# 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:
Changes include full integration of the HCBS 1915(c) Rule and Regulations published in January 2014, rate setting methodology and alignment of the DD Waiver with more clearly defined expectations under state Administrative Rule He-M 505 [Establishment and Operation of Area Agencies].

Performance measures have been updated to reflect the changes outlined in the CMS March 2014 Guidance: Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers.

## 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*):
**NH Developmental Disabilities Waiver 2016-2021**

C. **Type of Request: renewal**

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

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: NH.0053**
**Draft ID: NH.009.06.00**

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

E. **Proposed Effective Date:** *(mm/dd/yy)*
09/01/16

### 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:

NA

## 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.
Purpose/Goal: The purpose of the Developmental Disabilities Waiver is to provide services which maximize the ability and informed decision-making authority of people with developmental disabilities and which promote the individual's personal development, independence and quality of life in a manner that is determined by the individual.

Program Description:
Individuals must qualify for the NH developmental services system under State Statute RSA 171:A, available for review at: http://www.gencourt.state.nh.us/rsa/html/xii/171-a/171-a-mrg.htm and He-M 503, the State Administrative Rule which establishes standards and procedures for the determination of eligibility, the development of service agreements, and the provision and monitoring of services, are Medicaid eligible and meet the ICF/IID level of care.

The State has defined within this waiver a range of home and community-based services which support families and individuals. Families and individuals work with Area Agencies and the State to identify, through a person-centered planning process, those specific services and supports offered under this waiver that are needed to avoid placement in an institutional setting. The State maintains the ability to control costs and, in conjunction with Area Agencies, individuals or families, establishes mutual expectations regarding available resources.

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

Organizational Structure: The waiver is implemented within NH's regional developmental services system operating as an Organized Health Care Delivery System (OHCDS). Ten Area Agencies function as enrolled Medicaid HCBS providers; provider agreements have been established between the State Medicaid Agency and each of the ten Area Agencies.

Area Agencies are nonprofit (501 C) entities. Area Agencies function within state determined and identified geographic regions. Area Agencies are governed by independent Boards of Directors. One-third of each Area Agency's Board membership consists of individuals with disabilities and or family members. Further, Area Agencies are advised by regional Family Support Councils. NH's long-standing tradition of "local control" is a prominent element of the system and the overarching concepts of Choice, Control, and Self-Direction underpin the NH developmental service system.

Service Delivery Methods:
Initial application for developmental service eligibility is made through the local Area Agency for the geographic region in which the individual resides. If found eligible for services under He-M 503, an individualized Service Agreement and budget are developed using a person centered planning process, assessment based decision making and availability of resources. Service Agreements must include:

A personal profile that includes the individuals strengths, needs and preferences,
Current medical information,
Personal history,
Clinical and support needs identified through evaluations and assessments,
Health and safety considerations,
Risk status,

How providers will be identified, trained and hired,
Individuals need for guardianship, if any,
A list of who participated in the service planning meeting,
A list of specific activities to be carried out, including those regarding safety,
The specific schedule for when the services will be provided;
Goals to be addressed with timelines and methods for achieving goals,
Specific back-up plans for providers when the usual providers are not available,
Services needed but not currently available, if any, and,
Service documentation requirements including choice, satisfaction, notification of rights and process for filing a complaint.

Budget proposals are submitted to the Bureau of Developmental Services (BDS) by the Area Agency; the BDS makes all final budget determinations based on the cost effectiveness of proposed services.

The BDS processes all LOC determination reviews and applications for Prior Authorization of services. All waiver services must be prior authorized by State QIDP staff. No Medicaid billing can be done without a current prior authorization in the MMIS.

With an approved budget, the individual and/or guardian selects from all qualified and willing providers, the entity or person(s) to provide services is outlined in the Service Agreement. A contract is developed which addresses requirements and responsibility for the following: Implementation of the individual Service Agreement;
Specific qualifications, training and supervision required for the service providers;
Oversight of the service provision as required by the Service Agreement and applicable rules;
Quality assessment and improvement activities as required by State rules and Service Agreement;
Documentation of service provision and administrative activities;
Compensation amounts and procedures;
Compliance with applicable federal and state laws and regulations;
Procedures for review and revision of the contract

## 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:
BDS provided notification of the public input process for the Developmental Disabilities Waiver renewal.

Public Input period: March 30, 2016 through April 29, 2016. Information regarding Public Notice and Public Input can be found at: http://www.dhhs.nh.gov/dcbcs/bds/index.htm

The Public at large was notified through a newspaper advertisement in two statewide newspapers [NH Union Leader and Nashua Telegraph] on March 30, 2016 and via postings to the BDS website of the formal public input process.

In addition, notification was provided directly to our stakeholders via email including:
NH's Medical Care Advisory Committee
Area Agencies for Developmental Services
State Family Support Council
NH's Developmental Services Quality Council
Area Agency Service Coordinator Supervisors
NH Council for Developmental Disabilities
Institute on Disabilities, UCED, University of New Hampshire
Disability Rights Center - NH

The draft Application for 1915(c) HCBS Waiver: Developmental Disabilities Waiver, can be accessed from the BDS Home page: http://www.dhhs.nh.gov/dcbcs/bds/index.htm

Public hearings:

Tuesday, April 19, 2016
9:00-11:00 AM
Brown Auditorium
New Hampshire Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301

Thursday, April 28, 2016
5:30-7:30 PM
Brown Auditorium
New Hampshire Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301

The comments included the following themes: XXXXXXX

All of the comments received by BDS can be accessed from the BDS Home page:http://www.dhhs.nh.gov/dcbcs/bds/index.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:** Lorene

**First Name:** Reagan

**Title:**

Bureau Chief

**Agency:** DHHS, Bureau of Developmental Services

**Address:** 105 Pleasant Street

**Address 2:** Main Building

**City:** Concord

**State:** New Hampshire

**Zip:** 03301

**Phone:** (603) 271-5026 **Ext:** ☐ **TTY**

**Fax:** (603) 271-5166

**E-mail:** lorene.reagan@dhhs.state.nh.us

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** New Hampshire

**Zip:**

**Phone:** **Ext:** ☐ **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **New Hampshire**

**Zip:**

**Phone:**

**Ext:** ☐ **TTY**

**Fax:**

**E-mail:**

## Attachments

**Attachment #1: Transition Plan**

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

NH's Statewide Transition Plan, including information regarding the public notice/public input/public comments can be found at:

http://www.dhhs.nh.gov/ombp/medicaid/draft-transition-framework.htm

Statewide Transition Plan PUBLIC NOTICE:
New Hampshire's initial public notice and comment period ran from January 11th to February 16th. It was extended through March 5, 2016.

Notice was published in two statewide newspapers on Monday January 12, 2015 in the Nashua Telegraph and on Sunday January 11, 2015 in the NH Union Leader.

Notice was also published on a designated DHHS webpage found at http://www.dhhs.nh.gov/ombp/medicaid/draft-transition-framework.htm

The State hosted four public hearings during the public comment period. Participants were given the opportunity to attend via webinar, by phone or in person.

Public Hearing #1
Thursday, February 11, 2016
9:30-11:30 a.m.
Portsmouth Public Library
Levenson Community Room
175 Parrott Avenue
Portsmouth, NH 03801

Public Hearing #2
Friday, February 12, 2016
1:00 - 3:00 p.m.
Littleton Regional Health Care
600 St. Johnsbury Road
Littleton, NH 03561

Public Hearing #3
Tuesday, February 16, 2016
1:00pm – 3:00pm
New Hampshire Hospital Association
125 Airport Road, Room 1

Concord, NH 03301

Public Hearing #4
Wednesday, February 17, 2016
3:00 – 5:00pm
Historical Society of Cheshire County
246 Main Street Keene, NH 03431

Comments were received and responded to regarding the following:

Transparency and Stakeholder Engagement
The State's Draft Transition Plan
Aspects of the State's Assessment Phase
Application of 42 CFR 441.301(c)(4)

The State's Transition Plan Framework, including detailed information about public input and public comments can be found at: http://www.dhhs.nh.gov/ombp/medicaid/documents/finalhcbstransitionplan.pdf [Please note that the public comments and the State's responses cannot be included in this section due to insufficient space as they exceed the character count of 12,000].

**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 State assures that the settings transition plan included with this 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.

New Hampshire has drafted and submitted to CMS transition framework to show how it will establish compliance with these new regulations.
New Hampshire's draft transition framework has four main components:
1. Identification – review of existing state standards, policies, regulations, and statute to determine state level changes that are needed to align with the federal requirements.
2. Assessment – Development, implementation and validation of assessments completed by providers and participants.
3. Remediation – Development of a comprehensive, statewide transition plan based on assessment results.
4. Outreach and Engagement – Engagement of stakeholders in the transition plan process.

The Public Notice for the Transition Plan framework included a summary of the regulations as well as the dates and locations of the two public hearings. This information was posted here: http://www.dhhs.nh.gov/ombp/medicaid/draft-transition-framework.htm.

Following the Public Hearings, the Department worked with the Medical Care Advisory Committee to establish a HCBS Advisory Taskforce. Meetings of the Taskforce are held monthly and the minutes are posted on the web on the same page as the Public Notice. This Taskforce has begun the assessment process, which will include conducting a survey of

potentially affected settings to determine their status. Following this we will start the remediation phase of the framework, as described above.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Below is a summary of all the public comments received by BDS along with BDS responses (links to all public comments and summary with comments provided in Section 6. Requirements I. Public Input)

New Hampshire Department of Health and Human Services [DHHS]
Bureau of Developmental Services [BDS]
Responses to Public Comments on New Hampshire Draft Developmental Disabilities Waiver

This section will be completed following receipt of input from the public hearing process:

## 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.
   **The Bureau of Developmental Services**
   *(Complete item A-2-a).*

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

   Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by

that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
RSA 171-A establishes the program requirements and directs the NH Department of Health and Human Services (DHHS), which is the single state Medicaid agency, in its performance of ensuring that the waiver program requirements are met. As required by RSA 171-A, DHHS has adopted administrative rules which define how the BDS must establish, implement, and maintain a comprehensive service delivery system for people with developmental disabilities.

Administrative rule He-M 503 specifies that BDS is the responsible unit within DHHS to operate the service delivery system including the waiver program. In addition, the BDS Bureau Administrator directly reports to and is supervised by the State Medicaid Director. Daily communication and weekly meetings occur between the State Medicaid Director and the BDS Bureau Administrator.

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.:*

   ◉ **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:*

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

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

In accordance with RSA 171-A:18, ten Area Agencies are designated to establish, operate, and administer developmental services. NH's delivery of developmental services is operated as an Organized Health Care Delivery System (OHCDS) and the ten Area Agencies each serve as the single point of entry for state-funded developmental services within the Area Agency's designated catchment area.

In collaboration with the BDS, regional Area Agencies plan, establish, and maintain a comprehensive service delivery system for people with developmental disabilities who reside in the catchment area according to rules promulgated by NH's Commissioner of Health and Human Services.

NH's ten Area Agencies are:

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

Family Driven: Advised by Regional Family Support Councils;

Regionally Based: Responsible for providing services to individuals with developmental disabilities and their families within their catchment area; and

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

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Bureau of Developmental Services has the primary responsibility to assess the performance of and recommend to the Commissioner of Health and Human Services designation and redesignation of each Area Agency. Additional ongoing assessments are performed by other entities within the Single State Medicaid Agency/DHHS including the Office of Improvement and Integrity, Office of Program Support, DHHS Finance Administration, and Surveillance and Utilization Review Services.

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
As outlined in He-M 505, Establishment and Operation of Area Agencies, BDS conducts Redesignation of each Area Agency on a rotating five-year schedule. The Redesignation process involves a Governance Desk Audit, on-going quality review of Key Indicators Data, Individual and Family Forums, surveys and a joint meeting with each Area Agency Board of Directors and Management Team.

To supplement the every five year redesignation schedule, the BDS has developed an annual quality review process that includes many elements of the redesignation process. Information from the annual quality review serves to inform the redesignation process, but more importantly, provides meaningful data on an on-going basis to help inform the performance of Area Agencies and identify issues with compliance and/or quality of services.

The Governance Desk Audit includes a review of the following:

-Board Composition, including representation on the board by individuals/clients or their family members
-Current Board by-laws, policies and procedures
-Executive Director Qualifications
-Current Area Agency Plan and any amendments
-Board of Directors Minutes
-Information on how the AA assures individuals, families and stakeholders are involved in planning for the provision of and satisfaction of the services
-Review of the Human Rights Committee Membership and minutes
-Information on how the AA communicates with sub-contract agencies
-Report of the AA on-going quality assurance activities
-Contract Compliance

The Key Indicators Data includes a review of the following:
Financial Key Indicators = Monthly Review
Medicaid Billing Activity = Monthly Review
Certification Data from Bureau of Health Facilities Administration = Quarterly Review
Waitlist Utilization = Quarterly Review
Service Review Audits = Ongoing
Reports from Human Rights Committee - quarterly
Reports from Risk Management Committee - quarterly
Complaint Investigations = Ongoing with a review of trends and follow-up on corrective action plans twice per year
Health Risk Screening Tool Data = quarterly
Other existing data = NCI, Employment, etc...as available.

Regional forums are held for individuals and one for families/guardians following the redesignation schedule.

Surveys are conducted with provider agencies, individuals and families/guardians annually.

## 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 | 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 | ☑ | ☐ |

| Function | Medicaid Agency | Local Non-State Entity |
|---|---|---|
| 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:**
**Numerator: Number of Area Agencies engaged in an annual Quality Improvement Process; Denominator: Number of Area Agencies.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Redesignation**

| **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<br>Specify: | ☑ Annually | ☐ Stratified<br>Describe Group: |
| | ☐ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>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<br>Specify: | ☑ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

**Performance Measure:**
**Numerator: Number of Area Agencies with formal Quality Improvement processes that continuously assess and improve the quality of its services and ensure that the recipients of services are satisfied with the services they receive. Denominator: Total Number of Area Agencies.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| 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: |

**Performance Measure:**
**Numerator: Number of individuals enrolled per NH MMIS annual unduplicated count;**
**Denominator: Number of individuals approved to be served**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Redesignation**

| | | |
|---|---|---|

| **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: |

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.
The State requires a plan of correction for failure to submit evidence of a formal quality improvement process annually.

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

The State reviews the composition of each area agency's board of directors and issues a plan of correction to any area agency whose board composition is less than 1/3 individuals receiving services or their family members.

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

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

| **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 | | | ☐ |
| | ☐ | Disabled (Physical) | | | |
| | ☐ | Disabled (Other) | | | |
| ☐ Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | |
| | ☐ | Brain Injury | | | ☐ |
| | ☐ | HIV/AIDS | | | ☐ |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ☑ Intellectual Disability or Developmental Disability, or Both | | | | | |
| | ☑ | Autism | 0 | | ☑ |
| | ☑ | Developmental Disability | 0 | | ☑ |
| | ☑ | Intellectual Disability | 0 | | ☑ |
| ☐ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | |
| | ☐ | Serious Emotional Disturbance | | | |

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

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

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

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

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

**The limit specified by the State is** *(select one)*

- **A level higher than 100% of the institutional average.**

  Specify the percentage:

- **Other**

  *Specify:*

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

- **The following dollar amount:**

  Specify dollar amount:

  **The dollar amount** *(select one)*

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

    Specify the formula:

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

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

  Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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:

Individual eligibility, Level of Care and service plans are reviewed and approved in advance of waiver entrance by State QIDP staff to ensure that individual's needs can be adequately addressed within the developmental disabilities waiver.

In accordance with He-M 503, the State Administrative Rule regarding eligibility for DD services, any individual who has been denied as a result of not meeting eligibility or service criteria may appeal the decision individually or through his or her parent or guardian by requesting a fair hearing pursuant to He-M 202 and He-C 201.02(i) within 30 days of the denial letter.

The signature page of the service agreement documents that the individual, family or representative have been fully informed of the appeal process including how to file an appeal.

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

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

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

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

☑ **Other safeguard(s)**

Specify:

Depending on the age of the individual, he/she may be referred to another waiver or may have additional service needs met by the NH Medicaid State Plan. The individual's service coordinator also works with the individual's family to access additional services through the Medicaid State Plan and/or other generic resources.

## 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 | 5000 |

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| Year 2 | 5200 |
| Year 3 | 5400 |
| Year 4 | 5600 |
| Year 5 | 5800 |

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:

Selection of entrants to the waiver is in accordance with He-M 503, the state's administrative rule governing eligibility for services, and 517, the state's administrative rule governing waiver services.

State Administrative Rule He-M 503 defines eligibility for Developmental Services as follows: "Developmental disability" means "developmental disability" as defined in RSA 171-A:2, V, namely, "a disability:

(a) Which is attributable to an intellectual disability, cerebral palsy, epilepsy, autism or a specific learning disability, or any other condition of an individual found to be closely related to an intellectual disability as it refers to general intellectual functioning or impairment in adaptive behavior or requires treatment similar to that required for persons with an intellectual disability; and

(b) Which originates before such individual attains age 22, has continued or can be expected to continue indefinitely, and constitutes a severe disability to such individual's ability to function normally in society."

State Administrative Rule He-M 517 defines the requirements and procedures for qualifying for medicaid-covered home and community-based care waiver services.

The State ensures that all applicants are treated consistently across the state by ensuring that the elements of the rules noted above are followed by all ten area agencies and the BDS. This is done through review of eligibility determination materials done as part of the Waiver level of care and prior authorization processes and through review of DD Waiver service agreements upon initial entry to the waiver and ongoing.

## 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**
- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **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)**
- [x] **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)**
- [x] **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:*

## 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.*

- [x] **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: 148 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:

Level of Care determinations are made by State QIDPs as defined in 42 CFR 483.430(a) within the Bureau of Developmental Services.

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.

The following definition for ICF/IID level of care is in the State plan and for this waiver.

An individual requires ICF/IID level of care if he/she requires, on a daily basis, services for at least one of the following: Performance of basic living skills; Intellectual, physical/sensorimotor and/or psychological/emotional development and well-being; Medication administration and instruction in, or supervision of, self-medication by a licensed medical professional; or Medical monitoring or nursing care by a licensed professional person.

Initial requests for DD Waiver services require Area Agencies to submit the application for waiver services using the NH Bureau of Developmental Services Functional Screen signed by a licensed practitioner.

NH BDS Functional Screen Forms are reviewed in detail along with the individual's Service Agreement (Plan of Care) and available assessments, such as ICAP, SIB-R, and/or SIS as appropriate, to determine and redetermine 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:

The NH Department of Health and Human Services has fully implemented a web-based system, MMIS system, to standardize and track application for services, level of care and eligibility determinations and payment and processing to provider agencies. The Area Agency submits the NH BDS Functional Screen form, the Service Agreement and other relevant evaluations or assessments to be reviewed by the Bureau of Developmental Services' QIDPs to determine or redetermine the child's/individual's eligibility for the waiver.

