds Transfer (EFT) Agreement.

In the absence of statements imprinted on all provider claim forms as specified in 42 CFR 455.18, I agree that for each claim I submit to NH Title XIX Program for payment, I am certifying my compliance with the following requirements as stated in 42 CFR 455.18, as though the statements and my signature were present on the claim form:
(1) This is to certify that the foregoing information is true, accurate, and complete.
(2) I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

If I am a "performing-only provider," I agree that I will not independently bill and receive payment from the NH

Title XIX Program, and that any such payments may be recouped by the Department. ("Performing-only providers" are providers that the Title XIX Program, in accordance with federal and/or state law, does not allow to independently enroll and bill. Performing-only providers must be affiliated with a NH Title XIX program enrolled Group (provider). The Department designates those providers and provider types that are restricted to performing-only status in accordance with federal regulations. Designation as "performing-only" will be determined by the Department and indicated on the last page of the authorized copy of the Provider Participation Agreement which is returned to the provider upon the approval of the provider enrollment application.

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:
N= number of providers continuing to meet applicable requirements following enrollment, D= number of service providers reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
N= the number of new providers who meet state qualifications; D = the number of new providers reviewed.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State 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:
The number and percent of enrolled Environmental Accessibility Adaptation providers whose qualifications were reviewed annually. N = The number of EAA providers annually reconfirmed. D = The total number of EAA providers.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of Environmental Accessibility Adaptation providers whose qualifications were reviewed prior to enrollment N = The number of EAA providers whose qualifications were confirmed pre-enrollment. D = The number of new EAA providers.

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

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

Data Aggregation and Analysis:

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

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:
The number and percent of licensed providers whose records contain evidence that they meet provider training requirements upon review. N = The number of licensed providers with documentation of training. D = The total number of licensed providers reviewed.

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

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

		95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of annual recertifications of Other Qualified Agencies (OQAs) during which the Department is able to confirm that training has been provided as required by the State. N = The number of OQAs whose recertification documentation included proof of required training. D = The total number of OQAs recertified.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
	☐ **Weekly**	☑ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When individual problems are discovered, they are remediated through discussions with the enrolled Medicaid Provider by the NH DHHS Provider Relations staff, Office of Quality Improvement or the CFI Waiver Administrator. Documentation is via email communications.

When problematic trends are suspected or confirmed, the NH DHHS Office of Quality Assurance and Improvement is engaged to conduct a formal QI review; the results of the QI review are documented and suggested remediation strategies are shared within the Department and with involved providers/provider groups. When necessary, corrective action is required, including the submission of a corrective action plan by the provider. Follow up is conducted to ensure corrective action(s) have been taken and to evaluate the effectiveness of the strategies implemented.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Choices for Independence Waiver is designed to support adults with chronic illnesses, disabilities and elders. It does so by providing long term supports and services (LTSS) for individuals that are clinically eligible for nursing home placement, but choose to live in the community or at home. The definition of community includes many types of non-facility based care.

Just prior to the submission of this Waiver Renewal Request [during the fall of 2015 and winter of 2016] the settings in which CFI Waiver services are provided were included in an in-depth evaluation to determine the extent to which they meet federal HCBS settings requirements. This evaluation was submitted to CMS in March 2016 as part of New Hampshire's Statewide Transition Plan as noted in Module 1, Attachment #2 and is, as of January 2017, pending review and approval by CMS. The State will implement its Statewide Transition Plan as soon as it is approved to ensure all settings meet federal HCB settings requirements ongoing.

Description of Settings:

Adult Day Services: a program that provides one or more of the following services, for fewer than 12 hours a day, to participants 18 years of age and older:
(1) Supervision;
(2) Assistance with ADLs;
(3) Nursing care;
(4) Rehabilitation;
(5) Recreational, social, cognitive and physical stimulation; and
(6) Nutrition.

Adult Family Care Residence: a housing option for eligible individuals under the New Hampshire choices for independence waiver program, which includes a combination of personal care, homemaking and other services that are provided to a person in the certified residence of an unrelated individual in accordance with a person-centered plan.

Assisted Living Residence, Residential Care Services: means a long term care residence providing personal assistance at the residential care level pursuant to RSA 151:9, VII(a)(1).

Supported Residential Health Care Services: means a long-term care residence providing personal assistance at the supported residential care level pursuant to RSA 151:9VII(a)(2).

The following service areas were considered to be in compliance based on the Setting Rule Review. The services are provided in a participant’s home:

Certified Other Qualified Agencies: means an entity certified in accordance with He-E 601 to offer personal care services and/or intermediary services.

Home Health Care Services: means any organization or business entity, whether public or private, whether operated for profit or not, which is engaged in arranging or providing, directly or through contract arrangement, one or more of the following services: nursing services, home health aide services, or other therapeutic and related services, which can include but are not limited to, physical and occupational therapy, speech pathology, nutritional services, medical social services, personal care services and homemaker services which may be of a preventative, therapeutic, rehabilitative, health guidance or supportive nature to persons in their places of residence.

The in-depth evaluation conducted to determine compliance with HCB Settings Requirements is described below. Please note that NH used the same process and approach for evaluation of all of its 1915c waivers; hence, there is language in the description that references other waivers, including NH's Developmental Disabilities and Acquired Brain Disorders Waiver in addition to the CFI Waiver.

Provider Self Assessments - The initial survey effort included outreach to providers requesting that they complete a self-assessment specific to the settings requirements. There were 1,513 provider self-assessment responses across the three waivers including residential and non-residential providers. The surveys were distributed broadly via email, mail (when no email contact information was available), and through the Area Agency system. The surveys were not mandated and although tracking was possible, not all respondents included their address or the waiver type. The responses were general at best with minimal documentation of compliance across 100% of domains. While we were confident of compliance in many areas, the self-assessments were not as helpful due to the volume of unanswered areas.

Participant Surveys – The data from participants was collected in several ways. Surveys were provided to Area Agency staff for DD and ABD Waiver participants and Case Managers and Ombudsman's Office for CFI participants to assist with the surveys which focused on the participant's assessment of the extent to which their services/supports were home and community based. Additionally, Community Participation providers were asked to assist with data collection. There were 476 general participant survey responses from among the DD/ABD and CFI waivers. In addition, individual participant surveys were conducted, when possible, at each validation site visit. The questions were the same and data was entered into the database. There were 383 additional participant responses from among the DD/ABD and CFI waivers for a total of 859 survey responses.

Validation Visits - the State utilized non-state employee experts in the field of home and community based services to conduct on-site validation visits to evaluate the extent to which services were in compliance with the Settings Requirements. In addition the Department's Office of Program Support, which conducts certification reviews of community residences assisted by completing unannounced on-site visits to providers who were chosen for a validation visit but who declined to schedule a visit with one of the state's expert validators.

As reported in NH's Statewide Transition Plan, for CFI waiver settings, New Hampshire gathered information on 56 settings that provide services. There were 56 providers and 56 participants who gave information regarding residential services or day services. There were 43 residential providers and 43 participants interviewed as well as 13 non-residential providers and 13 participants. The total number of visits reflects 59% of the total number of residential sites (73) and 100% of the number of non-residential sites (13) providing Home and Community Based Services, which is statistically significant with a high level of confidence.

The findings of the CFI settings validation visits highlighted the need for implantation of strategies to address the following:

Enhance opportunities for activities, community participation and community integration in order to prevent isolation;

Investigate opportunities to pilot innovative options for ensuring community participation and integration;

Identify ways that participants can have greater access to their own personal funds;

Enhance the participants input into the decision making about their choice of setting;

To enhance the choices for participants, adopt and implement the philosophy of emphasizing the least restrictive setting when identifying the options available regarding where to live;

Develop training for participants, their families and guardians regarding HCBS expectations;

Ensure that there are locks on all bedroom and bathroom doors for privacy;

Enhance participants' ability to make their own decisions;

Develop processes for participants to have keys to their homes and or rooms;

Implement a process to identify and document when access is limited in a provider setting;

Update provider policies regarding informed choice;

Enhance process for implementation of care plans/person centered planning to ensure optimal input of participant; and,

Update Settings Agreements for all residential sites, to be sure all HCBS expectations are met.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Person Centered Plan

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 *(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:

Case managers are employed by a Case Management Agency or by the participant when participant directed and managed services are used.

Targeted Case Management services are provided under the NH Medicaid State Plan and the requirements for case management services are specified in NH State Administrative Rule He-E 805.

Targeted Case Management Services, and the qualifications are as follows:

805.02 Definition: “Case manager” means an individual employed by, or contracted with, a case management agency who:
(1) Meets the qualifications described in He-E 805.06;
(2) Is responsible for the ongoing assessment, person-centered planning, coordination and monitoring of the provision of services included in the comprehensive care plan; and
(3) Does not have a conflict of interest.
805.06 Qualification Requirements for Case Managers.
(a) Case managers employed by case management agencies shall have the following minimum requirements:
(1) Have demonstrated knowledge of the local service delivery system and the resources available to participants;
(2) Have demonstrated knowledge of the development and provision of integrated, person-centered services; and

(3) Have a degree in a human-services related field and one year of supervised experience, or a combination of training and experience that provides the knowledge base required in (1) and (2) above.
(b) Case manager supervisors employed by case management agencies shall have the following minimum requirements:
(1) Have a bachelor’s level degree; or
(2) Be a registered nurse with 2 years of related experience.
(c) Case management agencies shall not employ individuals who:
(1) Have a felony conviction;
(2) Have been found to have abused, neglected or exploited an individual based on a protective investigation completed by the BEAS in accordance with He-E 700 and an administrative hearing held pursuant to He-C 200, if such a hearing is requested; or
(3) Are listed in the state of NH central registry of abuse, neglect or exploitation pursuant to RSA 169-C: 35 or the BEAS state registry pursuant to RSA 161-F:49.

- ☐ **Social Worker**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *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.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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.

Participants have the opportunity to actively lead and engage in the development of the person centered plan, including identifying individuals who will be involved in the process.

Applicants and participants can access information about supports and services through New Hampshire's Aging and Disability Resource Center [ADRC], known in NH as Service Link Resource Centers [http://www.servicelink.nh.gov/]

Service Link provides a wide array of information about supports available to individuals with disabilities and elders and, through the NH Care Path, provides specific guidance to individuals seeking community based long term supports and services [http://www.nhcarepath.dhhs.nh.gov/].