NH BDS Functional Screen Forms are reviewed in detail along with the individual's Service Agreement (Plan of Care) and available assessments, such as ICAP, SIB-R, and/or SIS as appropriate, to determine and redetermine Level of Care.

Redeterminations are made annually by submitting through MMIS a revised NH BDS Functional Screen form, Service Agreement when appropriate and a Prior Authorization Request, also known as a Service Authorization Request.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  *Specify the other schedule:*

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  *Specify the qualifications:*

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

The State utilizes the following procedures to ensure timely reevaluations of level of care: The Area Agencies submit to MMIS reevaluation requests for HCBS-DD services which include a revised NH BDS Functional Screen form, Service Agreement when appropriate and a DD Community Care Waiver Prior Authorization Request. NH's MMIS does not allow payments for claims dated beyond the expiration date of the prior authorization. In order for payment under the DD waiver, a PA must be in place. PAs are issued only when appropriate redetermination documents are submitted to and reviewed and approved by the Bureau of Developmental Services QIDP staff.

QIDP staff review all HCBS-DD applications and relevant forms for each waiver participant at least annually, or more often when DD service changes are requested.

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

BDS Management staff periodically review participant files and determination and documentation of Level of Care decisions.

Any application with inconclusive evidence is reviewed by BDS Management Team staff.

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:

The Bureau of Developmental Services maintains hard copy files for each waiver recipient's entire Prior Authorization request and approval history. Since implementation of the MMIS system in April 2013, all waiver recipients' entire Prior Authorization requests and approval history are stored electronically in the MMIS system.

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

### Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**Numerator: Number and percent of new enrollees who had a level of care review conducted prior to the receipt of waiver services. Denominator: all new enrollees.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Prior Authorization Waiver System (PAWS)**

| **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: |

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:**
**Numerator: Level of care re-evaluations annually; Denominator: Number of Waiver recipients**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Prior Authorization Waiver System (PAWS)**

| **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**<br>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:**
**Numerator = Number of LOC reviews that were completed using BDS approved process and forms. Denominator = All waiver participants**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Prior Authorization Waiver System (PAWS)**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>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:**
**Numerator = Number of Service Authorizations Denied with communications specifying the denial reason. Denominator = Total Number of Service Authorizations Denied.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Prior Authorization Waiver System (PAWS)**

| **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: |

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

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

| **Responsible Party***(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).

Prior to the provision of services, the Area Agency convenes a person centered planning meeting during which the individual is informed of service options available through this waiver as well as the NH Medicaid State Plan, including institutional setting, community resources, and other alternatives that may be pertinent to the individual's

and family's specific situation.

As specified in State Administrative Rule He-M 503, eligibility for services, the signature page of all individual service agreements documents informed consent and that the family has been fully informed of community and institutional service alternatives as well as their right to a fair hearing if they are not in agreement with components of the individual service agreement.

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.

Within the individual's Service Agreement at the Area Agency.

## Appendix B: Participant Access and Eligibility

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

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
State regulation He-M 503 requires informed consent relative to services and service provision. Informed consent necessitates communication in a language that can be readily understood by the individual/guardian. Informational brochures in various languages are available.

He-M 503 requires: "Cultural competence" described as the "knowledge, attitudes, and interpersonal skills applied to a provider's practice methods that allow the provider to understand, appreciate, and work effectively with individuals from cultures other than his or her own."

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

## Appendix C: Participant Services

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

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

| Service Type | Service |
|---|---|
| Statutory Service | Community Participation Services |
| Statutory Service | Residential Habilitation/Personal Care Services |
| Statutory Service | Respite |
| Statutory Service | Service Coordination |
| Statutory Service | Supported Employment |
| Other Service | Assistive Technology Support Services |
| Other Service | Community Support Services (CSS) |
| Other Service | Crisis Response Services |
| Other Service | Environmental and Vehicle Modification Services |
| Other Service | Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services |
| Other Service | Specialty 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:**

Day Habilitation

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

Community Participation Services

**HCBS Taxonomy:**

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

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

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

Assist the individual to attain, improve, and maintain a variety of life skills, including vocational skills;
Emphasize, maintain and broaden the individual's opportunities for community participation and relationships;
Support the individual to achieve and maintain valued social roles, such as of an employee or community volunteer;
Promote personal choice and control in all aspects of the individual's life and services, including the involvement of the individual, to the extent he or she is able, in the selection, hiring, training, and ongoing evaluation of his or her primary staff and in determining the quality of services; and
Are provided in accordance with the individual's service agreement and goals and desired outcomes.

All community participation services shall be designed to:

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

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

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

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

Traveling safely in the community;

Managing personal funds;

Participating in community activities; and

Other life skills identified in the service agreement;

Promote the individual's health and safety;

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

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

Community participation services shall be primarily provided in community settings outside of the home where the individual lives.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
NA.

**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 | Day Service Provider |
| Individual | Day Service Provider |

## Appendix C: Participant Services

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

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

**Provider Category:**
Agency
**Provider Type:**
Day Service Provider
**Provider Qualifications**

**License** *(specify)*:
If clinical consultants are used, they shall be licensed or certified as required by New Hampshire law.
**Certificate** *(specify)*:
If clinical consultants are used, they shall be licensed or certified as required by New Hampshire law.

If medications are being administered by non-licensed staff in certified settings, staff members must be certified to administer medications in conjuction with He-M 1201.

Medication Administration Training and Authorization: All staff and providers are required to complete Medication Administration Training as outlined in NH's regulation He-M 1201 prior to administering medications to individuals receiving services in certified day settings. He-M 1201 training is conducted by a qualified, and BDS approved, registered nurse-trainer. Medication Administration Training consists of:
•8 hours of classroom instruction;
•Training regarding the specific needs of the individual;
•Standardized written testing; and
•Clinical observation by the nurse-trainer.

Ongoing supervision and quality assurance are conducted by an RN to ensure continued competency. This regulation and the accompanying curriculum have been approved by the New Hampshire Board of Nursing.
**Other Standard** *(specify)*:
Each applicant for employment shall meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description.

Staff Qualifications and Training.
(a) Day services staff and consultants shall collectively possess professional backgrounds and competencies such that the needs of the individuals who receive day services can be met.
(b) Direct service staff may include professional staff, non-professional staff, and volunteers who shall be supervised by professional staff or by the director of day services or his or her designee.
(c) Prior to a person providing day services to individuals, the provider agency, with the consent of the person, shall:
(1) Obtain at least 2 references for the person; and
(2) Complete, at a minimum, a New Hampshire criminal records check to ensure that the person has no history of:
a. Felony conviction; or
b. Any misdemeanor conviction involving:
1. Physical or sexual assault;
2. Violence;
3. Exploitation;
4. Child pornography;
5. Threatening or reckless conduct;
6. Theft;
7. Driving under the influence of drugs or alcohol; or
8. Any other conduct that represents evidence of behavior that could endanger the well being of an individual.
(d) If clinical consultants are used, they shall be licensed or certified as required by New Hampshire law.
(e) All persons who provide day services shall be at least 18 years of age.
(f) Prior to delivering day services to an individual, the provider agency shall orient staff and consultants to the needs and interests of the individuals they serve, in the following areas:
(1) Rights and safety;
(2) Specific health-related requirements including those related to:
a. Current medical conditions, medical history and routine and emergency protocols; and
b. Any special nutrition, dietary, hydration, elimination, or ambulation needs;
(3) Any specific communication needs;
(4) Any behavioral supports;

(5) The individuals' service agreements, including all goals and methods or strategies to achieve the goals; and
(6) The day services' evacuation procedures, if applicable.
(g) Provider agencies shall:
(1) Assign staff to work with an experienced staff member during their orientation if they have had no prior experience providing services to individuals;
(2) Train staff in accordance with He-M 506 within the first 6 months of employment; and
(3) Provide staff with annual training in accordance with their individual staff development plan.

Prior to delivering services to an individual, a prospective provider shall have received orientation in the following areas:
•Rights and safety;
•Specific health-related requirements of each individual including:
oAll current medical conditions, medical history, routine and emergency protocols; and
oAny special nutrition, dietary, hydration, elimination, and ambulation needs;
oAny specific communication needs;
o Any behavioral supports of each individual served;
oThe individual's fire safety assessment pursuant to He-M 1001.06(m); and
oThe community residence's evacuation procedures.
An overview of developmental disabilities including the local and state service delivery system;
oClients' rights as set forth in He-M 202 and He-M 310;
Everyday health including personal hygiene, oral health, and mental health;
oThe elements that contribute to quality of life for individuals including support to:
oCreate and maintain valued social roles;
oBuild relationships; and Participate in their local communities;
oStrategies to help individuals to learn useful skills;
oBehavioral support; and Consumer choice, empowerment and self-advocacy.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

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

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

**Frequency of Verification:**
Verification of provider qualification happens prior to hiring and service delivery. The Bureau of Health Facilities Administration verfies provider qualificaitons at certification site visits. BDS conducts service review audits on a sampling of records on an annual basis.

## Appendix C: Participant Services

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

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

**Provider Category:**
Individual

**Provider Type:**
Day Service Provider

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify):*
If medications are being administered by non-licensed staff in certified settings, staff members must be certified to administer medications in conjuction with He-M 1201.

Medication Administration Training and Authorization: All staff and providers are required to complete Medication Administration Training as outlined in NH's regulation He-M 1201 prior to administering medications to individuals receiving services in certified day settings. He-M 1201 training is conducted by a qualified, and BDS approved, registered nurse-trainer. Medication Administration Training consists of:
•8 hours of classroom instruction;
•Training regarding the specific needs of the individual;
•Standardized written testing; and
•Clinical observation by the nurse-trainer.

Ongoing supervision and quality assurance are conducted by an RN to ensure continued competency. This regulation and the accompanying curriculum have been approved by the New Hampshire Board of Nursing.
**Other Standard** *(specify):*
Each applicant for employment shall meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description.

Staff must be trained in accordance with He-M 506 and 507 prior to providing day services.
Qualified Providers: Direct Service Staff of an AA or provider agency/private developmental services agency must meet the following minimum qualifications for and conditions of employment identified in He-M 1001, 521, and or 525.
•Be at least 18 years of age
•Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description; and
•Meet professional certification and licensure requirements of the position.

Prior to hiring a person, the provider agency, with the consent of the person, shall:
•Obtain at least 2 references for the person, at least one of which shall be from a former employer; and
•Complete, at a minimum, a New Hampshire criminal records check to ensure that the person has no history of:
oFelony conviction; or
oAny misdemeanor conviction involving:
oPhysical or sexual assault;
oViolence;
oExploitation;
oChild pornography;
oThreatening or reckless conduct;
oTheft;
oDriving under the influence of drugs or alcohol; or
oAny other conduct that represents evidence of behavior that could endanger the well being of an individual.
•Complete a motor vehicles record check to ensure that the potential provider has a valid driver's license.
•Personnel records, including background information relating to a staff person's qualifications for the position held, shall be maintained by the provider agency for a period of 6 years after that staff person's employment termination date.

Prior to providing services to individuals, a provider shall have evidence of a negative mantoux tuberculin test, or if positive, evidence of follow up conducted in accordance with the Center for Disease Control Guidelines. Such test shall have been completed within the previous 6 months.

Prior to delivering services to an individual, a prospective provider shall have received orientation in

the following areas:
•Rights and safety;
•Specific health-related requirements of each individual including:
oAll current medical conditions, medical history, routine and emergency protocols; and
oAny special nutrition, dietary, hydration, elimination, and ambulation needs;
oAny specific communication needs;
o Any behavioral supports of each individual served;
oThe individual's fire safety assessment pursuant to He-M 1001.06(m); and
oThe community residence's evacuation procedures.
An overview of developmental disabilities including the local and state service delivery system;
oClients' rights as set forth in He-M 202 and He-M 310;
Everyday health including personal hygiene, oral health, and mental health;
oThe elements that contribute to quality of life for individuals including support to:
oCreate and maintain valued social roles;
oBuild relationships; and Participate in their local communities;
oStrategies to help individuals to learn useful skills;
oBehavioral support; and Consumer choice, empowerment and self-advocacy.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

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

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

**Frequency of Verification:**
Verification of provider qualification happens prior to hiring and service delivery. The Bureau of Health Facilities Administration verfies provider qualificaitons at certification site visits. BDS conducts service review audits on a sampling of records on an annual basis.

## Appendix C: Participant Services

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

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

**Service Type:**
Statutory Service

**Service:**
Residential Habilitation

**Alternate Service Title (if any):**
Residential Habilitation/Personal Care 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):*
Residential Habilitation/Personal Care Services includes a range of individually tailored supports to assist with the acquisition, retention, or improvement of community living skills including: assistance with activities of daily living such as meal preparation, eating, bathing, dressing, personal hygiene, medication management, community inclusion, transportation, social and leisure skills, therapeutic recreation, and adaptive skill development 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. Services are provided to eligible individuals with the following general assistance needs:
Level I: Intended primarily for individuals whose level of functioning is relatively high but who still require intermittent supports on a daily basis;
Level II: Intended for individuals whose level of functioning is relatively high but who nevertheless require supports and supervision throughout the day;
Level III: Intended for individuals whose level of functioning requires substantial supports and supervision;
Level IV: Intended for individuals whose level of functioning requires frequent supports and supervision;
Level V: Intended for individuals who have significant medical and /or behavioral needs and require critical levels of supports and supervision; and

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

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

Providers of this service must meet State standards. When provided in the home, all Residential Habilitation/Personal Care Services are provided in a State certified setting in accordance with either He-M 521 (Family Residence) which w/could include a private family home, He-M 525 (Certified Participant Directed and Managed Services) which w/could include a private family home, or He-M 1001 (Community Residences).

A Community Residence, He-M 1001, is either an agency residence or private residence exclusive of any independent living arrangement that:

(1) Provides residential services for at least one individual with a developmental disability (in accordance with He-M 503) or acquired brain disorder (in accordance with He-M 522);

(2) Provides services and supervision for an individual on a daily and ongoing basis, both in the home and in the community, unless the individual's service agreement states that the individual may be left alone;

(3) Serves individuals whose services are funded by the department; and

(4) Is certified pursuant to He-M 1001, Certified Community Residence.

Payment is not made for the cost of room and board, building maintenance, upkeep, nor improvement.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Except in circumstances were BDS has determined that any additional costs are related directly to the individual's safety, transportation costs may not exceed $5,000 per year.

**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**
- [x] **Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Residential Habilitation/Personal Care Services**

**Provider Category:**
Agency
**Provider Type:**
Direct Service Provider
**Provider Qualifications**
**License** *(specify)*:
If services are being provided in conjunction with a practice act, provider must comply with the State's licensure and certification laws as appropriate.
**Certificate** *(specify)*:
If medications are being administered by non-licensed staff in certified settings, staff members must be certified to administer medications in conjuction with He-M 1201.
Medication Administration Training and Authorization: All staff and providers are required to complete Medication Administration Training as outlined in NH's regulation He-M 1201 prior to administering medications to individuals receiving services in certified home or day settings. He-M 1201 training is conducted by a qualified, and BDS approved, registered nurse-trainer. Medication Administration Training consists of:
•8 hours of classroom instruction;
•Training regarding the specific needs of the individual;
•Standardized written testing; and
•Clinical observation by the nurse-trainer.

Ongoing supervision and quality assurance are conducted by an RN to ensure continued competency. This regulation and the accompanying curriculum have been approved by the New Hampshire Board of Nursing.
**Other Standard** *(specify)*:
Qualified Providers: Direct Service Staff of an AA or provider agency/private developmental services agency must meet the following minimum qualifications for and conditions of employment identified in He-M 1001, 521, and or 525.
•Be at least 18 years of age

•Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description; and
•Meet professional certification and licensure requirements of the position.

Prior to hiring a person, the provider agency, with the consent of the person, shall:
•Obtain at least 2 references for the person, at least one of which shall be from a former employer; and
•Complete, at a minimum, a New Hampshire criminal records check to ensure that the person has no history of:
oFelony conviction; or
oAny misdemeanor conviction involving:
Physical or sexual assault;
Violence;
Exploitation;
Child pornography;
Threatening or reckless conduct;
Theft;
Driving under the influence of drugs or alcohol; or
Any other conduct that represents evidence of behavior that could endanger the well being of an individual.
•Complete a motor vehicles record check to ensure that the potential provider has a valid driver's license.
•Personnel records, including background information relating to a staff person's qualifications for the position held, shall be maintained by the provider agency for a period of 6 years after that staff person's employment termination date.
•No provider or other person living or working in a community residence shall serve as the legal guardian of an individual living in that community residence.

Prior to providing services to individuals, a provider shall have evidence of a negative mantoux tuberculin test, or if positive, evidence of follow up conducted in accordance with the Center for Disease Control Guidelines. Such test shall have been completed within the previous 6 months.

Prior to delivering services to an individual, a prospective provider shall have received orientation in the following areas:
•Rights and safety;
•Specific health-related requirements of each individual including:
oAll current medical conditions, medical history, routine and emergency protocols; and
oAny special nutrition, dietary, hydration, elimination, and ambulation needs;
oAny specific communication needs;
o Any behavioral supports of each individual served;
oThe individual's fire safety assessment pursuant to He-M 1001.06(m); and
oThe community residence's evacuation procedures.
An overview of developmental disabilities including the local and state service delivery system;
oClients' rights as set forth in He-M 202 and He-M 310;
Everyday health including personal hygiene, oral health, and mental health;
oThe elements that contribute to quality of life for individuals including support to:
oCreate and maintain valued social roles;
oBuild relationships; and Participate in their local communities;
oStrategies to help individuals to learn useful skills;
oBehavioral support; and Consumer choice, empowerment and self-advocacy.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

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

BDS audits records as part of its service review audits and evaluates compliance with provider qualification standards.
**Frequency of Verification:**
Verification of provider qualification happens prior to hiring and service delivery.
The Bureau of Health Facilities Administration verfies provider qualificaitons at certification site visits.
BDS conducts service review audits on a sampling of records on an annual basis.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Residential Habilitation/Personal Care Services**

**Provider Category:**
Individual
**Provider Type:**
Direct Service Provider
**Provider Qualifications**
**License** *(specify)*:
If services are being provided in conjunction with a practice act, provider must comply with the State's licensure and certification laws as appropriate.
**Certificate** *(specify)*:
If medications are being administered by non-licensed staff in certified settings, staff members must be certified to administer medications in conjuction with He-M 1201.

Medication Administration Training and Authorization: All staff and providers are required to complete Medication Administration Training as outlined in NH's regulation He-M 1201 prior to administering medications to individuals receiving services in certified home or day settings. He-M 1201 training is conducted by a qualified, and BDS approved, registered nurse-trainer. Medication Administration Training consists of:
•8 hours of classroom instruction;
•Training regarding the specific needs of the individual;
•Standardized written testing; and
•Clinical observation by the nurse-trainer.

Ongoing supervision and quality assurance are conducted by an RN to ensure continued competency. This regulation and the accompanying curriculum have been approved by the New Hampshire Board of Nursing.
**Other Standard** *(specify)*:
Qualified Providers: Direct Service Staff of an AA or provider agency/private developmental services agency must meet the following minimum qualifications for and conditions of employment identified in He-M 1001, 521, and or 525.
•Be at least 18 years of age
•Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description; and
•Meet professional certification and licensure requirements of the position.

Prior to hiring a person, the provider agency, with the consent of the person, shall:
•Obtain at least 2 references for the person, at least one of which shall be from a former employer; and
•Complete, at a minimum, a New Hampshire criminal records check to ensure that the person has no history of:
oFelony conviction; or
oAny misdemeanor conviction involving:
Physical or sexual assault;
Violence;

Exploitation;
Child pornography;
Threatening or reckless conduct;
Theft;
Driving under the influence of drugs or alcohol; or
Any other conduct that represents evidence of behavior that could endanger the well being of an individual.
•Complete a motor vehicles record check to ensure that the potential provider has a valid driver's license.
•Personnel records, including background information relating to a staff person's qualifications for the position held, shall be maintained by the provider agency for a period of 6 years after that staff person's employment termination date.
•No provider or other person living or working in a community residence shall serve as the legal guardian of an individual living in that community residence.

Prior to providing services to individuals, a provider shall have evidence of a negative mantoux tuberculin test, or if positive, evidence of follow up conducted in accordance with the Center for Disease Control Guidelines. Such test shall have been completed within the previous 6 months.

Prior to delivering services to an individual, a prospective provider shall have received orientation in the following areas:
•Rights and safety;
•Specific health-related requirements of each individual including:
oAll current medical conditions, medical history, routine and emergency protocols; and
oAny special nutrition, dietary, hydration, elimination, and ambulation needs;
oAny specific communication needs;
o Any behavioral supports of each individual served;
oThe individual's fire safety assessment pursuant to He-M 1001.06(m); and
oThe community residence's evacuation procedures.
An overview of developmental disabilities including the local and state service delivery system;
oClients' rights as set forth in He-M 202 and He-M 310;
Everyday health including personal hygiene, oral health, and mental health;
oThe elements that contribute to quality of life for individuals including support to:
oCreate and maintain valued social roles;
oBuild relationships; and Participate in their local communities;
oStrategies to help individuals to learn useful skills;
oBehavioral support; and Consumer choice, empowerment and self-advocacy.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

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

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

**Frequency of Verification:**

Verification of provider qualification happens prior to hiring and service delivery.
The Bureau of Health Facilities Administration verfies provider qualificaitons at certification site visits.
BDS conducts service review audits on a sampling of records on an annual basis.

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Respite

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

**HCBS Taxonomy:**

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

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:

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 those persons normally providing the care.

**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**

☑ **Relative**
☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Respite Provider |
| Agency | Respite Provider |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Individual
**Provider Type:**
Respite Provider
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Applicant must have two unrelated referenes and no history of:
a. Felony conviction; or
b. Any misdemeanor conviction involving:
1. Physical or sexual assault;
2. Violence;
3. Exploitation;
4. Child pornography;
5. Threatening or reckless conduct;
6. Theft; or
7. Any other conduct that represents evidence of behavior that could endanger the well-being of an individual.

Respite providers shall have knowledge and training in the following areas:
(1) The value and importance of respite to a family;
(2) The area agency mission statement and the importance of family-centered supports and services as described in He-M 519.04(a);
(3) Basic health and safety practices including emergency first aid;
(4) The nature of developmental disabilities;
(5) Understanding behavior as communication and facilitating positive behaviors; and
(6) Other specialized skills as determined by the area agency in consultation with the family.

If the respite is to be provide in the respite provider's home, the home shall be visited by a staff member from the area agency prior to the delivery of respite.

The staff member who visited the provider's home shall complete a report of the visit that includes a statement of acceptability of the following conditions using criteria established by the area agency:
(1) The general cleanliness;
(2) Any safety hazards;
(3) Any architectural barriers for the individual(s) to be served; and
(4) The adequacy of the following:

a. Lighting;
b. Ventilation;
c. Hot and cold water;
d. Plumbing;
e. Electricity;
f. Heat;
g. Furniture, including beds; and
h. Sleeping arrangements.

The following criteria shall apply to area agency arranged respite providers:
(1) Providers shall be able to meet the day-to-day requirements of the person(s) served(2) Respite providers giving care in their own homes shall serve no more than 2 persons at one time; and
(3) If respite is provided overnight, respite providers shall identify a person for the area agency to contact who, in the judgment of the provider, is responsible and able to assist in providing respite to an individual in the event that the provider is unable to meet the respite needs of the individual or comply with these rules.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The Area Agency has the primary responsibility to verify provider qualifications.

**Frequency of Verification:**
Verification of provider qualification happens prior to service delivery. Agencies employ a feedback mechanism to elicit the level of satisfaction with provider competency, which they have incorporated into the reimbursement strategy for respite providers.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency

**Provider Type:**
Respite Provider

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Applicant must have two unrelated referenes and no history of:
a. Felony conviction; or
b. Any misdemeanor conviction involving:
1. Physical or sexual assault;
2. Violence;
3. Exploitation;
4. Child pornography;
5. Threatening or reckless conduct;
6. Theft; or
7. Any other conduct that represents evidence of behavior that could endanger the well-being of an individual.

Respite providers shall have knowledge and training in the following areas:
(1) The value and importance of respite to a family;

(2) The area agency mission statement and the importance of family-centered supports and services as described in He-M 519.04(a);
(3) Basic health and safety practices including emergency first aid;
(4) The nature of developmental disabilities;
(5) Understanding behavior as communication and facilitating positive behaviors; and
(6) Other specialized skills as determined by the area agency in consultation with the family.

If the respite is to be provide in the respite provider's home, the home shall be visited by a staff member from the area agency prior to the delivery of respite.

The staff member who visited the provider's home shall complete a report of the visit that includes a statement of acceptability of the following conditions using criteria established by the area agency:
(1) The general cleanliness;
(2) Any safety hazards;
(3) Any architectural barriers for the individual(s) to be served; and
(4) The adequacy of the following:
a. Lighting;
b. Ventilation;
c. Hot and cold water;
d. Plumbing;
e. Electricity;
f. Heat;
g. Furniture, including beds; and
h. Sleeping arrangements.

The following criteria shall apply to area agency arranged respite providers:
(1) Providers shall be able to meet the day-to-day requirements of the person(s) served, including all of the services listed in He-M 513.04(m);
(2) Respite providers giving care in their own homes shall serve no more than 2 persons at one time; and
(3) If respite is provided overnight, respite providers shall identify a person for the area agency to contact who, in the judgment of the provider, is responsible and able to assist in providing respite to an individual in the event that the provider is unable to meet the respite needs of the individual or comply with these rules.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Area Agency has the primary responsibility to verify provider qualifications.

**Frequency of Verification:**

Verification of provider qualification happens prior to service delivery. Agencies employ a feedback mechanism to elicit the level of satisfaction with provider competency, which they have incorporated into the reimbursement strategy for respite providers.

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Case Management

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

Service Coordination

**HCBS Taxonomy:**

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

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:
Service Coordination: Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
NA.

**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 | Service Coordinator |
| Individual | Service Coordinator |

## Appendix C: Participant Services

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

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

**Provider Category:**
Agency

**Provider Type:**
Service Coordinator
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Each applicant for employment shall:
(1) Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description; and
(2) Meet professional certification and licensure requirements of the position.

(a) The service coordinator shall be a person chosen or approved by the individual or guardian and approved by the area agency, provided that the area agency shall retain ultimate responsibility for service coordination.
(b) The service coordinator shall:
(1) Advocate on behalf of individuals for services to be provided;
(2) Coordinate the service planning process;
(3) Describe to the individual or guardian service provision options such as self-directed services;
(4) Monitor and document services provided to the individual;
(5) Ensure continuity and quality of services provided;
(6) Ensure that service documentation is maintained;
(7) Determine and implement necessary action and document resolution when goals are not being addressed, support services are not being provided in accordance with the service agreement, or when health or safety issues have arisen;
(8) Convene service planning meetings at least annually and whenever:
a. The individual or guardian is not satisfied with the services received;
b. There is no progress on the goals after follow-up interventions;
c. The individual's needs change; or
d. There is a need for a new provider; and
(9) Document service coordination visits and contacts;

(c) A service coordinator shall not:
(1) Be a guardian of the individual whose services he or she is coordinating;
(2) Have a felony conviction;
(3) Have been found to have abused or neglected an adult with a disability based on a protective investigation performed by the bureau of elderly and adult services in accordance with He-E 700 and an administrative hearing held pursuant to He-E 200, if such a hearing is requested;
(4) Be listed in the state registry of abuse and neglect pursuant to RSA 169-C:35 or RSA 161-F:49; or
(5) Have a conflict of interest concerning the individual, such as providing other direct services to the individual.
(d) If the service coordinator chosen by the individual or guardian is not employed by the area agency or its subcontractor:
(1) The service coordinator and area agency shall enter into an agreement which describes:
a. The role(s) for which the service coordinator assumes responsibility;
b. The reimbursement, if any, provided by the area agency to the service coordinator; and
c. The oversight activities to be provided by the area agency;

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
(2) If the area agency determines that the service coordinator is not acting in the best interest of the individual or is not fulfilling his or her obligations as described in the letter of agreement, the area agency shall revoke the designation of the service coordinator with a 30-day notice and designate a new service coordinator, with input from the individual or guardian

(3) If the area agency determines that a service coordinator chosen by the individual or guardian is posing an immediate and serious threat to the health or safety of the individual, the area agency shall terminate the designation of the service coordinator immediately upon issuance of written notice specifying the reasons for the action and designate a new service coordinator, with input from the individual or guardian

(e) The individual or guardian may appeal the area agency's decision. The area agency shall advise the individual or guardian verbally and in writing of his or her appeal rights.
(f) The role of service coordinator may, by mutual agreement, be shared by an employee of the area agency and another person. Such agreements shall be in writing and clearly indicate which functions each service coordinator will perform.
**Frequency of Verification:**
On-going relative to the best interests of the individual.

## Appendix C: Participant Services

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

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

**Provider Category:**
Individual
**Provider Type:**
Service Coordinator
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Each applicant for employment shall:
(1) Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;
(2) Meet professional certification and licensure requirements of the position.

The Service Coordinator is: a person chosen or approved by the individual or guardian and approved by the area agency, provided that the area agency shall retain ultimate responsibility for service coordination.

A service coordinator shall not:
(1) Be a guardian of the individual whose services he or she is coordinating;
(2) Have a felony conviction;
(3) Have been found to have abused or neglected an adult with a disability based on a protective investigation performed by the bureau of elderly and adult services in accordance with He-E 700 and an administrative hearing held pursuant to He-E 200, if such a hearing is requested;
(4) Be listed in the state registry of abuse and neglect pursuant to RSA 169-C:35 or RSA 161-F:49; or
(5) Have a conflict of interest concerning the individual, such as providing other direct services to the individual.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
The Area Agency has the primary responsibility to verify the qualification of service providers. If the service coordinator chosen by the individual or guardian is not employed by the area agency or its subcontractor: the service coordinator and area agency shall enter into an agreement which

describes:
a. The role(s) set forth for which the service coordinator assumes responsibility;
b. The reimbursement, if any, provided by the area agency to the service coordinator; and
c. The oversight activities to be provided by the area agency.
**Frequency of Verification:**
Prior to the delivery of services, the Area Agency verifies qualifications.
If the area agency determines that the service coordinator is not acting in the best interest of the individual or is not fulfilling his or her obligations as described in the letter of agreement, the area agency shall revoke the designation of the service coordinator with a 30-day notice and designate a new service coordinator, with input from the individual or guardian; and

If the area agency determines that a service coordinator chosen by the individual or guardian is posing an immediate and serious threat to the health or safety of the individual, the area agency shall terminate the designation of the service coordinator immediately upon issuance of written notice specifying the reasons for the action and designate a new service coordinator, with input from the individual or guardian.

The individual or guardian may appeal the area agency's decision about a service coordinator. The area agency shall advise the individual or guardian verbally and in writing of his or her appeal rights.

## Appendix C: Participant Services

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

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

**Service Type:**
Statutory Service

**Service:**
Supported Employment

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

**HCBS Taxonomy:**

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

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Employment services for persons with developmental disabilities served within the state community developmental services system who have an expressed interest in working to:

Provide access to comprehensive employment services by qualified staff;

Make available, based upon individual need and interest: employment, training and educational opportunities; and the use of co-worker supports and generic resources, to the maximum extent possible.

All employment services shall be designed to:

Assist the individual to obtain employment or self-employment that is based on the individual's employment profile and goals in the service agreement;

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

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

Creating a resume and employment portfolio;

Practicing job interviews; and

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

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

Developing accommodations;

Utilizing assistive technology; and

Creating and implementing a fading plan;

Help the individual to:

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

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

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

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

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

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

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

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

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

Traveling safely in the community;

Managing personal funds;

Utilizing public transportation; and

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

Promote the individual's health and safety;

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

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

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

**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 |
|---|---|
| Individual | Employment Consultant |
| Agency | Employment Consultant |

## Appendix C: Participant Services

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

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

**Provider Category:**
Individual

**Provider Type:**
Employment Consultant

**Provider Qualifications**

**License** *(specify)*:
N/A

**Certificate** *(specify)*:
N/A

**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), available as noted in Appendix A; 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.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

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

**Frequency of Verification:**

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

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

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Employment Consultant

**Provider Qualifications**

**License** *(specify)*:

NA

**Certificate** *(specify)*:

NA

**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), available as noted in Appendix A; 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.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

BDS audits records as part of its service review audits and evaluates compliance with provider qualification standards.
**Frequency of Verification:**
Verification of provider qualification happens prior to hiring and service delivery.

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

## Appendix C: Participant Services

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

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Assistive Technology Support 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):*
Assistive Technology Support Services: are intended to help individuals in selection, acquisition, and use of assistive technology devices. The Assistive Technology Support Services are designed to provide individuals

with evaluation, consultation, coordination, training and technical assistance as well as acquisition, designing, fitting, and customizing of devices.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Computer or electronic devices obtained under this category must be based on the written recommendation of a licensed professional, be needed based on the individual's disability, be related to goals and objectives in the service agreement and are subject to an annual service limit of $1,500; BDS may authorize additional funds in upon the written recommendation of a licensed professional or a recognized entity, such as NH ATECH.

Any items provided under this category must be based on an assessed need by a qualified provider and cannot be available as a benefit under the NH State Medicaid Plan.

**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 | Clinician |
| Individual | Clinician |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assistive Technology Support Services**

**Provider Category:**
Agency

**Provider Type:**
Clinician

**Provider Qualifications**

**License** *(specify)*:
OT, PT, Speech, or other licensed or certified clinician as applicable.

**Certificate** *(specify)*:

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
State licensing board(s)or certification entities as appropriate to license or certificate type.

**Frequency of Verification:**
Annual or other schedule as outlined by law or regulation.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assistive Technology Support Services**

**Provider Category:**
Individual

**Provider Type:**
Clinician

**Provider Qualifications**

**License** *(specify)*:
OT, PT, Speech, or other licensed or certified clinician as applicable.

**Certificate** *(specify)*:

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
State licensing board(s)or certification entities as appropriate to license or certificate type.

**Frequency of Verification:**
Annual or other schedule as outlined by law or regulation.

## 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 Support Services (CSS)

**HCBS Taxonomy:**

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

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Community Support Services: are intended for the individual who has developed, or is trying to develop, skills to live independently within the community. Community Support Services consist of assistance, excluding room and board, provided to an individual to improve or maintain his or her skills in basic daily living and community integration; and enhance his or her personal development and well being in accordance with goals outlined in the individual's service agreement. Services may begin and continue for a time limited period while the individual is still residing with his/her family. If services begin while the individual is still residing with his or her family, the service agreement must include specific goals and objectives as well as the expected duration of the services to be provided prior to the individual moving out of the family home.

Community Support Services include, as individually necessary, assistance in areas such as: daily living skills, money management, shopping skills, food preparation, laundry, household maintenance, use of community resources, community safety, and social skills. . Persons receiving Community Support Services require the continuous availability of, and access to, services and supports, which shall assure that the individual's needs are met.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
NA

**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 | CSS Staff |
| Individual | CSS Staff |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Support Services (CSS)**

**Provider Category:**
Agency
**Provider Type:**
CSS Staff

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Each applicant for employment shall meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description.

Direct Service Staff of an AA or provider agency/private developmental services agency must meet the following minimum qualifications:
•Be at least 18 years of age
•Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description; and
•Meet professional certification and licensure requirements of the position.

Prior to hiring a person, the provider agency, with the consent of the person, shall:
•Obtain at least 2 references for the person, at least one of which shall be from a former employer; and
•Complete, at a minimum, a New Hampshire criminal records check to ensure that the person has no history of:
oFelony conviction; or
oAny misdemeanor conviction involving:
oPhysical or sexual assault;
oViolence;
oExploitation;
oChild pornography;
oThreatening or reckless conduct;
oTheft;
oDriving under the influence of drugs or alcohol; or
oAny other conduct that represents evidence of behavior that could endanger the well being of an individual.
•Complete a motor vehicles record check to ensure that the potential provider has a valid driver's license.
•Personnel records, including background information relating to a staff person's qualifications for the position held, shall be maintained by the provider agency for a period of 6 years after that staff person's employment termination date.

Prior to providing services to individuals, a provider shall have evidence of a negative mantoux tuberculin test, or if positive, evidence of follow up conducted in accordance with the Center for Disease Control Guidelines. Such test shall have been completed within the previous 6 months.

Prior to delivering services to an individual, a prospective provider shall have received orientation in the following areas:
•Rights and safety;
•Specific health-related requirements of each individual including:
oAll current medical conditions, medical history, routine and emergency protocols; and
oAny special nutrition, dietary, hydration, elimination, and ambulation needs;
oAny specific communication needs;
oAny behavioral supports of each individual served;
oThe individual's fire safety assessment pursuant to He-M 1001.06(m); and
oThe community residence's evacuation procedures.
An overview of developmental disabilities including the local and state service delivery system;
oClients' rights as set forth in He-M 202 and He-M 310;
Everyday health including personal hygiene, oral health, and mental health;
oThe elements that contribute to quality of life for individuals including support to:

oCreate and maintain valued social roles;
oBuild relationships; and Participate in their local communities;
oStrategies to help individuals to learn useful skills;
oBehavioral support; and Consumer choice, empowerment and self-advocacy.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

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

**Frequency of Verification:**

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

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Support Services (CSS)**

**Provider Category:**
Individual

**Provider Type:**
CSS Staff

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

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

Each applicant for employment shall meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description.