Information made available to applicants and participants includes, but is not limited to:

Elderly and adult services and supports
Financial assistance and payment options for services
Housing resources
Information about Medicaid
Resources for managing mental health, emotional or behavioral health
Understanding personal and legal rights
Resources for managing Substance Misuse and Disorders
Transportation resources
Services specifically tailored for individuals seeking long term supports and services

Participants are supported by their case manager to access information about the supports and services available to them including Medicaid and non-Medicaid funded services.

In accordance with RSA 151-E:4, all participants have the right to have their plan developed through a person-centered planning process during which the participant’s family, and community supports are taken into consideration. The person centered planning process involves families, friends, and professionals as the participant desires or requires, in accordance with State Administrative Rule He-E 805.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. 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; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The types of assessments that are used to support the service plan development process, specific to the participant's needs, preferences and goals, and health status include the state's Medical Eligibility Assessment [MEA] or, if available, the current Minimum Data Set [MDS] or the current Outcome and Assessment Information Set [OASIS]. Information about the participant's goals and preferences is elicited from the individual or his/her representative. Additional information about health status and participant needs is obtained from medical records and other sources as appropriate.

Once the individual has selected a case manager, a comprehensive assessment is completed by the case manager pursuant to State Administrative Rule He-E 805. The comprehensive assessment is completed within 15 days of the case manager selection/assignment and includes:

Biopsychosocial history, including decision making capability, family relationships, employment, and any other area of significance in the participant’s life.

Functional ability, including activities of daily living and instrumental activities of daily living;

Living environment, including the participant’s in-home mobility, accessibility and safety;

Social environment, including social/informal relationships and supports, activities and interests, such as avocational and spiritual;

Self-awareness, or the degree to which the participant is aware of his/her own medical condition(s), treatment(s), and/or medication regime;

Risk, including the potential for abuse, neglect, or exploitation by self or others, as well as health, social or behavioral issues that may indicate a risk;

Legal status, including guardianship, legal system involvement, and availability of advance directives, such as durable power of attorney;

Community participation, including the participant’s need or expressed desire to access specific resources, such as the library, educational programs, restaurants, shopping, and medical providers; and

Any other area(s) identified by the participant as being important to his or her life.

According to State Administrative Rule He-E 805, within 20 days of the selection/assignment of the case manager, the case manager, participant and others identified by the participant discuss how the participant's needs, goals and preferences as identified through the comprehensive assessment process can be best met through a combination of waiver and non-waiver services and utilizes a person centered planning process to develop the person centered plan.

The case manager assists the individual with identifying measureable objectives and goals, with timelines, identifying non-paid services and supports, including the needs to be met and names of individuals or groups providing such services and supports, documents the participant’s strengths, capacities, and desired outcomes. After agreement by the individual concerning which services are preferable and appropriate, the participant selects the

service providers.

When there are changes in the participant's condition, goals, and needs, the case manager and others identified by the individual evaluate the changes to determine if changes to the plan are needed, and, at the direction of the individual, makes changes to the plan if required.

The case manager ensures that participant preferences, such as scheduling preferences and service provider specifications are incorporated into the plan.

The case manager assures that information is shared through the distribution of the plan to the identified providers in the plan at the individual's direction.

The person centered plan is updated regularly with contact notes documenting meetings of participants and case managers, whenever changes occur in the participant's medical condition, preferences, needs, or desires, or at the request of the participant or the participant's representative.

The person centered plan is updated at least annually for as long as the participant is receiving waiver services.

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.

As required in State Administrative Rule He-E 805, the case manager completes an initial, comprehensive assessment. Risk is assessed, including legal status, potential for abuse, neglect, or exploitation by self or others, as well as health, social, or behavioral issues that may indicate a risk. The participant's self-awareness is also assessed, including the degree to which the participant understands medical conditions, treatment, and the medication regime.

NH DHHS provides guidance regarding Risk Identification, Mitigation and Planning, through the use of a structured assessment process referred to as the "RIMP".

The RIMP process is intended to guide CFI waiver providers, applicants, participants and family members in determining the amount and types of risks involved in their current community living arrangements or in their transitions from nursing homes to community living. The protocol includes a list of potential risk factors, their definitions, alternate options considered and plans to mitigate identified risks. The protocol also includes a self-assessment to support participants in communicating potential risks to targeted case managers and to inform the person centered planning process.

In addition, in accordance with He-E 805, as part of the planning process, case managers are required to develop, with the individual others identified by the individual an individualized contingency plan. This plan is person centered, and addresses unexpected situations that could jeopardize the participant's health or welfare.

The contingency plan identifies alternate staffing resources in the event that normally scheduled care providers are unavailable, and addresses any special evacuation needs that require notification of the local emergency responders. Important information about the participant's desires, preferences, choice and direction are also recorded within this plan, to assist alternate staff in providing services for the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

CFI Waiver participants have the right to freely select from among any willing and qualified providers of waiver services.

Case managers are responsible to inform participants of all providers available in their geographical area, to encourage participants to choose their service providers, and to inform participants of how they can change providers after the initial selection.

Case managers are also responsible to inform participants of their right to self direct their services and select providers who are not yet enrolled [but who wish to enroll] as NH Medicaid providers.

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):

NH DHHS has the final authority for approval of the person centered plan.

NH DHHS reviews a representative sample of service plans retrospectively to ensure that plans have been developed in accordance with applicable federal Waiver requirements and NH Administrative Rules.

NH DHHS utilizes a record review process for reviewing person centered plans using the requirements for service planning described in this section to identify whether plans meet or do not meet requirements.

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 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

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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers monitor the implementation of the person centered plan and participant health and welfare through direct communication and face to face meetings with participants, as required by NH state administrative rule He-E 805.

Specifically:

The designated case manager shall monitor the services provided to a participant, as follows:
(1) Conduct the case management contacts required for each participant, as follows:
a. Case management contacts shall include no less than one monthly telephonic contact and one face-to-face contact every 60 days; and
b. Each case management contact shall be documented in a contact note;

Case managers may increase the frequency of monitoring and contact with each participant, based on an assessment of need and the participant's support system.

Case management performance is monitored annually by DHHS and compliance with case management requirements is assessed through onsite record review.

b. **Monitoring Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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 participants' person centered plans that include personal goals. N = The number of participants' service plans that include personal goals. D = Total number of plans reviewed

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of person centered plans that include documentation of progress toward or achievement of the personal goals identified in the plan. N: Number of plans with documentation of progress toward or achievement of the personal goals identified in the plan. D: Number of Plans reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of person centered plans that include documentation of risks identified in the comprehensive assessment. N = The number of plans that include documentation of risks identified in the comprehensive assessment. D: Number of plans reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of person centered plans that include documentation of monthly case management contacts. N: Number of person centered plans that include documentation of monthly case management contacts. D: Number of plans reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of person centered plans that include documentation of a face to face case management visit at least every 60 days. N: Number of person centered plans that include documentation of a face to face case management contact at least every 60 days. D: Number of plans reviewed.

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

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

		95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:

Number and percent of comprehensive assessments completed within the 15 day timeframe specified in He-E 805. N: number of comprehensive assessments completed within the 15 day timeframe specified in He-E 805. D: number of records reviewed

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of person centered plans completed within the 20 day timeframe specified in He-E 805. N: Number of person centered plans completed within the 20 day timeframe specified in He-E 805. D: Number of plans reviewed.

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

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

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 person centered plans updated annually. N: Number of person centered plans updated annually. D: Number of plans reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of person centered plans updated as a result of a change in the participant's needs. N: Number of person centered plans updated as a result of a change in the participant's needs. D: Number of plans reviewed.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***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:
N: number of person centered plans containing documentation of the type, scope, amount, description and frequency of services provided; D: number of person centered plans reviewed.

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

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

Data Aggregation and Analysis:

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

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

e. ***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:
The number and percent of participants whose records document that a choice was offered between institutional care and waiver services. N = The number of participant records with documentation that a choice was offered between institutional care and waiver services. D = The total number of records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants whose records document provider choice
N:Number of participants whose records document provider choice D = Number of records reviewed.

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

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

		Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When individual problems are discovered, they are remediated through discussions with the enrolled Medicaid Provider by the NH DHHS Provider Relations staff, Office of Quality Improvement or the CFI

Waiver Administrator. Documentation is via email communications.

When problematic trends are suspected or confirmed, the NH DHHS Office of Quality Assurance and Improvement is engaged to conduct a formal QI review; the results of the QI review are documented and suggested remediation strategies are shared within the Department and with involved providers/provider groups. When necessary, corrective action is required, including the submission of a corrective action plan by the provider. Follow up is conducted to ensure corrective action(s) have been taken and to evaluate the effectiveness of the strategies implemented.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The Choices for Independence Waiver offers the opportunity for participants who live in their own private residence, the home of a family member or in another living arrangement where services are furnished to fewer than four persons to direct and manage certain waiver supports and services.

The case manager is the primary source of information about participant direction and management. The opportunity to direct and manage services is discussed at the time of the initial person centered plan and, at a minimum, annually thereafter as part of the person centered planning process.

Participant Directed and Managed Services - PDMS- assist waiver participants to avoid institutionalization and function in the community by affording the option to exercise choice and control over a menu of waiver services and utilization of DHHS authorized funding.

This service category includes an individually tailored and personalized combination of services and supports for individuals in order to meet the individual's need for transportation, opportunities and experiences in living, working, socializing, personal growth, safety and health.

Authorized services that are directed and managed by the individual who is actively involved in all aspects of the service arrangement include: Designing the services; Selecting the service providers; Deciding how the authorized funding is to be spent based on the needs identified in the person centered plan; and performing ongoing oversight of the services provided.

The participant may engage a legal representative to assist with participant direction and management.

Legal representative is defined in NH State Administrative Rule He-E 801 as:

“Legal representative” means one of the following individuals, duly appointed or designated in the manner required by law to act on behalf of another individual, and who is acting within the scope of his or her authority:

An attorney;

A guardian or conservator;

An agent acting under a power of attorney;

An authorized representative acting on behalf of an applicant in some or all of the aspects of initial and continuing eligibility in accordance with He-W 603.01; or

A representative acting on behalf of another individual pursuant to RSA 161-I, Personal Care Services.

Participants who self direct assume employer and budget authority and have access to Financial Management Services (FMS)to assist them to manage and direct the disbursement of funds contained in the participant-directed budget; facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding Federal, state and local tax and making tax payments to appropriate tax authorities; and performing fiscal accounting and making expenditure reports to the participant or family and state authorities.

Financial management services also include employer functions such as assisting the participant to verify worker citizenship status, ensure criminal record and/or state or federal registry status is checked and confirmed, and process payroll. Budget management services include maintaining a separate account for each participant's 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. FMS also includes furnishing orientation/skills training to participants about their responsibilities when they function as the co-employer of their direct support workers.

The Case Manager works in partnership with the participant to ensure that all aspects of the person centered plan are implemented.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

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.

Information about the option to self direct is provided at the time of the initial person centered plan , during annual person centered planning and during any review as requested by the participant. Discussions regarding the option to self direct are documented in the person centered plan.

The case manager provides detailed information to participants who indicate a desire to self direct and ensure an informed decision is being made by providing information about the benefits, responsibilities and potential liabilities of self direction, including:

Benefits such as a greater degree of choice and control over selecting and hiring staff and flexibility to direct authorized funds to the services best able to meet the participant's needs; responsibilities including ongoing oversight of all aspects of service delivery such as staffing, budget and state/federal regulatory compliance (as appropriate); and potential liabilities such as the high level of responsibility required of self direction, particularly for those participants who have accessed agency driven service models where case managers and others, not the participant, are responsible for securing staff, ensuring payroll functions are appropriately completed and providing oversight to ensure services are delivered according to the person centered plan.

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
Specialized Medical Equipment Services	☑	☑
Personal Emergency Response System	☑	☑
Non Medical Transportation	☑	☑
Adult Medical Day Services	☑	☑
Homemaker	☑	☑
Respite	☑	☑
Home-Delivered Meals	☑	☑
Skilled Nursing	☑	☑
Supported Employment	☑	☑
Adult Family Care	☑	☑
Financial Management Services	☑	☑
Participant Directed and Managed Services	☑	☑
Environmental accessibility services	☑	☑
Adult In-Home Services	☑	☑
Supportive Housing Services	☑	☑
Community transition services	☑	☑
Home Health Aide	☑	☑
Personal Care	☑	☑

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:
Financial Management Services

○ **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:

A wide range of entities may furnish FMS.

Any willing and qualified provider meeting the definition of Financial Management Services Provider in Appendix C, and that have the capabilities to perform the required tasks in accordance with Section 3504 of the IRS code and Revenue Procedure 70-6 may do so when enrolled as a NH Medicaid Provider.

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

Financial Management Services are provided as a Waiver service.

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:

Services/functions that assists the family or participant to: manage and direct the disbursement of funds contained in the participant-directed budget; facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding Federal, state and local tax and making tax payments to appropriate tax authorities; and performing fiscal accounting and making expenditure reports to the participant or family and state authorities.

Financial management services include employer functions such as assisting the participant to verify worker citizenship status, ensure criminal record and/or state or federal registry status is checked and confirmed, and process payroll. Budget management services include maintaining a separate account for each participant's 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.

Financial Management Services also include providing orientation/skills training to participants about their responsibilities when they function as either the co-employer of their direct support 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:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **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.

NH DHHS monitors and assesses the performance of FMS entities, including the integrity of the financial transactions they perform through the following activities, performed on an annual basis:

Record review and audit of participant directed services, including post-payment review, to ensure documentation is in place to demonstrate that the FMS:

Assists participants in verifying support worker citizenship status;
Collects and processes timesheets of support workers appropriately;
Processes payroll, withholding, filing and payment of applicable Federal, state and local employment related taxes and insurance appropriately;
Maintains a separate account for each participant's budget;
Tracks and reports disbursements and balances of participant funds;
Processes and pays invoices only for goods and services approved in the service plan;
Provides participants with reports, on a schedule agreed upon by the participant, of expenditures and the status of the participant directed budget.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

- [x] **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:

Case Management activities are separate and distinct from FMS activities in that the case management activities provided for self direction are specific to ensuring that the individual is aware of the opportunity to self direct, for providing information about the opportunities and challenges associated with self directing and by ensuring that the following requirements of He-E 805 are met:

(1) Conduct the case management contacts required for each participant, as follows:

a. Case management contacts shall include no less than one monthly telephonic contact and one face-to-face contact every 60 days; and

b. Each case management contact shall be documented in a contact note;

(2) Ensure that services are adequate and appropriate for the participant's needs, and are being provided, as described in the comprehensive care plan;

(3) Ensure that the participant is actively engaging in the services described in the comprehensive care plan;

(4) Ensure that the participant is satisfied with the comprehensive care plan; and

(5) Identify any changes in the participant's condition, discuss these changes with the participant in order to determine whether changes to the comprehensive care plan are needed, and make changes to the comprehensive care plan as needed.

☑ **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
Specialized Medical Equipment Services	☐
Personal Emergency Response System	☐
Non Medical Transportation	☐
Adult Medical Day Services	☐
Homemaker	☑
Respite	☑
Home-Delivered Meals	☐
Residential Care Facility Services	☐
Skilled Nursing	☑
Supported Employment	☑
Adult Family Care	☑
Financial Management Services	☑
Participant Directed and Managed Services	☑
Environmental accessibility services	☐
Adult In-Home Services	☐
Supportive Housing Services	☐
Community transition services	☐
Home Health Aide	☑
Personal Care	☑

☐ **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:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participants who voluntarily terminate participant direction are assisted by the Case Manager to transition to provider managed service delivery. Transitional activities are discussed by the case manager, individual and his/her team and documented in the person centered plan. Provisions are specifically outlined in the plan to ensure all necessary services continue and to monitor participant health and safety.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Involuntary termination of participant direction of services may be necessary when the participant or his/her representative is unable to carry out their responsibilities under participant direction, to assure the participant's health and welfare or when there is evidence of misuse of public funds.

In the event that participant direction is involuntarily terminated, the case manager will assist the individual to transition to provider managed service delivery. Transitional activities are discussed with the case manager, individual and his/her team and documented in the person centered plan. Provisions are specifically outlined in the plan to ensure all necessary services continue and to monitor participant health and safety.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		80
Year 2		125
Year 3		173
Year 4		270
Year 5		280

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 participant 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 or family 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:

Provided via the Financial Management Service

☑ **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.**

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [ ] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **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.

Funding for participant directed services is based on the annual average cost of CFI Waiver services.

Participants whose assessed needs exceed the level of services provided, on average, may request additional funds. Requests for additional service funding are reviewed by DHHS and are approved based on demonstrated clinical need as documented in an approved assessment and on the requirements contained in NH State Statute RSA 151-E:11:

"No person whose costs would be in excess of 80 percent of the average annual cost for the provision of services to a person in a nursing facility shall be approved for home-based or mid-level services without the prior approval of the commissioner of health and human services. The prior approval shall include a comparison of the mid-level or home-based care costs of the person with the costs of a facility qualified to provide any specialized services necessary for the proper care and treatment of the individual".

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.

Service authorizations and the corresponding budgetary allocation are communicated by DHHS to the independent case manager who works with the participant to build the person centered plan.

Participants whose assessed needs indicate a need for a higher level of services/budgetary allocation can request additional services [and a corresponding budget increase]. This request is made by the case manager.

Requests for additional service funding are reviewed by DHHS and are approved based on demonstrated clinical need as documented in an approved assessment and on the requirements contained in NH State Statute RSA 151-E:11:

"No person whose costs would be in excess of 80 percent of the average annual cost for the provision of services to a person in a nursing facility shall be approved for home-based or mid-level services without the prior approval of the commissioner of health and human services. The prior approval shall include a comparison of the mid-level or home-based care costs of the person with the costs of a facility qualified to provide any specialized services necessary for the proper care and treatment of the individual".

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:

Participants have the authority to modify the waiver services included in the participant directed plan without prior approval so long as the changes do not result in an increase in the overall budget. Changes

in services must be preceded by an update/amendment to the person centered plan and communicated to the FMS by the participant.

As with all waiver services, the impact of any changes in the person centered plan as a result of modifications in the self directed budget are evaluated on a regular basis during monthly case management contacts and at the time of the service plan renewal.

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 FMS is required to provide budget management services that include maintaining a separate account for each participant's budget; tracking and reporting the use of participant funds, disbursements and the balance of participant funds; and processing and paying invoices for goods and services approved in the service plan.

The frequency of reports as outlined above is clearly articulated in the person centered plan and monitored by the participant and the case manager to prevent premature depletion of the participant directed budget and to address potential service delivery problems that may be associated with budget underutilization.

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.

NH DHHS provides notice for and opportunities to request a Fair Hearing of Department decisions as follows:

He-E 801.04 Eligibility Determination.

(a) The department shall make the clinical eligibility determination of the applicant as follows:

(1) A registered nurse employed or designated by the department shall:

a. Conduct an on-site, face-to-face visit with the applicant;

b. Perform a clinical assessment of the applicant; and

c. Develop a list of identified needs with the applicant;

(2) The applicant shall sign the following:

a. The identified needs section of the assessment, indicating his or her agreement or disagreement with the identified needs;

b. A consent for participation in the CFI program, including whether or not he or she has a preference of a case management agency;

c. An authorization for release of information; and

d. An authorization for release of protected health information;

(3) Pursuant to RSA 151-E:3, IV, if the department is unable to determine an applicant clinically eligible based on the assessment in (a) above, the department shall send notice to the applicant and the applicant's licensed practitioner(s), as applicable, requesting additional medical information within 30 calendar days of the notice and stating that the failure to submit the requested information will impede processing of the application and delay service delivery;

(4) Within the 30 day period in (3) above, if the requested information is not received, the department shall send a second notice to the applicable licensed practitioner(s), with a copy to the applicant, as a reminder to provide the requested information by the original deadline;

(5) Upon request from the treating licensed practitioner within the 30 day period in (3) above, the department shall extend the deadline in (3) above for a maximum of 30 days if the practitioner states that he or she has documentation that supports eligibility and will provide it within that time period; and

(6) If the information required by (3) above is not received by the date specified in the notice, or as extended by the department in accordance with (5) above, the applicant shall be determined to be clinically ineligible.