Direct Service Staff of an AA or provider agency/private developmental services agency must meet the following minimum qualifications:
•Be at least 18 years of age
•Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description; and
•Meet professional certification and licensure requirements of the position.

Prior to hiring a person, the provider agency, with the consent of the person, shall:
•Obtain at least 2 references for the person, at least one of which shall be from a former employer; and
•Complete, at a minimum, a New Hampshire criminal records check to ensure that the person has no history of:
oFelony conviction; or
oAny misdemeanor conviction involving:
oPhysical or sexual assault;
oViolence;
oExploitation;
oChild pornography;
oThreatening or reckless conduct;

oTheft;
oDriving under the influence of drugs or alcohol; or
oAny other conduct that represents evidence of behavior that could endanger the well being of an individual.
•Complete a motor vehicles record check to ensure that the potential provider has a valid driver's license.
•Personnel records, including background information relating to a staff person's qualifications for the position held, shall be maintained by the provider agency for a period of 6 years after that staff person's employment termination date.

Prior to providing services to individuals, a provider shall have evidence of a negative mantoux tuberculin test, or if positive, evidence of follow up conducted in accordance with the Center for Disease Control Guidelines. Such test shall have been completed within the previous 6 months.

Prior to delivering services to an individual, a prospective provider shall have received orientation in the following areas:
•Rights and safety;
•Specific health-related requirements of each individual including:
oAll current medical conditions, medical history, routine and emergency protocols; and
oAny special nutrition, dietary, hydration, elimination, and ambulation needs;
oAny specific communication needs;
oAny behavioral supports of each individual served;
oThe individual's fire safety assessment pursuant to He-M 1001.06(m); and
oThe community residence's evacuation procedures.
An overview of developmental disabilities including the local and state service delivery system;
oClients' rights as set forth in He-M 202 and He-M 310;
Everyday health including personal hygiene, oral health, and mental health;
oThe elements that contribute to quality of life for individuals including support to:
oCreate and maintain valued social roles;
oBuild relationships; and Participate in their local communities;
oStrategies to help individuals to learn useful skills;
oBehavioral support; and Consumer choice, empowerment and self-advocacy.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

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

**Frequency of Verification:**

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

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

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Crisis Response Services

**HCBS Taxonomy:**

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

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Crisis Response Services: include direct consultation, clinical evaluation, and staffing supports to individuals who are experiencing a behavioral, emotional or medical crisis or challenges. These services are intended to address the individual's specific problems, thereby reducing the likelihood of harm to the individual or others, and assisting the individual to return to his/her pre-crisis status.

**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**
- [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 |
|---|---|
| Individual | Clinician, or consultant, behavioral specialist, or direct support staff |

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Crisis Response Services**

**Provider Category:**

Individual

**Provider Type:**

Clinician, or consultant, behavioral specialist, or direct support staff

**Provider Qualifications**

**License** *(specify):*

Certain provider types may require licensure depending on what service is provided.

**Certificate** *(specify):*

Certain provider types may require certification depending on service provided.

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

Direct service staff would be required to meet, at a minimum, requirements as outlined under Day and Residential Habilitation/Personal Care Services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency or appropriate State Licensing Board.

**Frequency of Verification:**

Annual or as identified in law or regulation by licensing entity.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Environmental and Vehicle Modification Services

**HCBS Taxonomy:**

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

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

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

- (●) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:
Environmental and Vehicle Modification Services: Include those physical adaptations to the private residence of the participant or the participant's family, or vehicle that is the waiver participant's primary means of transportation, required by the individual's service plan, that are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and community, and without which, the individual would require institutionalization.

Such adaptations may include the installation of lifts, ramps and grab-bars, widening of doorways, modifications to allow for emergency egress and emergency medical and fire response, modification of bathroom facilities, installation of smoke and carbon monoxide detectors and other specialized electric and plumbing systems which are necessary to accommodate the individual's medical equipment and which are necessary for the welfare and the safety of the individual.

Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, painting, tiling, roof repair, central air conditioning, etc.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All modifications will be provided in accordance with applicable State or local building codes.

Relative to vehicle modification, the following are excluded: those adaptations or improvements to a vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; purchase of a vehicle; and regularly scheduled upkeep and maintenance of a vehicle with the exception of upkeep and maintenance of the modifications. Vehicles may not be owned by paid providers of waiver services.

For individuals with unsafe wandering or running behaviors, outdoor fencing may be provided under this waiver.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Waiver funds allocated toward the cost of outdoor fencing for individuals with unsafe wandering or running behaviors shall not exceed $2,500.

**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 |
|---|---|
| Individual | Private Contractor, or other similarly qualified provider |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Environmental and Vehicle Modification Services**

**Provider Category:**
Individual
**Provider Type:**
Private Contractor, or other similarly qualified provider
**Provider Qualifications**
**License** *(specify):*
As required by state law or local ordinance.
**Certificate** *(specify):*
As required by state law or local ordinance.
**Other Standard** *(specify):*
Permit, State and or local building codes
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Area agency.
**Frequency of Verification:**
As requests for individual environmental modifcations are made/approved.

## 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 (PDMS) formerly Consolidated Developmental 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)*:
Participant Directed and Managed Services - PDMS (formerly Consolidated Developmental Services)

PDMS enables individuals to maximize consumer direction affording the option to exercise choice and control over a menu of waiver services and utilization of BDS authorized funding. This service category includes an individually tailored and personalized combination of services and supports for individuals with developmental disabilities and their families in order to improve and maintain the individual's opportunities and experiences in living, working, socializing, recreating, personal growth, safety and health.
Individuals whose services are funded through PDMS have direct and manage their services.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Individualized PDMS budgets should not allocate more than approximately 15% of waiver services funding for Respite Care Services.

Except in circumstances were BDS has determined that additional costs are related directly to the individual's safety, transportation costs may not exceed $5,000 per year.

Personal care therapeutic recreation services have a service limit of $1,200 per year.

Computer or electronic devices obtained under this category must be based on the written recommendation of a licensed professional, be needed based on the individual's disability, be related to goals and objectives in the service agreement and are subject to an annual service limit of $1,500; BDS may authorize additional funds in upon the written recommendation of a licensed professional or a recognized entity, such as NH ATECH.

Any items provided under this category must be based on an assessed need by a qualified provider and cannot be available as a benefit under the NH State Medicaid Plan.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Direct Service Staff |
| Individual | Direct Service Staff |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services**

**Provider Category:**
Agency
**Provider Type:**
Direct Service Staff
**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Staff and providers must:
a. Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;
b. Meet the certification and licensing requirements of the position, if any; and
c. Be 18 years of age or older;
(8) The employer, when not the individual or representative, shall provide information to the individual and representative regarding the staff development elements identified in He-M 506.05 to assist him or her in making informed decisions with respect to orientation and training of staff and providers; and
(9)...the employer shall insure that the staff and providers receive the orientation and training selected by the individual or representative.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Verification of provider qualifications is done at the service level by area agencies and subcontract agencies.

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

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

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services**

**Provider Category:**
Individual

**Provider Type:**
Direct Service Staff

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
In accordance with He-M 525.06, staff and providers must:
a. Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;
b. Meet the certification and licensing requirements of the position, if any; and
c. Be 18 years of age or older;
(8) The employer, when not the individual or representative, shall provide information to the

individual and representative regarding the staff development elements identified in He-M 506.05 to assist him or her in making informed decisions with respect to orientation and training of staff and providers; and
(9)...the employer shall insure that the staff and providers receive the orientation and training selected by the individual or representative.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The Area Agency has the primary responsibility to verify provider qualifications.

**Frequency of Verification:**
Verification of provider qualification happens prior to service delivery. The certification process involves review of training records.

## Appendix C: Participant Services

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

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

**Service Type:**
Other Service

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

**Service Title:**
Specialty Services

**HCBS Taxonomy:**

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

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:
Specialty Services: are intended for recipients whose needs in the areas of medical, behavioral, therapeutic, health and personal well being require services which are specialized pertaining to unique conditions and

aspects of developmental disabilities. Services are utilized to provide assessments; consultations; design, development and provision of services; and evaluation of service outcomes.

**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**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Consultant, e.g. psychologist |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Specialty Services**

**Provider Category:**
Individual

**Provider Type:**
Consultant, e.g. psychologist

**Provider Qualifications**

**License** *(specify)*:
Dependent on nature of service being provided, for example, a licensed psychiatrist, psychologist, OT, PT, ST, or neurologist.

**Certificate** *(specify)*:
Dependent on nature of service being provided, for example, a certified behaviorist/applied behavior analyst.

**Other Standard** *(specify)*:
Any other specialist with expertise in developmental disabilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
State licensing or certification board or Area Agency.

**Frequency of Verification:**
Annual, or as outlined in regulation or law by licensing or certification entity.

## 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:*

- [x] **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:

## 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):

In accordance with He-M 503, the State's Administrative Rule which governs services under the DD Waiver, the state requires, prior to working directly with an individual, that the provider agency, with the consent of the person:

(1) Obtain at least 2 references for the person;

(2) Complete, at a minimum, a New Hampshire criminal records check no more than 30 days prior to hire;

(3) If a person's primary residence is out of state, complete a criminal records check for their state of residence;

(4) If a person has resided in New Hampshire for less than one year, complete a criminal records check for their previous state of residence; and

(5) Complete a NH Bureau of Elderly and Adult Services [BEAS] state registry check no more than 30 days prior to hire.

(e) Except as allowed in (f)-(g) below, the provider agency shall not hire a person:

(1) Who has a:

a. Felony conviction; or

b. Any misdemeanor conviction involving:

1. Physical or sexual assault;

2. Violence;

3. Exploitation;

4. Child pornography;

5. Threatening or reckless conduct;

6. Theft;

7. Driving under the influence of drugs or alcohol; or

8. Any other conduct that represents evidence of behavior that could endanger the well-being of an individual; or

(2) Whose name is on the BEAS state registry.

(f) A provider agency may hire a person with a criminal record listed in (e)(1)a. or b. above for a single offense that occurred 10 or more years ago in accordance with (g) and (h) below. In such instances, the individual, his or her guardian if applicable, and the area agency shall review the person's history prior to approving the person's employment.

(g) Employment of a person pursuant to (f) above shall only occur if such employment:

(1) Is approved by the individual, his or her guardian if applicable, and the area agency;

(2) Does not negatively impact the health or safety of the individual(s); and
(3) Does not affect the quality of services to individuals.

The State ensures that criminal background checks and state registry screenings are completed during on-site service review audits of DD Waiver service records.

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):

The DHHS maintains an abuse, neglect, and exploitation registry pursuant to state statute RSA 169-C:35 and state statute RSA 161-F:49. Information about this registry can be found at: http://www.dhhs.nh.gov/dcbcs/beas/registry.htm

The State ensures that criminal background checks and state registry screenings are completed during on-site service review audits of DD Waiver service records.

## 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 | |
|---|---|
| Community Residence | |

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.

Homes with 4 or more beds must be both Licensed and Certified under He-M 1001, Certification of Community Residences, and requires at a minimum that: Living space shall be arranged and maintained to support the health and safety of all household members, as follows:
(1) Each community residence shall be maintained in good repair and free of hazard to household members; and
(2) Each community residence shall be free from environmental nuisances, including loud noise and foul odors.
(l) A community residence shall provide the following:
(1) A specific sleeping area designated for each individual;
(2) A separate bed for each individual with each bedroom containing no more than 2 beds; and
(3) Storage space for each individual's clothing and other personal possessions.
(m) An individual's right to privacy shall be protected.
(n) Each bedroom shall be situated such that:
(1) No individual shall reside in a bedroom that is the access way to another bedroom or to a common area of the house; and
(2) Common areas shall not be used as bedrooms by any individual living in the home.
(o) The community residence shall have:
(1) At least one indoor bathroom which includes a sink, toilet, and a bathtub or shower for every 6 persons in the household;
(2) At least one telephone at all times when an individual is in the home;
(3) An integrated fire alarm system with a detector in each bedroom and on each level of the home including basement and attic, if the attic is used as living or storage space;
(4) A functioning septic or other sewage disposal system; and
(5) A source of potable water for drinking and food preparation, as follows:
a. If drinking water is supplied by a non-public water system, the water shall be tested and found to be in accordance with Env-Dw 704 through Env-Dw 706 initially and every 6 years thereafter; and
b. If the water is not approved for drinking, an alternative method for providing safe drinking water shall be implemented.

All waiver services provided within larger facilities are provided through the person centered planning process outline in He-M 503, eligibility for services. All services developed through the person centered planning process are focused on ensuring that individuals' services are in keeping with home and community based service principles.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Community Residence

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| Residential Habilitation/Personal Care Services | ☑ |
| Assistive Technology Support Services | ☑ |
| Crisis Response Services | ☑ |
| Respite | ☐ |
| Environmental and Vehicle Modification Services | ☐ |
| Specialty Services | ☑ |
| Community Participation Services | ☑ |
| Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services | ☑ |
| Community Support Services (CSS) | ☐ |
| Service Coordination | ☑ |
| Supported Employment | ☑ |

**Facility Capacity Limit:**

16

**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:**

## 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 individuals for furnishing Personal Care Services when they are qualified to provide the services and under the following circumstances:

As part of the State's Consumer Direction/Participant Directed and Managed Services and when the following criteria have been met:

Payment for provision of personal care services shall be available to a legally responsible person when:

(1) The individual has at least one of the following factors:

a. The individual's level of dependency in performing activities of daily living, including the need for assistance with toileting, eating or mobility, exceeds that of his or her developmentally disabled peers as determined by a nationally recognized standardized functional assessment tool;

b. The individual requires support for a complex medical condition, including airway management, enteral feeding, catheterization or other similar procedures; or

c. The individual's need for behavioral management exceeds that of his or her developmentally disabled peers, as determined by a nationally recognized standardized behavioral assessment tool, and the individual's destructive or injurious behavior represents a risk for serious injury or death;

(2) The legally responsible person has at least one of the following factors:

a. The person has exhausted all options for obtaining in-home support assistance due to the lack of availability of qualified providers, as noted below; or

b. The individual's need for care has an imminent, negative effect on a parent or legally responsible adult's ability to maintain paid employment; and

(3) The legally responsible person or parent meets all applicable provider qualifications and documentation requirements pursuant to He-M 503, eligibility for services.

Payments to legally responsible persons and parents apply solely to the provision of personal care services.

The State ensures that services provided by the legally responsible adult are in the best interest of the individual through on-going case management and through the annual/on-going person centered planning process.

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.

In those situations where a family member is to be reimbursed as a provider or subcontractor, the area agency or subcontract agency shall, in consultation with the individual, guardian, and family, develop a contract that:
(1) Identifies the responsibilities of the area agency, subcontract agency, if applicable, and the family member as a provider or subcontractor;
(2) Describes the provision of supports needed to administer medication safely;
(3) Includes provision for time off and identifying the area agency or subcontract agency responsibility in assisting the family to secure substitute providers when the family member is the provider;
(4) Includes a provision for either party to dissolve the contract with notice;
(5) Allows for review and revision as deemed necessary by either party; and
(6) Is signed by all parties.

The area agency shall:
(1) Have, at a minimum, quarterly contacts with the family to provide information and support to ensure that services are provided in accordance with the service agreement; and
(2) Ensure that the service arrangement is in compliance with He-M 506.03, STAFF QUALIFICATIONS AND STAFF DEVELOPMENT REQUIREMENTS FOR DEVELOPMENTAL SERVICE AGENCIES, Minimum Staff Qualifications; He-M506.05, Staff Development Requirements, and He-M 1201, Medication Administration.

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

Payment is contingent upon agency reciept of appropriate service documentation.

- **Other policy.**

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Choice, control, and self-direction are fundamental elements of NH's Developmental Services System. Each participant is afforded choice of service provider(s). An individual and/or guardian may choose any willing and qualified provider. New providers may be added at the request of an individual and/or guardian so long as that provider is qualified.

Area Agencies contract with numerous private developmental services agencies and individual service providers.

In addition to the ten Area Agencies, NH's Developmental Service System currently utilizes in excess of 65 private developmental services agencies, and hundreds of individual providers.

An individual and/or guardian may select any person, agency, or another Area Agency as a provider to deliver one or more of the services identified in the individual's Service Agreement. The Service agreement documents that the individual and/or guardian were offered a choice of providers.

All providers shall comply with the rules pertaining to the service(s) offered and meet the provisions specified within the individual's Service Agreement.

As noted above, waiver participants/families may select any willing and qualified provider without regard to whether or not that provider is currently a provider in the NH Developmental Services System. Any qualified prospective provider not already providing waiver services can be selected by the family or individual and thus become a provider within NH's regional developmental services system.

## 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:**
**Numerator: Number of Area Agencies meeting state certification standards for licensure and certification of services providers; Denominator: Number of Area Agencies.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS Bureau of Health Facilities Administration - Community Residence Certification Database (CRC)**

| **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<br>Confidence Interval = |
| ☑ Other<br>Specify:<br>NH DHHS Bureau of Health Facilities Administration | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☑ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>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<br>Specify:<br>NH DHHS Bureau of Health Facilities Administration | ☑ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>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:**
**Numerator: Number of Area Agencies that demonstrate non-licensed/non-certified providers meet waiver requirements. Denominator = Number of Area Agencies.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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:**
**Numerator= Number of Area Agencies demonstrating provider training is conducted according to state requirements and waiver requirements;**
**Denominator: Number of Area Agencies reviewed.**

**Data Source** (Select one):
**Training verification records**
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: BHFA | ☐ **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: BHFA | ☑ **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.
The BDS reviewer(s) will communicate any area found to be out of compliance to the Area Agency directly, while on-site and subsequently by written report. Follow up is coordinated by the BDS Liaison who will assure appropriate action(s) has been taken. Audit reports are completed and plans of correction are

requested, if applicable. Area agencies are required to provide corrective action plans within 30 days of the State's request.

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.*

NH BDS has implemented service caps in certain areas including assistive technology, therapeutic recreation, environmental modifications, consultative services and respite care when the respite care is provided as part of the state's Participant Directed and Managed Services program. The purpose for these service limits in these categories is to preserve the use of the Developmental Disabilities Waiver primarily for Personal Care, Community Support Services, Supported Employment and Day Habilitation/Community Participation Services.