(b) For each applicant who meets the clinical eligibility requirements, a registered nurse employed or designated by the department shall estimate the costs of the provision of home-based services by identifying medical and other services, including units, frequencies, and costs, that would meet the needs identified in the assessment in (a)(1) above in order to determine if services that meet the applicant's needs can be provided at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services, pursuant to He-E 801.03(a)(6), and does not exceed the cost limits described in He-E 801.09.

(c) The applicant shall be determined eligible for the CFI program if it is determined that the applicant meets the financial eligibility requirements described in He-W 600, the clinical eligibility requirements of He-E 801.03(a)(4), and the other eligibility requirements in He-E 801.03.

(d) Upon a determination of eligibility, the applicant or his or her legal representative shall be sent an approval notice, including:

(1) The name and contact information of the case management agency and case manager chosen by the applicant or assigned to the applicant by the department, if available at the time of the notice; and

(2) The eligibility start date.

(e) Upon a determination of ineligibility, because the applicant does not meet the eligibility requirements of He-E 801.03 or because required information is not received pursuant to (a)(6) above, the applicant or his or her legal representative shall be sent a notice of denial, including:

(1) A statement regarding the reason and legal basis for the denial;

(2) Information concerning the applicant's right of appeal pursuant to He-C 200, including the requirement that the applicant has 30 calendar days from the date of the notice of denial to file such an appeal; and

(3) An explanation that an applicant who is denied services and who chooses to appeal this denial pursuant to He-C 200 shall not be entitled to Medicaid payments for CFI services pending the appeal hearing decision.

He-E 801.07 Redetermination of Eligibility and Service Authorization.

(a) The eligibility of each participant, as determined in accordance with He-E 801.04, shall be subject to redetermination at least annually.

(b) The redetermination shall be conducted in accordance with He-E 801.04, except that (e)(2)c.2. below shall apply.

(c) The annual redetermination required in (a) above shall not preclude earlier redetermination or reevaluation and subsequent changes to the identified needs list or service authorizations.

(d) Upon a redetermination of eligibility, the identified needs list and service authorizations shall be updated as necessary

by the department.

(e) If a participant is determined ineligible, or if services are identified as no longer being clinically necessary, the department shall either terminate CFI eligibility or reduce or terminate the services authorized, respectively, as follows:

(1) Payment for services shall be terminated 30 calendar days from the date of the notice described in (2) below, unless an appeal has been filed within 15 calendar days of the date of the notice; and

(2) A written notice of eligibility termination or the reduction or termination of the services authorized, as applicable, shall be sent to the participant, or his or her legal representative, and the participant's case manager, including:

a. The reason and legal basis for the termination or reduction;

b. The date that service coverage shall be terminated or reduced, absent the filing of an appeal; and

c. Information concerning the participant's right to appeal pursuant to He-C 200, as follows:

1. The participant shall have 30 calendar days to file an appeal, otherwise the department's decision shall be final; and

2. If the participant files an appeal within 15 calendar days of the date of the notice of service coverage termination or reduction, continued payments for CFI services shall be authorized until 30 calendar days after a hearing decision has been made.

Within fifteen days of receiving the notice that services will be discontinued, the participant can appeal a decision through NH's Administrative Appeals Unit (AAU) in accordance with He-C 200, the rule established to govern the process regarding Administrative Appeals in accordance with the following State Laws: RSA 541-A:16 I and RSA 126-A:5, VII. The notice states that services will not be discontinued if the appeal is filed with fifteen days.

When a participant elects to make use of the dispute mechanism process, they are informed of all their right to have a fair hearing and that they are not required to use the dispute mechanism process prior to or in lieu of filing an appeal with the AAU.

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**

b. 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.

DHHS has a process through which applicants or participants who disagree with a service authorization request can request reconsideration. This is articulated in NH State Administrative rule He-E 801.

He-E 801.06 Service Authorization.

(a) Upon review of the information provided in He-E 801.05(b), the department shall authorize services that are consistent with services that meet the needs identified in the clinical assessment in He-E 801.04(a) and other verified long-term care needs not previously identified through the assessment.

(b) Service authorizations shall consist of specific types, units, and frequencies of medical and other services.

(c) Service authorizations shall be issued to specific service providers identified by the participant's case manager as a result of person centered planning.

(d) When the service authorization does not include all the services requested, the applicant or participant shall be sent a notice, including:

(1) The requested service;

(2) The authorized service;

(3) A statement regarding the reason and legal basis for the denial; and

(4) Information concerning the applicant's right of appeal pursuant to He-C 200, including the requirement that the applicant has 30 calendar days from the date of the notice authorizing services to file such an appeal.

(e) An applicant or participant who disagrees with a service authorization may request a reconsideration of the service authorization, as follows:

(1) The applicant or participant, or his or her representative, shall submit a written request to the bureau within 30 days of the service authorization; and

(2) The written request shall include an explanation of the reason why a specific service authorization should be changed, including any supporting documentation.

(f) The department shall review the request in (e) above and provide a written notice to the applicant or participant, or his or her representative, of its decision to maintain or change the original service authorization, including the reason therefor.

(g) Requesting a service authorization reconsideration shall not:

(1) Preclude in any way an applicant's or participant's right to appeal a disputed service authorization in accordance with He-C 200; and

(2) Change the timeframes established for filing an appeal.

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**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. 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).

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).

NH DHHS requires all enrolled CFI Waiver providers to comply with its Sentinel Event Reporting process and NH Adult Protective Services reporting requirements.

Reporting sentinel events under the provisions of this policy does not replace the mandatory reporting requirements of RSA 161-F:42-57 with regard to abuse, neglect, self-neglect, or exploitation. Therefore, depending on the incident, a report made on behalf of a CFI Waiver participant may be made under both requirements.

NH DHHS Sentinel Event Reporting Process: http://www.dhhs.nh.gov/dcbcs/sentinel.htm

The Department of Health and Human Services' (DHHS) Sentinel Event Policy is part of a comprehensive quality assurance program and establishes the reporting and review requirements of sentinel events involving individuals served by the Department. Both community providers

and components of DHHS which 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.

The goals of this sentinel event reporting and review policy are:
1. To have a positive impact in improving care and service delivery; and
2. To understand the causes that underlie sentinel events, and make changes to internal and external systems and processes to reduce the probability of such events in the future.

DHHS' definition of a Sentinel Event aligns with the Joint Commission which defines sentinel event as "an unexpected occurrence involving death or
serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase 'or the risk thereof' includes any process variation for which a recurrence would carry a significant change of a serious adverse outcome."

Client-centered sentinel events, involving victims and/or perpetrators, include:

1. (a) An unanticipated death, not including homicide or suicide; or
(b) permanent loss of function; or
(c) risk thereof, not related to the natural course of an individual's illness or underlying condition, resulting from such causes including, but not limited to:
o a medication error,
o an unauthorized departure or abduction from a facility providing care, or
o a delay or failure to provide services;
2. a. Homicide, i.e., the person is the victim of a homicide;
2. b. Suicide or suicide attempt, i.e., self-injurious behavior with a non-fatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die;
3. Rape or any other sexual assault, i.e., the person is the victim of rape or sexual assault;
4. A serious physical or psychological injury, i.e., one that jeopardizes a person's health, or risk thereof, that is associated with the planning and delivery of care.
Agency-involved sentinel events:
5. High profile events which may involve media coverage and/or police involvement when the police involvement is related to a crime or suspected crime and not primarily to provide assistance in a potentially unsafe situation

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) the person or entity shall provide immediate verbal notification to the appropriate DHHS Office Director or designee and, as applicable, the appropriate DHHS Bureau Administrator or designee. Immediate verbal notification shall be provided by direct telephone contact. If direct telephone contact is not possible, a voice-mail or e-mail message shall be left. Note: Protected health information shall not be left in a voice-mail or e-mail message.

Written notification of the sentinel event shall be provided by the reporting person or designated agency staff to the appropriate DHHS Office and/or Division/Bureau Directors within 72 hours of the event. Written notification shall be via a completed Sentinel Event Reporting Form, and uploaded to the protected web based E-Studio application, available at https://nh.same-page.com.

Within ten business days of an incident, an interim report regarding the incident is submitted to the Commissioner's Office, which includes a review of all relevant documentation, provider reports, interviews, and policies. A final report is submitted to the Commissioner in a time frame specified by the Commissioner, containing a full explanation of the actions leading up to and contributing to the event, and an action plan that identifies the strategies intended to implement to reduce the risk of similar events in the future.

Adult Protective Services Requirements: http://www.dhhs.nh.gov/dcbcs/beas/adultprotection.htm

NH DHHS requires all CFI Waiver providers to comply with RSA 161-F:42-57, the purpose of which is to provide protection for vulnerable adults who are abused, neglected, or exploited. Implicit in this subdivision is the philosophy that whenever possible an adult's right to self-determination should be preserved, and that each adult should live in safe conditions and should live his own life without interruption from state government. Only when these principles become impossible to follow should legal proceedings be initiated in order to care for and protect such adults.

NH Adult Protection Law requires any person who has a reason to believe that an vulnerable adult has been subjected to abuse, neglect, exploitation or self-neglect to make a report immediately by calling (603) 271-7014 or toll Free from within NH at (800) 949-0470.

For concerns pertaining to CFI Waiver participants living in Assisted Living Facilities, the NH Office of the Long Term Care Ombudsman can be contacted at: (800) 442-5640 or (603) 271-4375. Info at: NH Office of the Long Term Care Ombudsman: http://www.dhhs.nh.gov/oltco/index.htm

The Long-Term Care Ombudsman receives, services, investigates and resolves complaints or problems concerning residents of long-term health care facilities including assisted living/residential care facilities. The program also provides advocacy services to long-term care facility residents, and comments on existing and proposed legislation, regulations and policies affecting long-term care residents. Education is provided to residents, family members and facility staff concerning the legal rights of residents.

Long-Term Care Ombudsman activities are organized around three major areas, Prevention, Intervention and Advocacy.

Prevention: Education and consultation to both staff and individuals on issues affecting residents in long-term care facilities;
Problem solving before a crisis occurs and to make recommendations to facility administration and staff concerning needed changes in policy and procedures;
Information and referral to help connect persons to the best available resources; and
Regular visitation services to residents by Certified Long-Term Care Ombudsman Volunteers to try and identify and resolve issues before they become complaints or serious problems.

Intervention: Investigation of problems and complaints, negotiation and intervention to assist residents and their family members in resolving conflicts or problems.

Advocacy: Service gap assessment and recommendations for the development of programs and supports to meet the needs of elder long-term care residents; and represent the interests of residents before governmental agencies and seek administrative, legal and other remedies, to protect the health, safety, welfare and rights of the residents.

NH DHHS Health Facilities Administration [HFA]: [http://www.dhhs.nh.gov/oos/bhfa/index.htm] is responsible for the oversight and enforcement of basic standards designed to promote safe and appropriate care of persons receiving care and treatment residential facilities and through nonresidential health care providers. Critical incident reporting is required for “reportable incidents.” These are defined as follows:

“Reportable incident” means an occurrence of any of the following while the resident is either in the SRHCF [shared residential health care facility] or in the care of SRHCF personnel:

(1) The unanticipated death of the resident;
(2) An injury to a resident, that is of a suspicious nature of potential abuse or neglect under circumstances where the injury was not observed by any person or the cause of the injury could not be explained by the resident; or
(3) The elopement or unexplained absence of a resident from the SRHCF.
These incidents are reported to and investigated by health Facilities Administration.

To file a complaint against a Licensed Health Facility, please contact:

NH Department of Health & Human Services
Health Facilities Licensing Unit
129 Pleasant Street

Concord, NH 03301
Telephone: (603) 271-9039
E-mail:

To file a complaint against a Certified Health Facility, please contact:

NH Department of Health & Human Services
Health Facility Certification Unit
129 Pleasant Street
Concord, NH 03301-3857
Telephone: (603) 271-9049
E-mail:

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.

Training and information sharing concerning protections from abuse, neglect and exploitation is conducted by the NH DHHS Adult Protective Services [APS] Unit.

Information is shared online, through community presentations and through distribution of the NH APS brochure found at:http://www.dhhs.nh.gov/dcbcs/beas/documents/abuse-hurts.pdf

The brochure entitled "Abuse Hurts at Any Age" provides the following information for participants, and/or families or legal representatives, as appropriate, to notify APS when the participant may have experienced abuse, neglect, self-neglect or exploitation:

In New Hampshire, adult abuse is defined by the Adult Protection Law (RSA 161-F: 42-57). Adult abuse is any action or omission that results or could result in harm to a person age 18 or older who cannot provide for his or her own care and protection due to the effects of aging or a chronic illness or disability.

The Adult Protection Law identifies six types of abuse: physical, emotional, sexual, neglect, self-neglect and exploitation. As required by law, the NH Dept. of Health and Human Services, receives and investigates reports of adult abuse and, when necessary, provides protective services.

It’s the Law:

If you suspect or believe that you are, or someone else is, being abused, neglected, self-neglecting or exploited the Adult Protection Law requires that you report this to the Bureau of Elderly and Adult Services, Adult Protective Services. You can do this by:

Calling: 800-949-0470 or 603-271-7014
Faxing: 603-271-4743
Emailing: apsintake@dhhs.state.nh.us
All calls and contacts are completely confidential

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.

DHHS conducts Sentinel Event reviews, when indicated, for CFI Waiver participants.
Sentinel events to be reviewed include those:
1. Requested by the Office of the Commissioner, a Division or Bureau Director, or the DHHS Quality Improvement Director; or
2. That, given the available information, the Office of Quality Assurance and Improvement identifies those sentinel events in which more than one agency/system was involved with the individual’s care and, in which there is preliminary evidence of potentially one or more problematic systemic issues.

Within ten business days of an incident, an interim report regarding the incident is submitted to the Commissioner's Office, which includes a review of all relevant documentation, provider reports, interviews, and policies. A final report is submitted to the Commissioner in a time frame specified by the Commissioner, containing a full explanation of the actions leading up to and contributing to the event, and an action plan that identifies the strategies intended to reduce the risk of similar incidents in the future.

The Sentinel Event Review includes:
• Case presentation(s);
• Review of the event (including a review of relevant documentation); and
• Identification of systemic factors, opportunities for improvement and recommendations for follow-up activity, as applicable.

The review of the event identifies recommendations for follow-up activity to address identified systemic issues, if any. Opportunities for improvement and recommendations for follow-up activity(ies) are also made.

Reports alleging abuse, neglect, self-neglect and/or exploitation are managed according to NH Administrative rule He-E 700.

NH APS reviews all complaints received and, when appropriate, conducts an investigation to determine if the alleged abuse, neglect, self-neglect or exploitation can be substantiated. If necessary, as a result of a founded allegation, the need for protective services is considered when the participant's health or safety is in jeopardy, the participant's living arrangement is unsafe or if the participant has functional or cognitive limitations that prevent the necessary performance of personal care activities or household tasks.

NH DHHS receives information about allegations and findings of abuse, neglect or exploitation on behalf of CFI Waiver participants and uses this information to assess the need for additional services, secure alternative living arrangements for participants and to determine the need for additional provider education and training to ensure the safe and effective delivery of CFI Waiver services.

NH Adult Protective Services maintains a Registry of individuals for whom there is a finding of abuse, neglect or exploitation. New Hampshire Statute RSA 161-F:49 requires that all employers of programs that are licensed, certified, or funded by the NH Department of Health and Human Services to provide services, submit the name of prospective employees who may have client contact for review against the registry of founded reports of abuse, neglect, and exploitation of incapacitated adults. In addition, any individual hiring a caregiver directly, or through an authorized representative or fiscal intermediary may submit the prospective employee's name for registry review.

Additional information about the APS Registry can be found at: http://www.dhhs.nh.gov/dcbcs/beas/registry.htm

NH Health Facilities Administration investigates complaints made on behalf of licensed assisted living facility/residential care settings as well as certified residential settings in which individuals receiving CFI Waiver services live.

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

The NH DHHS Office of Medicaid Services is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants.

The Department's Office of Quality Assurance and Improvement [OQAI] plays a pivotal role in overseeing the reporting of and response to critical incidents or events that affect waiver participants and provides this support on an on-going basis.

OQAI convenes meetings of relevant state entities responsible for oversight of Waiver related activities and takes the

lead on receipt, documentation and follow up on Sentinel Event reports and facilitates Sentinel Event Reviews when indicated.

OQAI facilitates meetings to review, discuss, document and follow up on CFI Waiver incidents and events and reaches out to other state agencies that provide critical oversight and monitoring of CFI Waiver services including the Office of the Long Term Care Ombudsman, the Division of Client Services, Adult Protective Services and the Bureau of Licensing and Certification to ensure open lines of communication and follow up on critical incidents and events involving CFI Waiver participants.

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).

CFI Waiver participants are served in several different types of settings: their own homes, adult foster care homes, adult medical day, independent living centers, in the homes of their families or caregivers and in licensed residential care facilities.

Restraints may be used only in emergencies and only in Licensed Assisted Living Facilities regulated under State Administrative Rule He-P 804 when the requirements of the Patient's Bill of Rights are met [http://www.gencourt.state.nh.us/rsa/html/XI/151/151-21.htm] as outlined in RSA 151:21, IX:

The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

The use of restraints is monitored by the NH Bureau of Licensing and Certification and reported, when indicated, to the Office of Medicaid Services CFI Waiver Administrator. The NH Bureau of Licensing and Certification provides follow up and, when necessary, requires corrective action when use of restraints is not in keeping with the requirements noted above.

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 Health Facilities Licensing is responsible for licensing inspections and reinspections of residential care facilities, approving their policies and procedures concerning restraints, receiving the reports of restraint use, and imposing any applicable fines.

Information concerning investigations, findings or sanctions related to CFI Waiver participants is shared with the CFI Waiver Administrator.

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.

State law, RSA 151.21, "Patient Bill of Rights," prohibits the use of restrictive interventions except in the case of defined emergencies.

Only Licensed Assisted Living Residence/Residential Care Settings may use restraints and only in the case of an emergency, pursuant to RSA 151:21, IX, as described previously.

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:

The NH DHHS Bureau of Licensing and Certification inspects assisted living facilities for improper use of restraints during licensing inspections.

NH DHHS CFI Waiver Administration, in partnership with Licensing and Certification is responsible for oversight of the use of restrictive interventions for CFI Waiver participants and receives information ongoing [to report any findings at the time of the licensing visit] and annually.

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:

It is the responsibility of the case manager, through regular contacts and face to face visits, to provide oversight to ensure that CFI waiver participants are not subject to seclusion.

For CFI Waiver participants living in assisted living facilities, this oversight is conducted by the Bureau of Licensing and Certification.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. 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 an individual has a cognitive impairment or mental disorder, a skilled nursing visit is put into place via the CFI Waiver service authorization process to provide oversight of the individual's medication regimen including medication compliance, monitoring for side effects and communicating with the prescriber, as needed.

Individuals may also receive additional skilled nursing visits to set up pill boxes or pre-fill the individual's electronic medication dispensing device.

Individuals with severe mental illness who are receiving behavior modifying medications are also supported, by their case manager, to access medication management and psychiatry supports from their local Community Mental Health Center.

The Bureau of Licensing and Certification monitors medication management through its annual inspections of any provider where medication administration is performed. Monitoring is done through reviews of the provider's documentation.

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.

Regular licensing or certification reinspections by the Bureau of Licensing and Certification include whether the documentation in the medical records meets the requirements for safe and effective medication management. Findings and any subsequent action planned by the Bureau of Licensing and Certification are included in a corrective action plan to facility.

A reinspection by the Bureau of Licensing and Certification after a brief interval determines whether the provider has taken the necessary corrective action(s). If the provider has not taken the corrective action, the Bureau of Licensing and Certification may impose a fine or suspend or revoke the facility's license.

The Bureau of Licensing and Certification involves DHHS throughout this process to ensure CFI waiver participant safety and to assist with discharge/transition planning to another provider if necessary.

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)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication administration is provided by licensed personnel in any setting or by licensed nursing assistants or unlicensed assistive personnel in accordance with the Nurse Practice Act (NPA) under RSA 326-B:14, II-a and RSA 326-B:28 when the licensed nurse delegates the task of medication administration.