☐ **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 State of New Hampshire has two groups leading the efforts to address CMS's Home and Community Based Services expectations and to ensure that all settings meet the HCB Settings Requirement at the time of this submission and in the future.

The first is the Waiver Transition Team which includes a Senior Health Care Policy Specialist for the Department of Health and Human Services, subject matter experts for Division of Health and Human Services and Long Term Supports and Services, a Project Director, a HCBS Project Coordinator, both from the NH UCED and the Institute on Disability.

The second group is the Advisory Task Force which is made up of 16 members and was established in March 2015 to provide consumer and stakeholder feedback on the development activities for the Statewide Transition Plan. The group is advisory in nature and includes representatives from a broad array of stakeholders, including those potentially most

impacted by the new rules. There is representation from the following groups:

Adult Day Services Association
Brain Injury Association
Developmental Disability Council
Disability Rights Center (NH P&A organization)
Elder Rights Coalition
Granite State Independent Living
Medical Care Advisory Committee (3)
NH Association of Counties
NH Association of Residential Care Homes
NH Health Care Association
NH Legal Assistance
Office of Long Term Care Ombudsman
People First of New Hampshire
Private Provider Network

NH DHHS completed a thorough review of all standards, rules, and regulations to determine their current level of compliance with the settings requirements.

From April 2015 through March of 2016, New Hampshire has been engaged in the identification, assessment and remediation of all HCBS settings to ensure compliance with the Settings Rule. The culmination of that work informed the remediation steps within NH's Statewide Transition Plan.

An interdisciplinary team called the Waiver Transition Team (WTT), also identified as the Transition Work Group in the initial Transition Framework, was tasked with the development of this plan. The WTT is comprised of representatives from New Hampshire Department of Health and Human Services (NH DHHS) which houses New Hampshire's single state Medicaid agency, and the division of Long-Term Supports and Services (LTSS) as well as the University of New Hampshire Institute on Disability - University Center for Excellence in Disability (UCED). NH DHHS partnered with the University of New Hampshire Institute on Disability (IOD) to manage the assessment and plan development process. The IOD is an experienced research and project management organization that provided data collection, data analysis and remediation planning based on the assessment work it conducted.

Settings were assessed/evaluated using the following methods:

Provider Self Assessments - The initial survey effort included outreach to the providers recorded on the Master List requesting that they complete a self-assessment. There were 1,513 provider self-assessment responses across NH's HCBS 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.

Participant Surveys – The data from participants was collected in several ways. Surveys were provided to Area Agency staff for DD Waiver participants. Additionally, Community Participation providers were asked to assist with data collection. Some participants were able to provide information and enter the data into the survey database while others submitted the information in a paper format.

On-Site Validation Visits- A representative sample of eligible settings across the waivers was selected for validation site visits. To conduct validation field visits, New Hampshire hired a team of 15 Validation Team members and a Project Coordinator who completed on-site validation visits. The qualities that the team members needed to possess, which were identified by the Advisory Group, included a values-based philosophy, non-judgmental attitude, ability to conduct visits in a neutral manner, consistency in approach, and a commitment to the project's goal. During each on-site validation visit a provider survey and participant survey was conducted when possible. This allowed a cross-walk between the provider and participant responses at a particular site.

The State of New Hampshire has, to date, at the time of this initial Waiver renewal [March 2016] identified eleven sites under the DD Waiver that would be presumed institutional due to their location. The state intends to request heightened scrutiny of these settings.

In addition, the State of NH will be completing additional assessment regarding the issue of isolation outside of the settings presumed to be institutional and will initiate the heightened scrutiny process, remediation process or relocation process, as

needed. The state will focus its efforts on enhancing providers' ability to ensure that participants are not isolated. Monitoring will occur through certification/licensing visits, service coordination visits, provider documentation and participant satisfaction information. Any site that is determined to be isolating will have the opportunity to develop and implement a remediation plan, or the heightened scrutiny process may be initiated, or the relocation process may be implemented.

More detailed information about NH's Statewide Transition Plan can be found at:http://www.dhhs.nh.gov/ombp/medicaid/draft-transition-framework.htm

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**
Service Agreement

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(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)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  *Specify qualifications:*

- [ ] **Social Worker**

  *Specify qualifications:*

- [ ] **Other**

  *Specify the individuals and their qualifications:*

## 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.

According to State Administrative Rule He-M 503, eligibility for DD services, the state requires that:

All service planning shall occur through a person-centered planning process that:

Maximizes the decision-making of the individual;

Is directed by the individual or representative, if applicable;

Facilitates personal choice by providing information and support to assist the individual to direct the process, including information describing:

The array of services and service providers available; and

Options regarding self-direction of services;

Includes participants freely chosen by the individual;

Reflects cultural considerations of the individual and is conducted in clearly understandable language and form;

Occurs at times and a location of convenience to the individual, guardian or representative;

Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants;

Is consistent with an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint;

Includes a method for the individual, guardian, or representative to request amendments to the plan;

Records the alternative home- and community-based settings that were considered by the individual, guardian, or representative;

Includes strategies to address co-occurring severe mental illness or behavioral challenges which are interfering with the person's functioning, including positive behavior plans or other strategies based on functional behavior or other evaluations or referrals to behavioral health services;

Includes individualized backup plans and strategies;

Provides a method to request updates;

Includes strategies for solving disagreements;

Uses a strengths-based approach to identify the positive attributes of the individual;

Includes the provision of auxiliary aids and services when needed for effective communication, including low literacy materials and interpreters;

Addresses the individual's concerns about current or contemplated guardianship or other legal assignment of rights; and

Explores housing and employment in integrated settings, and develops plans consistent with the individual's goals

and preferences.

The service coordinator shall document that he or she has, as applicable, maximized the extent to which an individual participates in and directs his or her person-centered planning process by:

Explaining to the individual the person-centered planning process and providing the information and support necessary to ensure that the individual directs the process to the maximum extent possible;

Explaining to the individual his or her rights and responsibilities;

Providing the individual with information regarding the services and service providers available to enable the individual to make informed decisions as to whom they would like to provide services;

Eliciting information from the individual regarding his or her personal preferences and service needs, including any health concerns, that shall be a focus of service planning meetings;

Determining with the individual issues to be discussed during all service planning meetings; and

Explaining to the individual the limits of the decision-making authority of the guardian, if applicable, and the individual's right to make all other decisions related to services.

The individual, guardian, or representative may determine the following elements of the service planning process:

The number and length of meetings;

The location, date, and time of meetings;

The meeting participants;

Topics to be discussed; and

Whether any additional assessments or evaluations are needed to assist in the development of the service agreement.

In order to develop or revise a service agreement to the satisfaction of the individual, guardian, or representative, the service planning process shall consist of periodic and ongoing discussions regarding elements that:

Include the individual and other persons involved in his or her life;

Are facilitated by a service coordinator; and

Are focused on the individual's abilities, health, interests, and achievements.

The service planning process shall include a discussion regarding whether or not there is a need for a limited or full guardianship, conservatorship, representative payee for Social Security benefits, durable power of attorney, durable power of attorney for healthcare, or other less restrictive alternatives to guardianship. The discussion and any recommendations shall be incorporated into the service agreement and the area agency director shall implement any such recommendations.

The service planning process shall include a discussion of the need for assistive technology that could be utilized to support all services and activities identified in the proposed service agreement without regard to the individual's current use of assistive technology.

Service agreements shall be reviewed by the area agency with the individual, guardian, or representative at least once during the first 6 months of service and as needed. The annual review shall include a service planning meeting.

## 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):

According to He-M 503, NH's Administrative Rule for eligibility for DD Services, area agencies are required to develop service plans according to the following:

Within 5 days of the determination of eligibility, the area agency shall have conducted sufficient preliminary planning with the individual and guardian or representative at the time of intake or during subsequent discussions to identify and document the specific services needed.

The service coordinator shall hold an initial service planning meeting with the individual, the individual's guardian or representative, and any other person chosen by the individual within 30 days of the determination of eligibility.

Within 14 days of the initial service agreement meeting the service coordinator shall develop a written basic service agreement, signed by the individual, guardian, or representative and the area agency executive director or designee, that includes the following:

A brief description of the individual's strengths, needs, and interests, as applicable;

The individual's clinical and support needs as identified through current evaluations and assessments;

The specific services to be furnished and the goal associated with each service;

The amount, frequency, duration and desired outcome of each service;

Timelines for initiation of services;

The provider to furnish the service;

The individual's need for guardianship, if any;

Service documentation requirements sufficient to track outcomes;

Identification of the person or entity responsible for monitoring the plan;

Documentation that the setting the individual resides in was chosen by the individual or representative and is integrated in, and supports full access of individuals to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as people not receiving services;

Documentation that the setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting, and that the settings options are identified and based on the individual's needs, and preferences;

Documentation that any restriction on the right of an individual to realize his or her preferences or goals in the services plan is justified by:

An identified specific and individualized need that the modification is based on;

The positive interventions and supports used prior to any modifications to the individual's rights;

The less intrusive methods of meeting the need that were tried but did not work;

A clear description of the condition that is directly proportionate to the specific assessed need;

The regular collection and review of data to measure the ongoing effectiveness of the modification;

Established time limits for periodic reviews of the necessity of the modification;

The informed consent of the individual, guardian, or representative; and

An assurance that the modification will not cause harm to the individual; and

For individuals with a participant directed and managed service arrangement, reporting mechanisms regarding budget updates.

The service coordinator shall convene a meeting to prepare an expanded service agreement within 20 business days of the initiation of services with consideration of the following:

If people who provide services to the individual are not selected by the individual to participate in a service planning meeting, the service coordinator shall contact such persons prior to the meeting so that their input can be considered.

Copies of relevant evaluations and reports shall be sent to the individual and guardian at least 5 business days before service planning meetings.

Within 10 business days following a service planning meeting pursuant to (e) above, the service coordinator shall:

Prepare a written expanded service agreement that includes the following:

A personal profile; and

A list of those who participated in the service agreement planning meeting; and

In addition to the information included in the basic service agreement, also includes the following:

The specific services to be provided;

The goals to be addressed, and timelines and methods for achieving them;

The persons responsible for implementing each service in the expanded service agreement;

Any training needed to carry out the service agreement, beyond the staff training required by He-M 506.05 and other applicable rules, with the type and amount of such training to be determined by the service agreement participants;

Services needed but not currently available;

Service documentation requirements sufficient to describe progress on goals and the services received;

If applicable, reporting mechanisms under self-directed services regarding budget updates and individual and guardian satisfaction with services;

If applicable, risk factors and the measures required to be in place to minimize them, including backup plans and strategies; and

The individual's need for guardianship, if any;

Contact all persons who have been identified to provide a service to the individual and confirm arrangements for providing such services; and

Explain the service arrangements to the individual and guardian and confirm that they are to the individual's and

guardian's satisfaction.

For individuals who reside in a provider owned or controlled residential setting, the service agreement shall document any modifications of the individual's rights in said setting to:

Privacy in their sleeping or living unit, including doors lockable by the individual with only appropriate staff having keys to doors as needed;

Freedom and support to control their own schedule and activities;

Access to food at any time;

Having visitors of their choosing at any time; and

Freedom to furnish and decorate sleeping or living units.

A provider agency shall only make modifications pursuant to (i) above by documenting in the service agreement the following:

An identified specific and individualized assessed need that the modifications are based on;

The positive interventions and supports used prior to any modifications to the service agreement;

The less intrusive methods of meeting the need that have been tried but did not work;

A clear description of the condition that is directly proportionate to the specific assessed need;

The regular collection and review of data to measure the ongoing effectiveness of the modification;

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

The informed consent of the individual or representative; and

An assurance that the interventions and support will not cause harm to the individual.

Within 5 business days of completion of the service agreement, the area agency shall send the individual, guardian, or representative the following:

A copy of the expanded service agreement signed by the area agency executive director or designee;

The name, address, and phone number of the service coordinator or service provider(s) who may be contacted to respond to questions or concerns; and

A description of the procedures for challenging the proposed expanded service agreement for those situations where the individual, guardian, or representative disapproves of the expanded service agreement.

The individual, guardian, or representative shall have 10 business days from the date of receipt of the expanded service agreement to respond in writing, indicating approval or disapproval of the service agreement. Unless otherwise arranged between the individual, guardian, or representative and the area agency, failure to respond within the time allowed shall constitute approval of the service agreement.

When an expanded service agreement has been approved by the individual, guardian, or representative and area agency director, the services shall be implemented and monitored as follows:

A person responsible for implementing any part of an expanded service agreement, including goals and support services, shall collect and record information about services provided and summarize progress as required by the service agreement or, at a minimum, monthly;

On at least a monthly basis, the service coordinator shall visit or have verbal contact with the individual or persons

responsible for implementing an expanded service agreement and document these contacts;

The service coordinator shall visit the individual and contact the guardian, if any, at least quarterly, or more frequently if so specified in the individual's expanded service agreement, to determine and document:

Whether services match the interests and needs of the individual;

Individual and guardian satisfaction with services; and

Progress on the goals in the expanded service agreement; and

If the individual receives residential personal care services at least 2 of the service coordinator's quarterly visits with the individual shall be in the home where the individual resides.

Service agreements shall be renewed at least annually.

Service agreements shall be reviewed and revised:

When the individual's circumstances or needs change; or

At the request of the individual or representative.

As described in this Waiver application in section D-1:c, all service planning shall occur through a person-centered planning process.

All service agreements shall:

Be understandable to the individual, guardian, or representative and all services providers responsible for providing services;

At a minimum, be written in plain language and in a manner accessible to individuals with disabilities and persons who have limited proficiency in English;

Be finalized and agreed to in writing by the individual, guardian, or representative and signed by all providers responsible for the implementation of the service agreement;

Be written such that no unnecessary or inappropriate services or supports will be provided to the individual; and

Be distributed to the individual, guardian, or representative and all providers, including direct support providers, responsible for the implementation or monitoring of the service agreement.

Include information obtained through utilization of the Supports Intensity Scale for individuals aged 16 or older;

Include information obtained through the Health Risk Screening Tool;

Include information obtained through a risk assessment, which shall be administered to each individual with a history of, or exhibiting signs of, behaviors that pose a potentially serious likelihood of danger to self or others, or a serious threat of substantial damage to real property

Include information from specialty medical and health assessments and clinical assessments as needed, including, at a minimum, communication, assistive technology, functional behavior assessments;

Include information from personal safety assessments as applicable.

An area agency director, service coordinator, service provider, individual, guardian, or representative shall have the authority to request a service planning meeting when:

The individual's responses to services indicate the need;

A change to another service is desired;

A personal crisis has developed for the individual; or

A service agreement is not being carried out in accordance with its terms.

Service agreement amendments may be proposed at any time. Any amendment shall be made with the documented consent of the individual, guardian, or representative and the area agency.

## 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.

Area Agency service coordinators are required to operate and maintain a 24-hour on call back up system accessible to individuals, families and guardians.

NH requires, as part of the person centered planning process that risk to the participant be assessed through:

The Supports Intensity Scale assessment for individuals 16 years of age or older which, according to State Administrative Rule He-M 503, eligibility for services, shall be administered:

Initially, for each individual receiving funded community participation [day habilitation] services, community support services, employment services, residential/personal care services and participant-directed and managed services:

Upon an individual's entry onto the wait list;

Upon a significant change as defined under SIS protocols, available as noted in Appendix A; and

Five years following each prior administration;

The Health Risk Screening Tool [HRST], which shall be administered:

Within 30 days of the initiation of services;and

Annually or upon significant change in an individual's status;

Other risk assessments, which shall be administered:

To each individual with a history of, or exhibiting signs of, behaviors that pose a potentially serious likelihood of danger to self or others, or a serious threat of substantial damage to real property, such as, but not limited to, the following:

Sexual offending;

Violent aggression; or

Arson;

Assessments shall be administered:

Upon the earlier of said individual's entry onto the wait list or the individual's receiving services;

Prior to any significant change in the level of the individual's treatment or supervision;

At any time an individual who previously has not had a risk assessment begins to engage in behaviors referenced above; and

By an evaluator with specialized experience, training, and expertise in the treatment of the types of behaviors being exhibited;

Include information from specialty medical and health assessments and clinical assessments as needed, including, at a minimum, communication, assistive technology, functional behavior assessments;

Include information from personal safety assessments as applicable;

Include strategies to address co-occurring severe mental illness or behavioral challenges which are interfering with the person's functioning, including positive behavior plans or other strategies based on functional behavior or other evaluations or referrals to behavioral health services;

Include individualized backup plans and strategies;

Provide a method to request updates;

Include strategies for solving disagreements;

Use a strengths-based approach to identify the positive attributes of the individual;

Include the provision of auxiliary aids and services when needed for effective communication, including low literacy materials and interpreters;

Address the individual's concerns about current or contemplated guardianship or other legal assignment of rights

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each participant is afforded choice of service provider(s). An individual/guardian may choose any willing, qualified provider and new providers may be added at the request of an individual/guardian so long as that provider is qualified.

Individuals and/or guardians meet with their selected and approved Service Coordinator to identify what services are appropriate to meet the needs of the individual and to develop a plan to meet identified needs.

When making provider selections, or at any time subsequent to initial selection, individuals and/or guardians are provided information about the various vendors/providers including a general overview of each provider agency and service(s) provided. Individuals/guardians select the provider they wish to interview among all qualified providers.

Throughout the provider selection process, Service Coordinators work closely with individuals/guardians to inform them about various potential providers.

Providers must meet the requirements specified for each of the individual service components, and in addition, each applicant for employment must:

-Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;
-Identify former employers and agree to 2 reference checks;
-Meet certification and licensure requirements of the position, if any;

-Present documentation of a TB test performed within the past year or undergo a TB test;
-Agree to a criminal records check, prior to a final hiring decision, to ensure that the applicant has no history of a felony conviction;
-Agree to a check of the state registry of founded reports of abuse, neglect and exploitation;
-Be a minimum of eighteen years of age. However, on an individual basis and upon agreement between the family and the Area Agency, persons as young as fifteen may be chosen as a provider.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Service Agreement, along with other documentation (e.g., client profile, individual assessments, and BDS Functional Screen) is reviewed by BDS QIDP staff for initial authorization and annual reauthorizations of waiver services.

One hundred percent of Service Agreements are reviewed by BDS QIDP staff during the first three years an individual receives any HCBS. Thereafter, a full review is conducted whenever significant changes occur, as indicated by the annual Level of Care redetermination, but not less than every five years during the Area Agency's Redesignation.

All HCBS services must be approved by BDS and included in the Service Agreement to be billable.