Additionally, medication administration for CFI Waiver participants living in assisted living/residential care facilities is governed by State Administrative Rules He-P 804 and 805 [http://www.gencourt.state.nh.us/rules/state_agencies/he-p800.html] and allows for self administration, self-directed medication administration, self administration of medications with supervision, administration of medications by a licensed nurse or medication nursing assistant.

Prior to supervising medication administration in an assisted living facility/residential care setting, personnel who are not licensed practitioners or nurses but who assist a resident with self administration with supervision or self-directed administration are required to complete, at a minimum, a 4-hour medication supervision education program covering both prescription and non-prescription medication taught by a licensed nurse, licensed practitioner or pharmacist, or other person who has undergone such training by a licensed nurse, licensed practitioner or pharmacist, and shall be conducted either in person or through other means such as electronic media.

iii. 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:

Providers are required to record and report medication errors to the Bureau of Licensing and Certification [and to the participant's primary care provider].

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

Home Health agencies must report errors as follows, as required by He-P 809:

Develop and implement a system for reporting to the client's prescribing, licensed practitioner any:
Observed adverse reactions to medication; and
Side effects, or medication errors such as incorrect medications.

Assisted Living/Residential Care Facilities are required by He-P 804 to:

Report to the resident's licensed practitioner any adverse reactions and side effects to medications or medication errors, such as incorrect medications, within 24 hours of the adverse reaction or medication error, including documentation in the resident's file.

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

Any error, such as incorrect medications, or adverse reaction that results in The unanticipated death of a resident; an injury that requires treatment by a licensed practitioner; or other circumstances that resulted in the notification and/or involvement of law enforcement.

○ **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:

iv. 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.

Compliance is monitored during regular, usually annual unless otherwise specified, licensing inspections conducted by the Bureau of Licensing and Certification .

Findings regarding CFI Waiver participants, and any subsequent actions planned, are reported to DHHS.

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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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 records demonstrating that the NH Adult Protective Services brochure was provided at the time of the initial person centered planning meeting N: Number of participant records demonstrating that the NH Adult Protective Services brochure was provided at the time of the initial person centered planning meeting D: Number of records reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participants records demonstrating that the NH Adult Protective Services brochure was provided at the time of the annual person centered planning renewal meeting N: Number of participant records demonstrating that the NH Adult Protective Services brochure was provided at the time of the annual person centered planning renewal meeting D: Number of records reviewed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of assisted living/residential care facility licensing visits demonstrating compliance with RSA 161-F:49: APS Registry requirements N: number of assisted living/residential care facility licensing visits demonstrating compliance with APS Registry requirements D: number of assisted living/residential care facility licensing visits conducted

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

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

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of PDMS records demonstrating that provider qualifications reflect sufficient training, expertise, experience and/or education N: Number of PDMS service records demonstrating that provider qualifications reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services D: Number of PDMS records reviewed

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

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

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of Sentinel Event reports received for CFI Waiver Participants. N: Number of Sentinel Event reports received for CFI Waiver participants D: Total number of Sentinel Event Reports

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

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

Performance Measure:
Number and percent of Sentinel Event Reviews conducted for CFI Waiver participants N: Number of Sentinel Event Reviews conducted for CFI Waiver participants D: Number of Sentinel Events reported for CFI Waiver participants

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of assisted living facility/residential care licensing visits demonstrating compliance with regulatory requirements for restraint or seclusion. N:Number of ALF/RC licensing visits demonstrating compliance with regulatory requirements for restraint or seclusion D: Number of ALF/RC licensing visits

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of assisted living facility/residential care licensing visits demonstrating compliance with regulatory requirements for medication management. N:Number of ALF/RC licensing visits demonstrating compliance with regulatory requirements for medication management D: Number of ALF/RC licensing visits

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

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

Performance Measure:
Number and percent of quarterly case management participant records that include the requirements found in He-E 805. N: Number of quarterly case management participant records that include the requirements found in He-E 805. D: Number of quarterly case management participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports submitted to DHHS, upon requests, by the Case Management Agency

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
CFI Waiver Case Management Agencies are required, according to State Administrative Rule He-E 805, to conduct on a quarterly basis a participant record review to evaluate the delivery of services identified in the person centered plan to ensure that participants' health and safety needs are met. This review is documented in a quarterly quality management report. The requirements for the quarterly management report include: number of records reviewed; summary of review results; description of deficiencies identified; remedial action taken or planned to address any deficiencies and a summary of unmet service needs.

Case Management Agencies are also required to, on a quarterly basis, conduct a review of all reported complaints, incidents and sentinel events related to services provided through the CFI Waiver participant's person centered plan and document the results of the review. Reports include: number of reported complaints, incidents and sentinel events, summary of the review results, description of deficiencies and remedial action taken or planned including the dates the action was taken or will be taken.

Case Management Agency reports are retained by the case management agency for a minimum of two years and are made available to the department upon request.

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. In addition, provide information on the methods used by the State to document these items.
The Department's Office of Quality Assurance and Improvement [OQAI] plays a pivotal role, in collaboration with the CFI Waiver Administrator, in promoting safe and effective CFI Waiver Services.

OQAI works with the CFI Waiver Administrator to ensure the results of data collection related to health and safety are made available on a timely basis; convenes meetings of relevant state entities responsible for oversight of Waiver related health and safety activities; assists with on-site record/compliance reviews and the development of follow up reports and, when indicated, corrective action reports; takes the lead on receipt, documentation and follow up on Sentinel Event reports and facilitates Sentinel Event Reviews when indicated. OQAI also facilitates meetings to review and discuss CFI Waiver issues and trends when necessary, reaching out to the other state agencies that provide critical oversight and monitoring of CFI Waiver services including the Office of the Long Term Care Ombudsman, the Division of Client Services,

Adult Protective Services and the Bureau of Licensing and Certification to ensure open lines of communication and follow up on issues and concerns related to CFI Waiver participants.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §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 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;
- 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. 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 2)

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 Department’s Office of Quality Assurance and Improvement [OQAI] plays a pivotal role in promoting all aspects of CFI Waiver Quality management. OQAI works with the CFI Waiver Administrator to ensure the results of data collection related to performance measures and state regulatory requirements are made available on a timely basis; convenes meetings of relevant state entities responsible for oversight of Waiver related activities; assists with on-site record/compliance reviews and the development of follow up reports and, when indicated, corrective action reports; takes the lead on receipt, documentation and follow up on Sentinel Event reports and facilitates Sentinel Event Reviews when indicated. OQAI also facilitates meetings to review and discuss CFI Waiver issues and trends when necessary, reaching out to the other state agencies that provide critical oversight and monitoring of CFI Waiver services including the Office of the Long Term Care Ombudsman, the Division of Client Services, Adult Protective Services and the Bureau of Licensing and Certification to ensure open lines of communication and follow up on issues and concerns related to CFI Waiver participants.

The Office of Quality Assurance and Improvement is continually assessing the effectiveness of the systems in place for trending, prioritizing and implementing improvements and reports changes and enhancements, when indicated, to the CFI Waiver Administrator.

CFI Waiver Performance measures are reviewed and analyzed, at a minimum, on an annual basis.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	Frequency of Monitoring and Analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The NH DHHS Quality Assurance and Improvement Unit provides analysis and recommendations for system design changes identified during monitoring activities; the Quality Improvement Unit also assesses the effectiveness of system design changes. The Quality Assurance and Improvement Unit provides this information on an on-going basis and no less than annually.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Department's Quality Improvement strategy is constantly evolving and its effectiveness is evaluated on an ongoing basis.

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).

All claims for CFI services are paid through the New Hampshire Medicaid MMIS and edits are applied to ensure that only authorized services are covered, provided by properly enrolled providers, and rendered to individuals who were eligible on the dates of service. Service authorizations are maintained in the Options Information System with a direct feed from the Options Information System, which contains all authorization information, to the MMIS.

This ensures that only those services authorized by DHHS will be paid and will prevent payment of any service that is not authorized for the participant.

The Office of Improvement and Integrity [OII] within the Department of Health and Human Services monitors financial claims for NH's Medicaid Unit. OII reviews all provider claims for fraud, waste or abuse. The unit also recovers overpayments. The State conducts post-payment reviews yearly.

If fraud is suspected a referral is made to the NH Attorney General's office for further review. .

Specifics activities include:
On-site audits and desk reviews of provider bills and medical records;
Monitor the Quality Inpatient Organization Contract for in-patient claims;

Review of pended provider claims;
Verification of recipient medical services;
Monitor provider sanctions received by Medical Boards;
Make recommendations for claims processing system modifications;
Assess and report on program outcomes and recommend policy and procedure changes as necessary; and
Review of new provider enrollment applications as necessary.

In accordance with NH Rule He-C all DHHS providers that receive $500,000 or more in Federal Funds are required to submit an annual audit or certified financials.

The Office of Improvement and Integrity (OII) monitors financial claims for fraud, waste, or abuse in a number of ways, including, but not limited to: 1) upon a referral from a participant, DHHS staff, provider staff, etc. when a suspicion of fraud, waste, or abuse occurs; 2) When OII's data analytic system determines an anomaly in the claims data; or 3) Upon request due to a post-payment review. The State conducts post-payment reviews yearly.

The State's recoupment process is as follows: OII sends a letter to the provider indicating an overpayment has occurred and recoupment will occur from future claims. Included in the letter is the process for appealing the finding of overpayment and recoupment.

Multiple department staff and programs conduct financial integrity and accountability. When there is suspicion of fraud, waste of abuse, the OII will conduct reviews and audits. On an annual basis CFI Staff will conduct post-payment reviews.

The OII typically review records within a six year period of the time of the review. Providers may be reviewed after the initial investigation, depending on the situation, they are reviewed typically between six months to a year after the initial investigation. The time period selected depends on the case and its circumstances.

KPMG is the entity responsible for conducting the independent audit under this waiver.

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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

Number and percent of claims paid for waiver services in accordance with the service authorization N: number of claims paid for waiver services in accordance with the service authorization D: Number of records reviewed

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of providers with a greater than 5% claims denial rate for personal care services N = number of providers with a greater than 5% claims denial rate for personal care services D = total number of personal care service providers reviewed

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
N: Number of records with documentation of services rendered as billed; D: Number of records reviewed.