## Appendix D: Participant-Centered Planning and Service Delivery

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

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update 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:*

The responsible Area Agency maintains Service Agreement history and all service agreements are electronically maintained in MMIS as part of the AA submission for Level of Care determination/redeterminations and service authorizations.

## 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.

When a Service Agreement has been approved by the individual or guardian and Area Agency director, services are implemented and monitored as follows:

A provider responsible for implementing elements of a Service Agreement records information about services provided and summarizes progress as required by the Service Agreement or, at a minimum, quarterly.

On at least a monthly basis, the Service Coordinator visits or has verbal contact with the individual to monitors the implementation of the service agreement through direct communication with individuals and or guardians.

On at least quarterly, or more frequently if specified in the Service Agreement, the Service Coordinator documents whether services:

a. Match the interests and needs of the individual;
b. Meet with the individual's/family's satisfaction;
c. Meet the terms of the Service Agreement; and

The Service Coordinator ensures that all service documentation is maintained pursuant to State Administrative Rule He-M 503.

The State collects systemic information about problems and identifies areas for improvement via monthly meetings with the Area Agency Service Coordinator Supervisors. In addition, the BDS Liaison to the Area Agency is a mechanism for receiving and following up on areas of individual or systemic concern. Families have access to Area Agency as well as State BDS Liaisons to discuss issues and concerns.

Systemic service delivery issues are also identified and addressed during annual service review audits and during the Area Agency Redesignation process.

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:**
**Numerator = Number of Service Agreements reviewed that address participants' assessed needs including health and welfare risks. Denominator = Number of Service Agreements reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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:**
**Numerator = Number of Service Agreements reviewed that address participants' individualized goals. D = Number of Service Agreements reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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**<br>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**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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:**
**Numerator: Service plans that have been developed in accordance with state standard He-M 503, Elibility for DD Services; Denominator: Number of service plans**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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: |

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:**
**Numerator = Number of participants service plans that have been updated at least annually. Denominator = Total Number of service plans reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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** |

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

**Performance Measure:**
**Numerator = Number of service agreements that were revised based on assessment, evaluation or screening. Denominator = Total number of service agreements reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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:**
**Numerator = Number of participants whose services were delivered in accordance with the service plan including the type, scope, amount, duration and frequency. Denominator = Total number of service plans reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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 = 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: |

c. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:**
**Numerator = Number of service agreements documenting participants/families were informed of the choice between waiver services and institutional care;**
**Denominator = Total number of service agreements reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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:**
**Numerator = Number of service agreements documenting choice among waiver services and providers; Denominator = Number of service agreements reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool**

| **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.
Upon completion of records review, reports are released to each of the Area Agencies with findings identified and a plan of correction required within a designated time frame.

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** |
| | |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.

Services provided under NH's DD waiver are specifically tailored to the competencies, interests, preferences, and needs of the individual and his or her family and respectful of the personal values and lifestyle of the family/individual.

In extending the family/individual choice and control over their service arrangements, the Service Coordinator provides information and assistance to facilitate and optimize consumer participation, direction and management of services.

Responsiveness to family/individual preferences and requests occur within the context of state and federal laws and

regulations and policies of the Area Agency.

Beginning with the initial discussion about services, Area Agency staff share information with the family/individual regarding such expectations, requirements and limitations.

All DD Waiver participants are provided with information regarding their option to Direct and Manage their services under the State's Participant Directed and Managed Service [PDMS] option which involves either the individual or his/her representative being actively involved in all aspects of the service arrangement, including:

Designing the services;

Selecting the service providers;

Deciding how the authorized funding is to be spent based on the needs identified in the individual's service agreement; and

Performing ongoing oversight of the services provided.

Service Agreements and contracts with the family/individual document consumer choice and control as well as responsibilities of the different parties involved in the service arrangement and compliance with laws and regulations.

PDMS enables people to maximize consumer direction and affords participants the option to fully exercise choice and control over the menu of waiver services. PDMS is utilized by those individuals/guardians who want to be actively engaged in the planning, design, provision, and monitoring of services and allocation of authorized service funding.

PDMS are a combination of services and assistance for individuals with developmental disabilities and their families in order to improve and maintain the individual's opportunities and experiences in living, working, socializing, recreating, personal growth, safety and health.

The individual, guardian, family, Area Agency, private developmental services agencies and the BDS collaborate to find an appropriate balance relative to service provision and funding while ensuring safety, satisfaction, and effective utilization of authorized funds.

Participants may select provider(s) for each aspect of the service arrangement.

In cases where services are to be provided by relatives or friends, these individuals must meet all relevant provider qualifications.

Service Coordinators work with individuals and their team to develop an individualized budget and Service Plan identifying all supports and services.

Individualized budgets are created for all individuals in order that

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
☑ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Participant directed and managed services is available to all invididuals with the exception of those in congregate service arrangements or programs where individuals, families, or guardians do not have the opportunity to direct and manage the services and approved funding.

In addition, individuals who present with high risk behaviors may be subject to review prior to the development of a participant directed and managed service plan in order to determine if direction and management by the individual could result in risk of serious harm to the individual or the community.

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one)*:

○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

State Administrative Rule He-M 503, eligibility for DD Services, requires Area Agencies to guarantee that services will facilitate as much as possible the individual's ability to determine and direct the services he or she will receive. This rule also articulates individuals' right to choose his/her service coordinator.

At the time of the initial and annual service agreement, area agency service coordinators are required to provide the

following information to individuals/guardians:

Documentation that he or she has, as applicable, maximized the extent to which an individual participates in and directs his or her person-centered planning process by:

Explaining to the individual the person-centered planning process and providing the information and support necessary to ensure that the individual directs the process to the maximum extent possible

Explaining to the individual his or her rights and responsibilities;

Providing the individual with information regarding the services and service providers available to enable the individual to make informed decisions as to whom they would like to provide services;

Eliciting information from the individual regarding his or her personal preferences and service needs, including any health concerns, that shall be a focus of service planning meetings;

Determining with the individual issues to be discussed during all service planning meetings; and

Explaining to the individual the limits of the decision-making authority of the guardian, if applicable, and the individual's right to make all other decisions related to services.

## 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 |
|---|---|---|
| Residential Habilitation/Personal Care Services | ☑ | ☑ |
| Assistive Technology Support Services | ☑ | ☑ |
| Respite | ☑ | ☑ |
| Environmental and Vehicle Modification Services | ☑ | ☑ |

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| Specialty Services | ☑ | ☑ |
| Community Participation Services | ☑ | ☑ |
| Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services | ☑ | ☑ |
| Community Support Services (CSS) | ☑ | ☑ |
| Service Coordination | ☑ | ☑ |
| Supported Employment | ☑ | ☑ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.***(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.***Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

◉ **FMS are provided as an administrative activity.**

**Provide the following information**

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Area Agencies or subcontract agencies

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Costs related to FMS are included in the overall waiver budget.

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:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

*Specify:*

Assists with processing criminal background checks on prospective workers

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **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.

BDS conducts post payment reviews of DD Waiver PDMS services.

The post payment review starts with an extensive self-assessment process conducted by the Area Agency and then verified by BDS on-site monitoring. Elements of post payment review include:

-verification that receipts/invoices are available to support all expenditures charged to the individual's budget;

-expenditures that have been paid are supported by the individual's service agreement;

-reimbursement for wages paid include details regarding who was paid, on what dates, hours and rate of pay per hour;

-verification of detailed accounting records payroll records; timesheets or similar payroll documents signed by the employee and approved by their supervisor;

-that all expenditures are DD Waiver allowable expenses;

-review of utilization within the individualized budget to confirm that families are provided with regular reports of actual spending versus budgeted amount

## 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)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| Residential Habilitation/Personal Care Services | ☐ |
| Assistive Technology Support Services | ☐ |
| Crisis Response Services | ☐ |
| Respite | ☐ |
| Environmental and Vehicle Modification Services | ☐ |
| Specialty Services | ☐ |
| Community Participation Services | ☐ |
| Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services | ☐ |
| Community Support Services (CSS) | ☐ |
| Service Coordination | ☑ |
| Supported Employment | ☐ |

☐ **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:*

Since 1992, BDS has assisted with funding for People First of New Hampshire, a statewide independent self-advocacy organization. Currently, there are 14 recognized self-advocacy chapters and a total of 17 groups located throughout NH. Individuals with disabilities are members of local self-advocacy chapters and each chapter elects two representatives to serve on the board of directors of People First of NH. People First is a non -profit entity run and governed completely by individuals with disabilities.

People First of New Hampshire, Inc.'s mission is to assists individuals to take control of their lives through learning how to make decisions and choices which increase their level of independence as well as becoming aware of both their rights and responsibilities. People First exists to help individuals speak up and speak out about their beliefs and needs.

As a result of a summit hosted by the Administration on Developmental Disabilities and Self Advocates Becoming Empowered, NH established a group named Advocate NH. More than half of the members of this group are individuals with intellectual or developmental disabilities. The others are representatives of the University Centers for Excellence in DD, DHHS/Bureau of Developmental Services, state Disability Councils, and Protection and Advocacy agencies, Advocate NH has hosted an annual statewide advocacy conference since 2013.

New Hampshire's system allows individuals to hire an independent service coordinator; the individual and the family can secure service coordination from independent case management organizations or hire someone of their choosing to act as an independent advocate.

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**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:

In accordance with State Administrative Rule He-M 503, an individual or guardian may withdraw voluntarily from any service(s) at any time or from participant direction of any service. Likewise, an individual or his/her guardian may withdraw from DD waiver services at any time.

If an individual, representative or guardian no longer wishes to participate in Participant Managed and Directed Services the service coordinator will provide assistance to access alternate Waiver or State Plan services.

The State assures continuity of services and participant health and safety during transition from PDMS to more traditional service delivery models through the provision of Service Coordination and enhanced contacts with the individual or guardian. Upon request of the individual or guardian, PDMS services may be reinstated.

## 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.

Individuals may be disallowed or terminated from managing and directing their services under the following circumstances:

Incident(s) of behaviors that pose a risk to community safety with or without police or court involvement, or a history of civil commitment under RSA 171-B, NH's Statute for involuntary committment;

A formal risk assessment conducted within the past year by a N.H. licensed psychologist or psychiatrist that finds the individual to pose a moderate or high risk to community safety and includes recommendations on the level of security, services, and treatment necessary for the individual; and

Concurrence from the area agency's human rights committee, established pursuant to RSA 171-A:17, I, that services under He-M 525 would not provide the degree of security, services, or treatment needed by the individual.

Upon a positive finding pursuant to the elements above, the individual may obtain a second opinion from a New Hampshire licensed psychologist or psychiatrist.

The human rights committee shall consider the findings of the assessment conducted as noted above;

If a human rights committee convenes, the committee shall meet, if requested, with the individual and the individual's representative to explain its decision.

Individuals who are not permitted to direct or manage their services are assisted to access Waiver services.

Individuals and their guardians have the right to appeal a decision to disallow or terminate participant direction and management.

## 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 | | |
| Year 2 | | |
| Year 3 | | |
| Year 4 | | |
| Year 5 | | |

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Both strategies are supported.

The individual and family 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:

The Bureau of Developmental Services has an arrangement with the NH Department of Safety for reduced fee criminal records checks.

☑ **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.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☑ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

## 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.

BDS' method for establishing the amount of the Participant Directed and Managed Services budget is as follows:

Preliminary planning to determine the services needed occurs with the individual and family at time of intake or during subsequent discussions. Preliminary evaluations are completed and preliminary recommendations for services are made within 21 days of application for service or within 5 days of the eligibility determination.

Within 5 business days of the determination of eligibility, the Area Agency conducts preliminary planning with the individual and guardian to identify and document the specific services needed. Information and evaluations shared by the family that may have been conducted through the participant's school or private practitioner, evaluations conducted as part of the eligibility determination process, and results from the Supports Intensity Scale, HRST and any other relevant evaluations form the basis for support level of need and budget development.

As part of the person centered planning process, the family/individual is provided the opportunity to fully participate and have the "lead voice" in the decision-making process, within the parameters, service limits and guidelines set by BDS.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The budgeting process starts with identification of the individual's and care-giving family's service needs as part of the person-centered planning process. Information gathered through the eligibility process, the family (which may include existing evaluations through the participant's school or private practitioner), the supports intensity scale (SIS), HRST, and any other relevant evaluations needed to determine appropriate services and support level needed.

The person centered plan of care (Service Agreement) is developed jointly using the information outlined in the above paragraph with the individual/family and Area Agency staff. Service needs identified drive the development of an individualized budget request which is submitted to BDS for review/approval/denial/renegotiation.

Once the budget is approved by BDS, the communication of final budget approval to the individual/family is done through the Area Agency.

If an individual's service needs change as demonstrated by assessments, adjustments are made to his/her Service Agreement via an amendment to the Service Agreement. If additional service funding is needed, subsequent requests follow the same process as an initial funding request in that the AA develops with the family the revised Service Agreement based on changes in needs and this is costed out and submitted to BDS for approval.

Individuals/families have the right to appeal BDS' decisions.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The Area Agency, particularly through the Service Coordinator and Business Office, communicates with the individual/guardian or representative relative to available funds remaining in the individual's budget. Monthly reports of the status of each individual's budget and expenditures are provided to the family. Discrepancies relative to planned spending versus actual spending are addressed by the AA and family jointly. Utilization is carefully monitored by the Area Agency.

If additional funds are needed as a result of increased service needs, the Service Agreement is modified and a request for additional funding is submitted to BDS.

Conversely, when funds are projected to be underutilized on a short term basis, the underutilized

funding amount may be reallocated to another waiver eligible individual for one time needs (such as an Environmental Modifications).

Flexibility in this regard plays a significant role in the Participant Directed and Managed Services model. If significant changes are desired, for example, ending one service and adding a new service not previously included in the service agreement, a modification of the Service Agreement would be required. As long as these changes are budget neutral, meet the requirements for the DD Waiver, and do not exceed service limits, there may be no need for BDS to review/approve such changes. All budgets and service arrangements are reviewed on at least an annual basis.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Area Agency, particularly through the Service Coordinator and Business Office, communicate with the family relative to available funds. Monthly reports of the status of each individual's budget and expenditures are provided and discussed with the family. Utilization is carefully monitored by the Area Agency.

If a participant/family appear to be utilizing the funding at a higher/lower rate than the monthly average, the service coordinator/business office monitors the spending and works with the family to understand if the over spending or under spending in any given quarter is related to changes in service needs.

If additional funds are needed as a result of increased service needs, the Service Agreement is modified (based on updated assessments)and a request for additional funding is submitted to BDS. All requests for increased funds must be accompanied by appropriate justifications to support the change. This includes information from recent or updated assessments/evaluations/screenings such Supports Intensity Scale, Health Risk Screening Tool, risk assessment, and/or any other relevant evaluation.

Conversely, when funds are projected to be underutilized on a short term basis, the underutilized funding amount may be reallocated to another waiver eligible individual for one time needs (such as an Environmental Modifications).

If a participant has not fully utilized the allocated funding for two consecutive years, the Area Agency must discuss and initiate with the participant and family, a reduction to the total allocated budget.

Discrepancies relative to planned spending vs. actual spending are addressed by the AA and family jointly on an on-going basis.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Any Medicaid recipient who has been denied waiver services because he/she does not meet the eligibility criteria may appeal the decision by requesting a fair hearing per State Administrative Rule He-M 202. If a fair hearing is requested, the following actions occur:

For current waiver service(s) recipients, services and payments continue as a consequence of an appeal for a fair hearing until a decision has been made; and

If BDS' decision is upheld, benefits will cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later.

As outlined in He-M 503.05(l), Within 3 days of determination of an applicant's ineligibility, the Area Agency must convey to each applicant, guardian or representative a written decision that describes the specific legal and factual basis for the denial, including specific citation of the applicable law or department rule, and advise them of their appeal rights under He-M 503.17.

In each instance when eligibility is denied, information on the reason for denial, the right to appeal, and the process for appealing the decision shall be provided, including the names, addresses, and phone numbers of the Administrative Appeals Unit, Office of Client and Legal Services, and advocacy organizations which the individual or guardian may contact for assistance in appealing the decision.

Decisions made by BDS(waiver eligibility determinations, redeterminations of eligibility, appeals relative to service agreement disputes, termination or suspension of services) may be appealed as outlined in He-M 202, Rights Protection Procedures, to the DHHS Administrative Appeals Unit.

Copies of any materials related to the above actions would be located in the MMIS system under the applicant's name and/or within the Area Agency file depending on which stage of the eligibility process the denial was issued.

## 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.

   Individuals and families have multiple opportunities to appeal a decision by BDS while maintaining the current level of service.

   An individual or representative may choose to pursue informal resolution to resolve any disagreement with an area agency, or, within 30 business days of the area agency decision, she or he may choose to file a formal appeal pursuant to (e) below.

   Any determination, action, or inaction by an area agency may be appealed by an individual or representative including:

   Adverse eligibility actions;

   Area agency disapproval of service agreements or proposed amendments to service agreements; and

   Denial of services by the Bureau.

The Bureau or an area agency shall provide written and verbal notice to the applicant and representative of the actions specified in (b) above, including:

The specific rules that support, or the federal or state law that requires, the action;

Notice of the individual's right to appeal in accordance with He-C 200 within 30 days and the process for filing an appeal, including the contact information to initiate the appeal with the Bureau administrator;

Notice of the individual's continued right to services pending appeal, when applicable;

Notice of the right to have representation with an appeal by:

Legal counsel;

A relative;

A friend; or

Another spokesperson;

Notice that neither the area agency nor the Bureau is responsible for the cost of representation;

Notice of organizations with their addresses and phone numbers that might be available to provide legal assistance and advocacy, including the Disabilities Rights Center and pro bono or reduced fee assistance; and

Notice of individual's right to request a second formal risk assessment from a qualified evaluator.

Appeals shall be submitted, in writing, to the Bureau administrator in care of the department's office of client and legal services within 30 days following the date of the notification of an area agency's decision. An exception shall be that appeals may be filed verbally if the individual is unable to convey the appeal in writing.

The NH DHHS Office of Client and Legal Services shall immediately forward the appeal to the Department's administrative appeals unit which shall assign a presiding officer to conduct a hearing or independent review

If a hearing is requested, the following actions shall occur:

For current recipients, services and payments shall be continued as a consequence of an appeal for a hearing until a decision has been made; and

If the Bureau's or area agency's decision is upheld, benefits shall cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later.

## 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:

Pursuant to State Statute RSA 171-A:19 the NH Department of Health and Human Services has established a Client and Legal Services Unit; its functions and responsibilities include but may not be limited to:

-Assisting the Commissioner in responding to inquiries and complaints by or on behalf of people with mental illness or developmental disabilities
-Assisting the Commissioner in securing needed services and information for people with mental illness or developmental disabilities or their respective families; and
-Assisting the Commissioner in assuring that the human rights of people with mental illness or developmental disabilities in the service delivery system are protected.

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).

The Office of Client and Legal Services (OCLS) administrates and directly implements the complaint system outlined in State Administrative Rule He-M 202. OCLS maintains a 24 hour hot line to receive complaints. User friendly brochures are shared with all participants, family, area agency staff, providers and stakeholders on an on-going basis to ensure awareness of the process and telephone numbers to call.

Complaints are generally reported when there is an allegation, assertion or indication that the following has occurred:

When a rights violation as outlined in State Administrative Rule He-M 310 such as abuse neglect or exploitation has been witnessed or suspected; DHHS, the area agency, or any other program has acted in an illegal or unjust manner with respect to an individual or category of individuals.

The OCLS has 3 persons designated as complaint investigators at all times. Additional investigators are hired if more are needed to carry out all the duties of the complaint investigation process within the timelines required by He -M 202.

OCLS assigns each complaint to a complaint investigator as soon as possible but not later than one business day following receipt of the complaint.

Complaints involving abuse, neglect, or exploitation are investigated prior to any other complaints and the compliant is jointly shared with Adult Protective Services or the Division of Children and Family Services depending on the age of the participant. In such cases, Area Agencies are required to assure participants are protected pending completion of any investigation of abuse, neglect or exploitation. Other complaints are investigated in the order in which they are received.

The complaint investigator investigates and attempts to resolve the complaint to the satisfaction of the individual or his or her guardian or representative within 15 business days following the process outlined in He-M 202.07. A formal report must be issued within the 15 business day timeline. The timeline may be extended by an additional 10 business days if any of the following factors makes it impossible to issue a report as required:

(1) The number of allegations to be investigated;
(2) The number or availability of witnesses to be contacted;
(3) The availability of evidence; or
(4) Other similar complicating circumstances.

The full report is shared with the individual or his or her guardian, the area agency executive director, and the program involved, if any. If the report includes recommendations for resolution that require area agency, program, or Bureau action, the action must be taken within 20 business days of the date of the final report, unless a shorter timeline is specified. The area agency or program must send written documentation of such actions to the complaint investigator and the Bureau upon completion. The Bureau conducts a statewide audit twice per year to ensure implementation of the recommended actions has taken place.

As part of the overall complaint investigation process, the following is also required in He-M 202 and He-M 503:

Each area agency must annually share information to all programs, participants, families and stakeholders the procedures and contact information for filing a complaint. Additionally, each Area Agency must have this information posted internally within their offices and to their website.

At a minimum, the service coordinator must discuss and provide information in writing, to the individual, guardian, and family the procedures and contact information for filing a complaint during the annual person-centered planning meeting.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In addition to the Complaint Investigation Process outlined in He-M 202, The Department of Health and Human Services (DHHS) has a critical events policy, referred to as "Sentinel" Events Policy that 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.

Sentinel Events are defined 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;
(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

If a provider reports an allegation of abuse, neglect or exploitation, they are required by State law to contact the appropriate authorities such as Adult Protective services, Child Protective Services, or law enforcement.

Reportable sentinel events shall be those sentinel events that involve individuals who:

- Are receiving Department funded services, as described in B and C below;
- Have received Department funded services within the preceding 30 days;
- Have been evaluated by a service provider within the preceding 30 days; or
- Are the subject of a Child or Adult Protective Services report.

Individuals that are required to report such events: All providers of the DHHS services and BDS are required to report critical events that involve a person or persons who are receiving BDS funded services; have received BDS funded services within the preceding 30 days; have been evaluated by a contract service provider within the preceding 30 days; are employed in a BDS funded program; or are visiting a BDS funded program when an event occurs.

Immediate verbal notification shall be provided by direct telephone contact. The Policy details the information that must be provided immediately and to whom.

Written notification of the sentinel event shall be provided by the reporting person or designated agency staff to the appropriate DHHS Division and/or Bureau Directors within 72 hours of the event. Written notification shall be via a completed "Sentinel Event Reporting Form," and uploaded to the protected E-Studio application.

Each agency is expected to complete its own review of a reportable sentinel event consistent with the applicable DHHS administrative rules and its agency policies regarding incidents and events that are consistent with this policy's definition of a sentinel event and that involve individuals that are receiving, or who have recently received, Department funded services, i.e., within the previous 30 days, as described in the policy.

The review of the event shall identify recommendations for follow-up activity to address identified systemic issues, if any.

In support of its commitment to quality in the delivery of health and human services, critical events are reviewed as part of quality assurance activities in order to have a positive impact in improving care, to focus the attention of a program to make changes to reduce the probability of such an event in the future, to increase the general knowledge of causes and prevention of critical events, and to maintain the confidence of the public.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The rights of all individuals with developmental disabilities are protected as outlined in the Right Protection Procedures found in He-M 202. In cases of suspected abuse, neglect, exploitation, the State of NH, DHHS, Bureau of Elderly and Adult Services, Adult Protection Services must investigate.

In accordance with He-M 503, individuals and guardians are annually informed, verbally and in writing at the time of the service agreement, of their rights and reminded to contact the Area Agency and or the State's Adult Protection Services, through the Bureau of Elderly and Adult Services, if they believe their rights have been violated.

Area Agencies are required to post information to their offices of operation and to their website.

In addition, workshops are offered every year at all conferences including the Self-Advocacy Conference, the Family Support Conference and the Direct Support Conference. The Statewide People First Group regularly shares

information about the importance of all participants understanding their rights and what constitutes abuse, neglect and exploitation.

The BDS Liaisons play an active role in helping to avert or diffuse crisis situations which may lead to abuse, neglect or exploitation, of individuals including:

o Serving as a source of direct contact and information for individuals, families, and guardian inquiries
o Assisting in ascertaining eligibility for benefits
o Making recommendations regarding wait list funds
o Responding to waiting list questions
o Addressing issues regarding certification of services
o Providing follow-up to certification deficiencies
o Reviewing client right violations, investigations, appeals
o Monitoring medical or behavioral crises, homelessness
o Reviewing mortality reports
o Monitoring admissions to and discharges from NHH
o Attending court hearings

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The NH DHHS Quality Management Unit is responsible for the review and response to Sentinel Events.

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) identified in the Applicability section above, that person or entity shall provide immediate verbal notification to the appropriate DHHS Division Director or designee. Written Notification must be submitted within 72 hours using the process outlined in the Sentinel Event Policy.

In addition, each agency is expected to complete its own review of a reportable sentinel event consistent with the applicable DHHS administrative rules and its agency policies regarding incidents and events that are consistent with this policy's definition of a sentinel event and that involve individuals that are receiving, or who have recently received, Department funded services, i.e., within the previous 30 days, as described in the policy.

Methods that are employed to evaluate: Identification of all individuals directly involved in the event, the circumstances leading up to the event, date, time location, and an assessment of the cause of the event, a review of all relevant documentation, witness interviews, policies and Individual Service and or Support Plans when applicable.

Processes and time-frames for responding: An interim report regarding the event is submitted to the Commissioner's Office within ten business days, and 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.

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.

NH DHHS has established a Quality Management Unit that is responsible for the oversight of the reporting and response to Sentinel Events.

Upon receipt of the final reports described above, the Quality Management Unit reviews the findings and implements pertinent action plans as agreed upon to improve operational practices and systems. When these reports involve a waiver participant, the waiver manager will be involved in the planning. The action plan shall describe risk reduction strategies and include a strategy for the organizations, including the Department, and the provider, to reduce the risk and to evaluate the effectiveness of their plan.

## 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).

In accordance with State Administrative Rule He-M 310 which articulates the rights of individuals receiving services, any use of restrictive interventions or protocol designed to alter an individual's challenging behaviors are permitted only when approved in advance by the individual's guardian [if applicable] and the Area Agency's Human Rights Committee (HRC).

Individuals are assured the right to freedom from restraint including:
a. For individuals under the age of 18, the right to limitations on the use of restraint pursuant to State Statute RSA 126-U; and
b. The right to be free from seclusion and physical, mechanical or pharmacological restraint except that in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:
1. Such means of restraint as are authorized by a prescribing practitioner and approved by a human rights committee pursuant to State Statute RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and
2. The minimum necessary degree of restraint may also be used:
(i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
(ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
(iii) When the person is involuntarily admitted in accordance with RSA 171-B: involuntary commitment.

State Statute RSA 171:A requires that each Area Agency have a Human Rights Committee of 5 or more people, the majority of the members are people who represent the interests of individuals with developmental disabilities and who are not employees of the department.

The duties of the HRC include, but are not limited to:
·Evaluating the treatment and habilitation provided;
·Regularly monitoring the implementation of individual Service Agreements;
·Monitoring the use of restrictive or intrusive interventions designed to address challenging behavior;
·Fostering the capacity of individuals served by the Area Agency to exercise more choice and control in their lives; and
·Promoting advocacy programs on behalf of the clients.

The DHHS contract with each area agency also includes a special provision for each area agency to have a local Risk Management Committee [RMC]. For each individual who is deemed in an assessment to pose a risk to community safety, the RMC shall review and approve a risk management plan. The local RMC shall also seek input from the statewide Risk Management Committee and work closely with the Human Rights Committee.

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 BDS monitors the use of authorized and unauthorized restraints through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committees (HRCs) within each area agency that identifies monitoring and review of any use of authorized restraints and unauthorized restraints broken down by waiver. The report must identify follow-up action if an unauthorized restraint was used.

Complaint Investigations conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS clients. Reports indicate if an unauthorized use of restraint was used and recommendations for corrective action are made. Aggregated Complaint Investigation data is reviewed and reported twice per year and audits are conducted to ensure 100% follow-up of all corrective actions by each area agency.

If a report was made to Child Protective Services or Adult Protective Services and a finding was issued for any reason, the individual's name would appear on both registries as having a founded report.

If an incident occurred that falls under the definition of the DHHS Sentinel Event process, BDS would be immediately notified. The outcome of the Sentinel Event Review would indicate corrective actions necessary.

Health information is reviewed and updated at least annually (by the Area Agency)using the Health Risk Screening Tool that includes utilization of psychotropic medications. BDS runs quarterly reports to monitor changes in health risk screening levels.

As part of service review audits, service agreements are reviewed along with progress notes, approved behaviors plans, documentation of approval from the HRC, satisfaction surveys, and data from all relevant evaluations, assessments and screenings including the Supports Intensity Scale, Health Risk Screening Tool, Risk Assessment (if applicable)and any other relevant evaluations.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. **Use of Restrictive Interventions.** *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including

restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Any use of restrictive interventions or protocol designed to alter an individual's challenging behaviors are permitted only when approved in advance by the guardian [if applicable] and the Area Agency Human Rights Committee (HRC).

Individuals are assured the right to freedom from restraint including:
a. For individuals under the age of 18, the right to limitations on the use of restraint pursuant to RSA 126-U; and
b. The right to be free from seclusion and physical, mechanical or pharmacological restraint except in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:
1. Such means of restraint are authorized by a prescribing practitioner and approved by a human rights committee pursuant to RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and
2. The minimum necessary degree of restraint may also be used:
(i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
(ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
(iii) When the person is involuntarily admitted in accordance with RSA 171-B.

RSA 171:A requires that each Area Agency have a Human Rights Committee of 5 or more people, the majority of the members are people who represent the interests of individuals with developmental disabilities and who are not employees of the department.

The duties of the HRC include, but are not limited to:
·Evaluating the treatment and habilitation provided;
·Regularly monitoring the implementation of Individual Service Agreements;
·Monitoring the use of restrictive or intrusive interventions designed to address challenging behavior;
·Fostering the capacity of individuals served by the Area Agency to exercise more choice and control in their lives; and
·Promoting advocacy programs on behalf of the clients.

The DHHS contract with each area agency also includes a special provision for each area agency to have a local Risk Management Committee. For each individual who is deemed in an assessment to pose a risk to community safety, the RMC shall review and approve a risk management plan. The local RMC shall also seek input from the statewide Risk Management Committee and work closely with the Human Rights Committee. BDS reviews the quarterly reports from the HRC and RMC for each Area Agency.

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 BDS monitors the authorized and unauthorized use of restrictive interventions through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committees (HRCs) within each area agency that identifies monitoring and review of any use of authorized restraints and unauthorized restraints broken down by waiver. The report must identify follow-up action if an unauthorized restraint was used.

Complaint Investigations conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS clients. Reports indicate if an unauthorized use of restraint was used and recommendations for corrective action are made. Aggregated Complaint Investigation data is reviewed and reported twice per year and audits are conducted to ensure 100% follow-up of all corrective actions by each area agency.

If a report was made to Child Protective Services or Adult Protective Services and a finding was issued

for any reason, the individual's name would appear on both registries as having a founded report.

If an incident occurred that falls under the definition of the DHHS Sentinel Event process, BDS would be immediately notified. The outcome of the Sentinel Event Review would indicate corrective actions necessary.

Health information is reviewed and updated at least annually (by the Area Agency)using the Health Risk Screening Tool that includes utilization of psychotropic medications. BDS runs quarterly reports to monitor changes in health risk screening levels.

As part of service review audits, service agreements are reviewed along with progress notes, approved behaviors plans, documentation of approval from the HRC, satisfaction surveys, and data from all relevant evaluations, assessments and screenings including the Supports Intensity Scale, Health Risk Screening Tool, Risk Assessment (if applicable)and any other relevant evaluations.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.***(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c -i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.**Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals are assured the right to freedom from restraint (and seclusion) including:

a. For individuals under the age of 18, the right to limitations on the use of restraint pursuant to RSA 126-U; and
b. The right to be free from seclusion and physical, mechanical or pharmacological restraint except that in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:
1. Such means of restraint as are authorized by a prescribing practitioner and approved by a human rights committee pursuant to RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and
2. The minimum necessary degree of restraint may also be used:
(i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
(ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
(iii) When the person is involuntarily admitted in accordance with RSA 171-B.

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:

The BDS monitors the authorized limited use of seclusion through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committees (HRCs) within each area agency that identifies monitoring and review of any use of seclusion broken down by waiver. The report must identify follow-up action if seclusion was used.

Complaint Investigations conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS clients. Reports indicate if unauthorized use of seclusion was used and recommendations for corrective action are made. Aggregated Complaint Investigation data is reviewed and reported twice per year and audits are conducted to ensure 100% follow-up of all corrective actions by each area agency.

If a report was made to Child Protective Services or Adult Protective Services and a finding was issued for any reason, the individual's name would appear on both registries as having a founded report.

If an incident occurred that falls under the definition of the DHHS Sentinel Event process, BDS would be immediately notified. The outcome of the Sentinel Event Review would indicate corrective actions necessary.

As part of service review audits, service agreements are reviewed along with progress notes, approved behaviors plans, documentation of approval from the HRC, satisfaction surveys, and data from all relevant evaluations, assessments and screenings including the Supports Intensity Scale, Health Risk Screening Tool, Risk Assessment (if applicable)and any other relevant evaluations.

## Appendix G: Participant Safeguards

### Appendix G-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.

Area Agencies and vendor agencies through their State designated nurse trainers in conjunction with State Administrative Rule He-M 1201: Administration of Medications.

Nurse Trainers are required to have 2 years of licensed nursing experience within the past 5 years, at least one of which was as a registered nurse and to have completed a 6-hour orientation program conducted by the Division of Developmental Services.

The scope of monitoring is specific to timely and accurate administration of medications.

Medication administration practices that are potentially harmful identified and managed in the quality review process noted below.

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.

All medications not administered by family members must be administered in conjunciton with He-M 1201 which requires a number of overlapping protective practices.

He-M 1201 requires a Quality Review including:

(a) A registered nurse shall review the following for all individuals whose medications are administered by authorized providers:
(1) Documentation that the provider administering the medication(s) holds a current authorization;
(2) Medication orders and PRN protocols;
(3) Medication labels and medications listed on the medication log to ensure that they match the prescribing practitioner's orders;
(4) Medication logs to ensure that documentation indicates:
a. That medication was administered as prescribed;
b. Refusal by the individual to take medication, if applicable;
c. Any medication occurrences; and
d. The full signatures of all authorized providers who initial the log; and
(5) Medication storage to ensure compliance with He-M 1201.07.
(b) Reviews pursuant to (a) above shall be performed according to the following timeframes:
(1) For family residences with 3 or fewer individuals and services provided pursuant to He-M 521 or He-M 524, reviews shall occur at least semiannually; and
(2) For all other settings in which authorized providers administer medications, reviews shall occur at least monthly.
(c) The review pursuant to He-M 1201.08(a) shall be documented, dated and signed by the registered nurse and retained for at least 6 years by the provider agency.

He-M 1201.10 outlines the requirement for a State Medication Committee:
(a) The Director shall appoint a medication committee
(b) The committee shall be composed of at least the following:
(1) The medical director of the division or physician designee who shall serve as chairperson of the committee;
(2) Two registered nurses from provider agencies;
(3) Two non-nurse representatives from provider agencies; and
(4) A representative of the Division.
(c) Each provider agency shall complete and submit semiannually to the area agency Form 1201-a according to table 12.1.1 for each service in which authorized providers administer medications.
(d) Form 1201-a required by (c) above shall include the following:
(1) The name of the provider agency;
(2) The name and type of service;
(3) The dates during which information was collected;
(4) The number of individuals receiving medications from authorized providers;
(5) The total number of doses administered;
(6) The total number of providers authorized;
(7) The average number of hours of supervision provided by the nurse trainer per month;
(8) The number and type of department-issued He-M 1201 certification deficiencies pursuant to He-M 1001.14 and He-M 507.03;
(9) The total number of medication occurrences listed by specific medication(s) involved, type of occurrence, and the immediate corrective action taken;
(10) A narrative summary of systemic trends, if any, associated with occurrences within the setting;
(11) A corrective action plan that identifies specific steps to be taken to prevent future occurrences;
(12) The signature of the nurse trainer completing the form; and
(13) The signature of the provider agency director or designee and the date on which the report is submitted.
(e) Using Form 1201-b, an area agency shall report on each provider agency's performance regarding medication administration based on the information submitted through 1201-a forms. The area agency shall submit Forms 1201-a and 1201-b to the medication committee semiannually, according to table 12.1.1.
(f) The Form 1201-b required by (e) above shall include the following:
(1) The name of the area agency and the provider agency;

(2) The type of service;
(3) The dates during which information was collected;
(4) The total number of doses administered;
(5) The total number of providers authorized;
(6) A summary of the number and type of medication occurrences for each provider agency;
(7) A summary of the provider agency's corrective action plan;
(8) The area agency's plan for monitoring, oversight and quality improvement; and
(9) The signature of the area agency director or designee.
---
Identify areas of non-compliance and recommend to the Director that corrective action be taken by those provider agencies that, as demonstrated by the reports, have failed to comply with the provisions of He-M 1201.
(j) For those provider agencies for which areas of non-compliance have been identified, the medication committee shall make recommendations regarding the area agency's plan for monitoring, oversight and quality improvement.
(k) The Director shall review all recommendations for corrective action made pursuant to (i)(3) and (j) above. For those provider agencies for which corrective action has been identified, the Director shall require such action to be taken if he or she determines that the action is necessary for the provider agency to be in compliance with the provisions of He-M 1201.
(l) An agency which is in receipt of a requirement for corrective action from the Director pursuant to (k) above shall, within 30 days of such receipt, forward a corrective action plan to the medication committee and begin implementation of such a plan.