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

Performance Measure:
N: Rates that remain consistent with the approved rate methodology throughout the five year waiver cycle; D: Sampled claims during the five year waiver cycle.

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

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

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

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

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. In addition, provide information on the methods used by the State to document these items.
DHHS works closely with the Department's Office of Improvement and Integrity. If a payment irregularity is identified through a DHHS review, all supporting documentation is forwarded to OII, which initiates the appropriate further action, including payment recovery when appropriate.

If it appears that a provider does not understand the program rules and requirements, DHHS provides individual training and considers the likelihood of other providers having similar misunderstandings. Additional provider training and written guidance targeted to specific issues is provided as needed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

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

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

The following approach is taken by the State Medicaid Agency regarding Rate Setting Methodology for all CFI Waiver services:

(a) The rate setting methodology shall use baseline rates in effective on June 30, 2017.

(b) All CFI rates shall be adjusted each Biennium to be effective July 1 of the even State Fiscal year (For example, for State Fiscal Year 2018 and 2019 Biennium, rates will be adjusted to be effective on July 1, 2017).
(c) Rates shall be calculated by adjusting the rate in effect the prior July 1 of the even State Fiscal Year of the previous biennium by applying the Centers for Medicare and Medicaid Services (CMS) Federal Register, Actual Regulation Market Basket Update for Home Health Agency Prospective Payment System (PPS) Market Basket Update (For example, the federal fiscal year 2017, or calendar year 2017 on the Home Health Agency PPS table, will be used to calculate the July 1, 2017 rates).
(d) The calculated rates in (c) above shall be multiplied by an estimated utilization by service to reach an aggregate estimated expenditure for all CFI services.
(e) Using the aggregate estimated expenditure, calculated in (c) and (d) above, rates for CFI waiver services may be subject to a budget neutrality provision.
(f) When the New Hampshire Legislature approves CFI rate increases in a state budget, the rate increases rather than the rate adjustments established in (c) above, shall be applied as required by the budget legislation. The Department shall apply the procedures in (d) and (e), for rates not established by the New Hampshire Legislature, above to align the aggregate estimated expenditures with the legislative appropriation.
(g) No updated rates shall be in excess of the usual and customary charge for the service as provided to the general public as required by RSA 126-A:3III.(b).

DHHS through its Office of Medicaid Services and Office of Business Operations, with input from the CFI Waiver program is responsible for baseline rate determination and oversight.

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:

Providers bill the MMIS directly via the electronic system. All HCBS billing is processed through the NH Medicaid Management Information System [MMIS]. All billing for HCBS-CFI services requires a Prior Authorization be open and current in the MMIS. Prior Authorizations include only the services outlined in the approved service plan. 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].

Providers are not authorized to bill for services without documentation that the services have been provided.

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 provider billings are processed through the MMIS, which has claim edits and audits in place that limit the procedure codes that can be billed by CFI providers. Edits also ensure that payment is made only for Program-covered services rendered by qualified providers to participants who were Program-eligible on the date(s) of service. Enhanced automation between the Options System and the MMIS links service authorizations so that only claims for authorized services are paid.

The state ensures that services billed were rendered and documented during record review audits. This is specified in the QI section of this Appendix (I) in the performance measure which describes the state's review of records to ensure appropriate documentation of services rendered.

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

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

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **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 §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 §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§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 §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 ◆1115/◆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 ◆1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☑ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

According to state statute RSA 167:18-a: county governments pay the state a fixed amount, set biennially by the NH legislature, to fund a portion of the non-federal share of CFI Waiver costs.

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:

According to state statute RSA 167:18-a: county governments pay the state a fixed amount, set biennially by the NH legislature, to fund a portion of the non-federal share of CFI Waiver costs.

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Participants who live in residential settings are responsible for paying room and board from their income. This is paid directly to the residential care provider. The waiver payment is designated for Waiver services only.

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	14619.54	11466.00	26085.54	47112.00	4309.00	51421.00	25335.46
2	14848.95	11581.00	26429.95	48054.00	4396.00	52450.00	26020.05
3	15316.34		27013.66			53499.00	26485.34

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)
		11697.32		49015.00	4484.00		
4	15874.80	11814.30	27689.10	49995.00	4573.00	54568.00	26878.90
5	16120.92	11932.44	28053.36	50995.00	4604.00	55599.00	27545.64

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:		
		Nursing Facility		
Year 1	3619		3619	
Year 2	3656		3656	
Year 3	3692		3692	
Year 4	3729		3729	
Year 5	3766		3766	

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.

289 based on average length of stay over 5 years.

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 for these estimates is as follows:

NH used the 372 reports for FY 2012-FY2015, which showed an average growth of 1% for this time period. NH then took the actual unduplicated count for FY 2016 from MMIS as a base for WY 1-5, adding a 1% growth rate for each waiver year, based on the FY 2012-2015 actual growth.

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:

NH used the 372 reports for FY 2012-FY2015, which showed an average growth of 1% for this time period. NH then took the actual unduplicated count for FY 2016 from MMIS as a base for WY 1-5, adding a 1% growth rate for each waiver year, based on the FY 2012-2015 actual growth.

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:

NH used the FY 2016 372 data as a base and then increased the Factor G by 2%, consistent with the growth for FY 2014 and 2015 372 reports.

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:

G' waiver estimates have been updated in Appendix J-1 and J-2-c to show the same growth of 2%, based on MMIS data.

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	
Adult Medical Day Services	
Home Health Aide	
Homemaker	
Personal Care	
Respite	
Supported Employment	
Financial Management Services	
Adult Family Care	
Adult In-Home Services	
Community transition services	
Environmental accessibility services	
Home-Delivered Meals	
Non Medical Transportation	
Participant Directed and Managed Services	
Personal Emergency Response System	
Residential Care Facility Services	
Skilled Nursing	
Specialized Medical Equipment Services	
Supportive Housing Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
				GRAND TOTAL:		52908115.48
				Total Estimated Unduplicated Participants:		3619
				Factor D (Divide total by number of participants):		14619.54
				Average Length of Stay on the Waiver:		289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						**1195251.76**
Adult Medical Day Services	day	265	91.60	49.24	**1195251.76**	
Home Health Aide Total:						**3932299.07**
Home Health Aide visit	visit	237	170.97	31.08	**1259358.18**	
Home Health Aide	15 min	503	881.26	6.03	**2672940.89**	
Homemaker Total:						**992150.78**
Homemaker	15 min	480	431.52	4.79	**992150.78**	
Personal Care Total:						**25458735.24**
Personal Care	15 min	2134	2593.49	4.60	**25458735.24**	
Respite Total:						**124668.84**
Respite	15 min	48	1555.25	1.67	**124668.84**	
Supported Employment Total:						**520626.16**
Supported Employment	15 min	40	2829.49	4.60	**520626.16**	
Financial Management Services Total:						**40320.00**
Financial Management Services	month	40	12.00	84.00	**40320.00**	
Adult Family Care Total:						**441523.17**
Adult Family Care	day	26	269.85	62.93	**441523.17**	
Adult In-Home Services Total:						**127036.80**
Adult In-Home Services	15 min	15	2406.00	3.52	**127036.80**	
Community transition services Total:						**18000.00**
Community transition services	transition	12	1.00	1500.00	**18000.00**	
Environmental accessibility services Total:						**317618.82**
Environmental accessibility services	occurence	57	1.02	5463.00	**317618.82**	
Home-Delivered Meals Total:						**1049310.38**
Home-Delivered Meals	meal	925	162.52	6.98	**1049310.38**	

GRAND TOTAL:	**52908115.48**
Total Estimated Unduplicated Participants:	**3619**
Factor D (Divide total by number of participants):	**14619.54**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non Medical Transportation Total:						**621600.00**
Non Medical Transportation	trip	700	111.00	8.00	**621600.00**	
Participant Directed and Managed Services Total:						**520000.00**
Participant Directed and Managed Services	month	40	1.00	13000.00	**520000.00**	
Personal Emergency Response System Total:						**779992.29**
Personal Emergency Response System	month	2297	9.90	34.30	**779992.29**	
Residential Care Facility Services Total:						**10712625.00**
Residential Care Facility Services	day	825	265.00	49.00	**10712625.00**	
Skilled Nursing Total:						**3998860.80**
Skilled Nursing	15 min	2000	21.12	94.67	**3998860.80**	
Specialized Medical Equipment Services Total:						**374433.70**
Specialized Medical Equipment Services	item	260	0.91	1582.56	**374433.70**	
Supportive Housing Services Total:						**1683062.66**
Supportive Housing Services	day	125	242.91	55.43	**1683062.66**	
				GRAND TOTAL:		**52908115.48**
				Total Estimated Unduplicated Participants:		**3619**
				Factor D (Divide total by number of participants):		**14619.54**
				Average Length of Stay on the Waiver:		289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						**1082469.02**
Adult Medical Day Services	day				**1082469.02**	
				GRAND TOTAL:		**54287771.61**
				Total Estimated Unduplicated Participants:		**3656**
				Factor D (Divide total by number of participants):		**14848.95**
				Average Length of Stay on the Waiver:		289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		199	110.47	49.24		
Home Health Aide Total:						**4086402.76**
Home Health Aide visit	visit	246	170.97	31.08	**1307181.91**	
Home Health Aide	15 min	523	881.26	6.03	**2779220.85**	
Homemaker Total:						**1031423.42**
Homemaker	15 min	499	431.52	4.79	**1031423.42**	
Personal Care Total:						**26926131.88**
Personal Care	15 min	2257	2593.49	4.60	**26926131.88**	
Respite Total:						**129863.38**
Respite	15 min	50	1555.25	1.67	**129863.38**	
Supported Employment Total:						**520626.16**
Supported Employment	15 min	40	2829.49	4.60	**520626.16**	
Financial Management Services Total:						**40320.00**
Financial Management Services	month	40	12.00	84.00	**40320.00**	
Adult Family Care Total:						**509449.82**
Adult Family Care	day	30	269.85	62.93	**509449.82**	
Adult In-Home Services Total:						**169382.40**
Adult In-Home Services	15 min	20	2406.00	3.52	**169382.40**	
Community transition services Total:						**18000.00**
Community transition services	transition	12	1.00	1500.00	**18000.00**	
Environmental accessibility services Total:						**328763.34**
Environmental accessibility services	occurence	59	1.02	5463.00	**328763.34**	
Home-Delivered Meals Total:						**1091282.80**
Home-Delivered Meals	meal	962	162.52	6.98	**1091282.80**	
Non Medical Transportation Total:						**643800.00**
					643800.00	

GRAND TOTAL:	**54287771.61**
Total Estimated Unduplicated Participants:	**3656**
Factor D (Divide total by number of participants):	**14848.95**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non Medical Transportation	trip	725	111.00	8.00		
Participant Directed and Managed Services Total:						**520772.40**
Participant Directed and Managed Services	month	40	1.00	13019.31	**520772.40**	
Personal Emergency Response System Total:						**707329.68**
Personal Emergency Response System	month	1887	10.09	37.15	**707329.68**	
Residential Care Facility Services Total:						**10777550.00**
Residential Care Facility Services	day	830	265.00	49.00	**10777550.00**	
Skilled Nursing Total:						**3564984.40**
Skilled Nursing	15 min	1783	21.12	94.67	**3564984.40**	
Specialized Medical Equipment Services Total:						**388834.99**
Specialized Medical Equipment Services	item	270	0.91	1582.56	**388834.99**	
Supportive Housing Services Total:						**1750385.17**
Supportive Housing Services	day	130	242.91	55.43	**1750385.17**	
				GRAND TOTAL:		**54287771.61**
				Total Estimated Unduplicated Participants:		**3656**
				Factor D (Divide total by number of participants):		**14848.95**
				Average Length of Stay on the Waiver:		289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						**1125985.36**
Adult Medical Day Services	day	207	110.47	49.24	**1125985.36**	
Home Health Aide Total:						**4251134.19**
				GRAND TOTAL:		**56547917.61**
				Total Estimated Unduplicated Participants:		**3692**
				Factor D (Divide total by number of participants):		**15316.34**
				Average Length of Stay on the Waiver:		289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide visit	visit	256	170.97	31.08	1360319.39	
Home Health Aide	15 min	544	881.26	6.03	2890814.80	
Homemaker Total:						1072763.04
Homemaker	15 min	519	431.52	4.79	1072763.04	
Personal Care Total:						28166857.49
Personal Care	15 min	2361	2593.49	4.60	28166857.49	
Respite Total:						135057.91
Respite	15 min	52	1555.25	1.67	135057.91	
Supported Employment Total:						650782.70
Supported Employment	15 min	50	2829.49	4.60	650782.70	
Financial Management Services Total:						4200.00
Financial Management Services	month	50	1.00	84.00	4200.00	
Adult Family Care Total:						577376.46
Adult Family Care	day	34	269.85	62.93	577376.46	
Adult In-Home Services Total:						186320.64
Adult In-Home Services	15 min	22	2406.00	3.52	186320.64	
Community transition services Total:						18000.00
Community transition services	transition	12	1.00	1500.00	18000.00	
Environmental accessibility services Total:						345480.12
Environmental accessibility services	occurence	62	1.02	5463.00	345480.12	
Home-Delivered Meals Total:						1135523.99
Home-Delivered Meals	meal	1001	162.52	6.98	1135523.99	
Non Medical Transportation Total:						666000.00
Non Medical Transportation	trip	750	111.00	8.00	666000.00	
Participant Directed and Managed Services Total:						650000.00
			GRAND TOTAL:			56547917.61
			Total Estimated Unduplicated Participants:			3692
			Factor D (Divide total by number of participants):			15316.34
			Average Length of Stay on the Waiver:			289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant Directed and Managed Services	month	50	1.00	13000.00	650000.00	
Personal Emergency Response System Total:						735817.79
Personal Emergency Response System	month	1963	10.09	37.15	735817.79	
Residential Care Facility Services Total:						11037250.00
Residential Care Facility Services	day	850	265.00	49.00	11037250.00	
Skilled Nursing Total:						3566983.83
Skilled Nursing	15 min	1784	21.12	94.67	3566983.83	
Specialized Medical Equipment Services Total:						404676.42
Specialized Medical Equipment Services	item	281	0.91	1582.56	404676.42	
Supportive Housing Services Total:						1817707.68
Supportive Housing Services	day	135	242.91	55.43	1817707.68	
				GRAND TOTAL:		56547917.61
				Total Estimated Unduplicated Participants:		3692
				Factor D (Divide total by number of participants):		15316.34
				Average Length of Stay on the Waiver:		289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						1169501.70
Adult Medical Day Services	day	215	110.47	49.24	1169501.70	
Home Health Aide Total:						4421179.62
Home Health Aide visit	visit	266	170.97	31.08	1413456.86	
Home Health Aide	15 min				3007722.75	
				GRAND TOTAL:		59197113.52
				Total Estimated Unduplicated Participants:		3729
				Factor D (Divide total by number of participants):		15874.80
				Average Length of Stay on the Waiver:		289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		566	881.26	6.03		
Homemaker Total:						**1116169.63**
Homemaker	15 min	540	431.52	4.79	**1116169.63**	
Personal Care Total:						**29359862.89**
Personal Care	15 min	2461	2593.49	4.60	**29359862.89**	
Respite Total:						**140252.45**
Respite	15 min	54	1555.25	1.67	**140252.44**	
Supported Employment Total:						**780939.24**
Supported Employment	15 min	60	2829.49	4.60	**780939.24**	
Financial Management Services Total:						**60480.00**
Financial Management Services	month	60	12.00	84.00	**60480.00**	
Adult Family Care Total:						**611339.78**
Adult Family Care	day	36	269.85	62.93	**611339.78**	
Adult In-Home Services Total:						**211728.00**
Adult In-Home Services	15 min	25	2406.00	3.52	**211728.00**	
Community transition services Total:						**18000.00**
Community transition services	transition	12	1.00	1500.00	**18000.00**	
Environmental accessibility services Total:						**356624.64**
Environmental accessibility services	occurence	64	1.02	5463.00	**356624.64**	
Home-Delivered Meals Total:						**1179765.18**
Home-Delivered Meals	meal	1040	162.52	6.98	**1179765.18**	
Non Medical Transportation Total:						**688200.00**
Non Medical Transportation	trip	775	111.00	8.00	**688200.00**	
Participant Directed and Managed Services Total:						**780000.00**
Participant Directed and Managed Services	month	60	1.00	13000.00	**780000.00**	

GRAND TOTAL:	**59197113.52**
Total Estimated Unduplicated Participants:	**3729**
Factor D (Divide total by number of participants):	**15874.80**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System Total:						**765430.43**
Personal Emergency Response System	month	2042	10.09	37.15	**765430.43**	
Residential Care Facility Services Total:						**11361875.00**
Residential Care Facility Services	day	875	265.00	49.00	**11361875.00**	
Skilled Nursing Total:						**3856901.24**
Skilled Nursing	15 min	1929	21.12	94.67	**3856901.24**	
Specialized Medical Equipment Services Total:						**420369.04**
Specialized Medical Equipment Services	item	292	0.91	1582.00	**420369.04**	
Supportive Housing Services Total:						**1898494.68**
Supportive Housing Services	day	141	242.91	55.43	**1898494.68**	
				GRAND TOTAL:		**59197113.52**
				Total Estimated Unduplicated Participants:		**3729**
				Factor D (Divide total by number of participants):		**15874.80**
				Average Length of Stay on the Waiver:		289

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						**1169501.70**
Adult Medical Day Services	day	215	110.47	49.24	**1169501.70**	
Home Health Aide Total:						**4421179.62**
Home Health Aide visit	visit	266	170.97	31.08	**1413456.86**	
Home Health Aide	15 min	566	881.26	6.03	**3007722.75**	
Homemaker Total:						
				GRAND TOTAL:		**60711399.32**
				Total Estimated Unduplicated Participants:		**3766**
				Factor D (Divide total by number of participants):		**16120.92**
				Average Length of Stay on the Waiver:		289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						1116169.63
Homemaker	15 min	540	431.52	4.79	**1116169.63**	
Personal Care Total:						**30552868.29**
Personal Care	15 min	2561	2593.49	4.60	**30552868.29**	
Respite Total:						**140252.45**
Respite	15 min	54	1555.25	1.67	**140252.44**	
Supported Employment Total:						**846017.51**
Supported Employment	15 min	65	2829.49	4.60	**846017.51**	
Financial Management Services Total:						**65520.00**
Financial Management Services	month	65	12.00	84.00	**65520.00**	
Adult Family Care Total:						**645303.10**
Adult Family Care	day	38	269.85	62.93	**645303.10**	
Adult In-Home Services Total:						**211728.00**
Adult In-Home Services	15 min	25	2406.00	3.52	**211728.00**	
Community transition services Total:						**18000.00**
Community transition services	transition	12	1.00	1500.00	**18000.00**	
Environmental accessibility services Total:						**356624.64**
Environmental accessibility services	occurence	64	1.02	5463.00	**356624.64**	
Home-Delivered Meals Total:						**1179765.18**
Home-Delivered Meals	meal	1040	162.52	6.98	**1179765.18**	
Non Medical Transportation Total:						**710400.00**
Non Medical Transportation	trip	800	111.00	8.00	**710400.00**	
Participant Directed and Managed Services Total:						**845000.00**
Participant Directed and Managed Services	month	65	1.00	13000.00	**845000.00**	
Personal Emergency Response System Total:						**765430.43**

GRAND TOTAL:	**60711399.32**
Total Estimated Unduplicated Participants:	**3766**
Factor D (Divide total by number of participants):	**16120.92**
Average Length of Stay on the Waiver:	289

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System	month	2042	10.09	37.15	**765430.43**	
Residential Care Facility Services Total:						**11491725.00**
Residential Care Facility Services	day	885	265.00	49.00	**11491725.00**	
Skilled Nursing Total:						**3856901.24**
Skilled Nursing	15 min	1929	21.12	94.67	**3856901.24**	
Specialized Medical Equipment Services Total:						**420517.84**
Specialized Medical Equipment Services	item	292	0.91	1582.56	**420517.84**	
Supportive Housing Services Total:						**1898494.68**
Supportive Housing Services	day	141	242.91	55.43	**1898494.68**	

GRAND TOTAL:	**60711399.32**
Total Estimated Unduplicated Participants:	**3766**
Factor D (Divide total by number of participants):	**16120.92**
Average Length of Stay on the Waiver:	289