## Appendix G: Participant Safeguards

### 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).

If medications are being administered by non-licensed staff in certified settings, staff members must be certified to administer medications in conjuction with He-M 1201.

Medication Administration Training and Authorization: All staff and providers are required to complete Medication Administration Training as outlined in NH's regulation He-M 1201 prior to administering medications to individuals receiving services in certified home or day settings. He-M 1201 training is conducted by a qualified, and BDS approved, registered nurse-trainer. Medication Administration Training consists of:

•8 hours of classroom instruction;
•Training regarding the specific needs of the individual;
•Standardized written testing; and
•Clinical observation by the nurse-trainer.

Ongoing supervision and quality assurance are conducted by an RN to ensure continued competency. This regulation and the accompanying curriculum have been approved by the New Hampshire Board of Nursing.

**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:

All providers must document all doses of medications administered and all medication errors. Medication errors are reported using a format outlined in He-M 1201. Each individual certified setting must produce a report every six months documenting any errors and corrective action taken.

Each Area Agency must collate these reports for their catchment area, sorted by provider agency which is then aggregated into a separate report of all settings. The Area Agency's report is submitted to the Bureau of Developmental Services Medication Committee for review and approval.

(b) Specify the types of medication errors that providers are required to *record:*

Medication error means any deviation in the administration of a medication as prescribed or in the documentation of such administration, with the exception of an individual's refusal. Deviations include: omission, wrong dose, wrong person, wrong time, wrong route, or wrong medication.

Providers who are authorized to administer medications shall have their authorization rescinded if they fail to maintain competence to safely administer medications.

(c) Specify the types of medication errors that providers must *report* to the State:

All as noted above.

○ **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.

In accordance with He-M 1201.10 (e) The Bureau of Developmental Services Medication Committee requires the following information be submitted for its review and analysis every six months:

Using Form 1201-b, an area agency shall report on each provider agency's performance regarding medication administration based on the information submitted through 1201-a forms. The area agency shall submit Forms 1201-a and 1201-b to the medication committee semiannually, according to table 12.1.1.

(f) The Form 1201-b required by (e) above shall include the following:

(1) The name of the area agency and the provider agency;

(2) The type of service;

(3) The dates during which information was collected;

(4) The total number of doses administered;

(5) The total number of providers authorized;

(6) A summary of the number and type of medication occurrences for each provider agency;

(7) A summary of the provider agency's corrective action plan;

(8) The area agency's plan for monitoring, oversight and quality improvement; and

(9) The signature of the area agency director or designee.

## 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:**
**Numerator = Number of individuals for whom there is documentation of the provision of the NH BDS "Individual Rights and Responsibilities Brochure" [http://www.dhhs.nh.gov/dcbcs/bds/documents/individualrights.pdf] at the time of their annual service agreement, about how to report a complaint regarding abuse, neglect or exploitation; Denominator = Number of individual service agreements reviewed.**

**Data Source** (Select one):
**Training verification records**
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: BHFA | ☐ **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: BHFA | ☑ **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:**
**N = Number of abuse, neglect, and exploitation complaints that were investigated within required timelines. D= Total number of complaints.**

**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 = |
| ☐ **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<br>Specify: |

**Performance Measure:**
**N = Number of abuse, neglect, and exploitation complaints where immediate protective action was to protect the individual when indicated. D= Total number of complaint where protective actions were indicated.**

**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<br>Specify: | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

**Performance Measure:**

**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<br>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**<br>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:**
**Numerator = Number of Area Agencies with documentation that policies are in place regarding the use of restraint and prohibition of seclusion are followed.**
**Denominator = Total number of Area Agencies.**

**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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**The number and percent of area agencies that submitted quarterly data from the Human Rights Committee breaking down the review and monitoring of any use of restraint or seclusion by waiver. Numerator = Total number of area agencies**

**that submitted quarterly HRC data. Denominator = Total number of area agencies.**

**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:**
**The Number and percent of individuals who have an active Health Risk Screening Tool Completed. Numerator = Number of individuals who have an HRST completed. Denominator = Total Number of Individuals receiving IHS services.**

**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: |

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.
The state has policies and procedures in place that require reporting of 100% of suspected incidents of abuse, neglect, or exploitation and an administrative rule, He-202, which outlines the State's Rights Protection procedures. BDS' legal counsel, Office of Client and legal services, tracks 100% of all reported incidents. BDS' Office of Client and Legal Services, through Bureau Liaisons provide feedback in individual cases when appropriate, issues a report twice per year identifying trends and addresses systemic improvements, and reports findings to the Quality Council for Developmental Services twice per year.

The DHHS also utilizes a Sentinel Event Reporting Protocol for unexpected occurrences involving the death or serious physical or psychological injury which may signal the need for immediate investigation and response.

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** |

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

As part of the BDS internal analysis of existing quality improvement processes, BDS determined that there was opportunity to improve the overall approach to quality assurance. The previous methodology relied on the Area Agency Redesignation process that occurred over a 5 year period, with two regional Area Agencies reviewed per year. As part of the overhaul of the Area Agency Redesignation process in 2015, BDS created an annual quality improvement process that systematically reviews essential data from several key areas to inform the BDS, Area Agencies, DHHS, stakeholders and CMS on the overall performance, quality and satisfaction with services.

Information from the annual quality review serves to inform the redesignation process, but more importantly, provide meaningful data on an on-going basis to help inform the performance of Area Agencies that identify issues with compliance and/or quality of services. The standardized and timely reporting schedule provides BDS with the opportunity to review and discuss the results and develop recommendations or plans of correction as part of regular internal and external meetings such as regularly scheduled meetings with the Bureau Liaisons, joint meetings with certification staff from the Bureau of Certification and Licensing, monthly meetings with Area Agency Executive Directors, Business Managers, Service Coordinator Supervisors, IHS Coordinators, PDMS Coordinators, QI Staff, Statewide Family Support Council, and every other month with the NH Developmental Disabilities Quality Council.

Although the Governance Desk Audit is completed at the time of redesignation, components of Governance are required and reviewed annually.
-Board Composition
-Current Board by-laws, policies and procedures
-Executive Director Qualifications
-Current Area Agency Plan and any amendments
-Board of Directors Minutes
-Information on how the AA assures individuals, families and stakeholders are involved in planning for the provision of and satisfaction of the services
-Information on how AA communicates with sub-contract agencies
-Minutes from Human Rights Committee
-Report of the AA on-going quality assurance activities
-Contract Compliance

The Key Indicators Data includes a review of the following:
Financial Key Indicators = Monthly Review
Medicaid Billing Activity = Monthly Review
Certification Data from Bureau of Health Facilities Administration = Quarterly Review

Waitlist Utilization = Quarterly Review
Service Review Audits = Ongoing
Human Rights Committee Reports - Quarterly
Risk Management Committee Reports - Quarterly
Complaint Investigations Reports - Twice per year with a review of trends and follow-up on corrective action plans twice per year
HRST Data - Quarterly Review
Other existing data = National Core Indicators and Employment data as available.

Regional forums are held for individuals and one for families/guardians following the redesignation schedule.

Surveys are conducted with provider agencies, individuals and families/guardians annually.

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.

As indicated in section a. System Improvements above, a systematic and standardized approach for reviewing Key Indicator data is reviewed by internal DHHS staff, Area Agency staff and stakeholders at the frequency outlined. The data is reviewed as part of regularly scheduled meetings to engage all levels of the system to better understand performance data and the importance of remediation, as necessary, to ensure a meaningful and timely quality improvement process.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Area Agency Service Coordinator Supervisors meet monthly with the BDS to discuss policies and best practices as well as current quality improvement activities and strategies.

At least annually, the BDS Waiver Manager will review the information needed to assess waiver quality and whether aspects of the quality improvement system require revision. The analysis and any recommendations, if necessary, will be shared with the BDS Management Team and staff for initial review and then broadly shared with area agencies and stakeholders.

## Appendix 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).

The State requires each provider of HCBS Waiver services to submit an annual independent financial audit. The results of this independent audit are submitted to the State within 30 days of conclusion of the independent audit.

Additionally, the State Office of Improvement and Integrity ensures that annual audits are conducted in accordance with the provisions of the Single Audit required under OMB Circular A-133 for state agencies.

Providers are selected for further review on the basis of their monthly financial reporting if ratios, days of cash on hand or other negative financial signals are noted.

In accordance with He-M 505 and the State's contracts between the BDS and each designated Area Agency, each Area Agency is required to provide the State an annual independent audit performed by a Certified Public Accountant, covering the Area Agency and all funds received under the contract, including those associated with this waiver.

Beginning with the NH DHHS FY'16 contracts, additional financial reporting requirements have been included in the Area Agency contracts that include the following:

On a monthly basis, each Area Agency must submit to BDS, their Balance Sheet, Summary of Revenues and Expenditures, and the Agreement's State Fiscal Year approved budget to actual analysis within 30 days of the preceding month's end.

On a quarterly basis, each Area Agency must submit to BDS, their Balance Sheet, Summary of Revenues and Expenditures, a statistical report, and program reports within 30 days of the preceding quarter's end.

On a quarterly basis, for entities which are controlled by, under common ownership with, or an affiliate of, or related party to the Area Agency, the Area Agency must submit to NH BDS a Summary of Revenues and Expenditures and a Balance Sheet within 30 days of the preceding quarter's end.

On an on-going basis, BDS collects and analyzes Area Agency and provider certified financial audits. As a result, a Statewide Report of Financial Condition is prepared. This report represents the financial condition of the developmental services system. It assists the system in several respects, including:

·Serving as an early warning system for financially distressed services providers;
·Evaluating the economic impact of policy decisions that affect reimbursement or expenditures;
·Assessing the overall financial health of the service system and critical statewide operating trends over a five-year period;

·Establishing important objectives and specific criteria that can be used by BDS in contract negotiations;
·Developing standards and "best practices" that can be used by providers and BDS for "benchmarking"; and
·Informing providers, legislators, and other interested parties.

In addition to monitoring by the Surveillance and Utilization Review unit of DHHS and Medicaid Fraud Investigators at the NH Attorney General's Office, the BDS waiver unit generates a monthly Medicaid Key Indicator Report that displays Medicaid Utilization for each Area Agency under each waiver.

The waiver unit operates as the BDS' contact for MMIS, NH's Medicaid financial intermediary. This role requires that the waiver unit be able to address provider billing issues relative to procedure codes, Medicaid, HCBS-DD eligibility, Medicaid eligibility determination, and claims processing interfaces. The waiver unit also provides consultation to BDS, Area Agencies, and provider agency staff regarding Medicaid HCBS-IHS requirements.

BDS conducts an annual post-payment review of DD Area Agency billing to assure no Medicaid payments were made without accurate "attendance/service provision" records indicating date(s) of service, units of service, service provider, and that the required contact notes/progress notes are complete. On those occasions where Medicaid payment has been made but service records are not adequate upon review/audit, recoupments are made. As noted earlier, NH has an organized Health Care Delivery System.

AAs, as primary agencies in the OHCDS, are the enrolled Medicaid providers within the NH MMIS. Area Agencies must have a current BDS approved and issued Prior Authorization to bill for HCBS-DD. Payment for claims without an appropriate Prior Authorization would be denied by MMIS, NH's fiscal intermediary for Medicaid payments.

Prior Authorizations are issued for a period not to exceed one year and are only issued by State QIDP staff who has determined LOC after the approval of the State BDS Liaison.

As noted earlier, there are multiple steps in the approval of a Prior Authorization for HCBS-DD waiver services. BDS utilizes databases that contain all budget and service information for every NH HCBS-DD participant. This information is maintained by BDS Liaisons and is verified for each request for a Prior Authorization by BDS QIDP staff.

In addition to multiple programmatic tasks, BDS Liaisons also have substantial financial responsibilities including:
o Area Agency contract development
o Review of service units for all HCBS-DD eligible individuals
o Review of Area Agency revenues and expenses
o Approving Area Agency requests for Prior Authorizations of HCBS-DD services from the standpoint of available funds and appropriateness of proposed services
o Approval of proposals for changes in individual budgets
o Maintenance of a database of changes to Area Agency budgets and Prior Authorizations
o Review of financial reports and audits from Area Agency.

In conjunction with their financial responsibilities, BDS Liaisons closely monitor all Medicaid HCBS-DD service authorizations. An Area Agency may neither exceed the authorization on any given Prior Authorization for any given individual nor the aggregate amount of Medicaid as defined in each BDS contract, which is in accordance with the HCBS-IHS waiver cap for each waiver year.

Business Managers representing all 10 Area Agencies meet with members of the BDS' Management Team each month to explore system, program, financial management and accountability issues in an effort to enhance statewide consistency in methodology and operations related to Medicaid. Topics addressed include:
o Review of Key Financial Indicator Reports: Monthly Medicaid Utilization Report and Monthly/Quarterly AA Fiscal Health Reports
o Budget development
o Other Financial monitoring
o Documentation requirements to support Medicaid billing
o System modification requests
o Implementation of legislative and legal initiatives
o Fiscal intermediary operations
o Prior Authorization Process

## 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**
***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*** *(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:**
**Numerator = Number of claims paid according to the rates and amounts established in the Prior Authorization. Denominator = All claims reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DHHS/BDS Validation Review Tool comparison to MMIS data**

| **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: |

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:**
**Numerator = Number of participants records reviewed to document that waiver service claims paid correspond to those specified in the service agreement.**
**Denominator = Number of participants 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:**
**Numerator = Number of waiver rates that follow the approved methodology;**
**Denominator = Number of waiver rates.**

**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 = |
| ☐ **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.
If payment errors are noted, the State requires that payments be recouped through the MMIS.

Staff in the Surveillance and Utilization Review Unit (SURS) monitors financial claims for NH's Medicaid plan. SURS reviews all provider claims for fraud, waste or abuse. The unit also recovers overpayments. If there appears to be a case of fraud, it is referred to the Attorney General's office for further review. SURS also conducts reviews to determine if recipients are inappropriately using certain types of medications.

SURS provides management of the Quality Improvement Organization (QIO) contract, which is responsible for the review of all hospital admissions for medical necessity and quality of care.

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

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 New Hampshire Department of Health & Human Services (NH-DHHS), New Hampshire's single state Medicaid agency, is responsible for the development of statewide rates for waiver services. The rate methodology development process includes input from stakeholders. Once approved by NH-DHHS, this methodology will be incorporated into the New Hampshire Administrative Code, which includes a period for public comment according to relevant state and federal requirements as well as a public hearing process that allows for public testimony before New Hampshire's Joint Legislative Committee on Administrative Rules (JLCAR).

The baseline for all Intellectual Disabilities/Developmental Disabilities (ID/DD) waiver services Rates will be the rates in effect on July 1, 2017; and, which have been in effect since 2007. From this base, NH-DHHS will make adjustments, using a combination of the following indices and factors as applicable and necessary:

Health Risk & Support Needs adjustment;
CMS Home Health Agency PPS Market Basket Update; and,
Access and availability adjustment.

In establishing the rates the Department desires to provide fair and equal compensation for comparable service delivery while maintaining the flexibility to meet individual needs as required and ensure adequate access to services.

The rates for waiver services will be set subject to funds appropriated by the New Hampshire State Legislature. NH-DHHS is responsible for the final review and approval of all rates once each biennium. NH-DHHS periodically reviews the rate setting model to determine if the model accurately reflects the adjustment items listed above. Ensure the direct support professional wages in the applicable service market are sufficient to ensure adequate access to services for waiver members.

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:

While the NH Developmental Services System utilizes in excess of 65 private developmental services agencies and hundreds of private subcontractors, it is the Area Agencies in their capacity as lead agencies within the OHCDS that have a Medicaid Provider Agreement with the NH State Medicaid Agency and are enrolled in the MMIS.

Area Agencies must have a current BDS approved and issued Prior Authorization to bill for any individual receiving HCBS-DD services.

Billing is done on a fee for services basis in that AAs do not bill for HCBS services until rendered and documentation to support each bill must be maintained and available for review by the State Medicaid Agency.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures***(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one:***

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.**Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All HCBS billing is processed through the NH Medicaid Management Information System. All billing for HCBS-DD services requires a Prior Authorization be open and current in MMIS. Prior Authorizations includes only the services outlined in the individual's Service Agreement. If an individual's Medicaid status changes, claims are not paid until or unless the individual has open Medicaid status for the time period included on the claim(s).

Area Agencies are not authorized to bill for services without documentation that the services have been provided.

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.**
- [x] **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:

In accordance with RSA 171-A and He-M 505, BDS contracts with 10 private, non-profit community 501-C (3) providers known as Area Agencies.

Area Agencies are:

· Locally Controlled: Governed by independent Boards of Directors made up of volunteer families and community business professionals;
Family Driven: Advised by Regional Family Support Councils;
· Regionally Based: Responsible for providing services to individuals with developmental disabilities and their families within their catchment area; and
· Overseen by the Bureau of Developmental Services: Redesignated every 5 years.

Area Agencies are considered successful, operating efficiently and eligible for redesignation when:
· There is a high level of involvement of those who use and depend on services in all aspects of system planning, design, and development;
· The Area Agency demonstrates through its coordination of services and supports a commitment to a mission which embraces community membership for persons with developmental disabilities;
· Ongoing inquiry regarding individual and family satisfaction is a common practice;
· Recipients of services and supports are satisfied;
· The Area Agency is fiscally sound and manages resources effectively to support its mission;
· The Area Agency board of directors demonstrates effective governance of the agency management and functions;
· Supports and services are flexible and represent the needs, preferences, and capacities of individuals and families;
· The Area Agency promotes preventative services and supports which reduce the need or the intensity of long-term care;
· The Area Agency, through multiple means, demonstrates its commitment to individual rights and safeguards;
· The Area Agency seeks to achieve continuous quality improvement in managing its operations and services; and
· There is adherence to state and federal requirements. Approval of an Area Agency's request for Redesignation is granted if, based on the following information, the Area Agency is found to be in compliance with He-M 505:
· Public comments regarding the Area Agency's demonstrated ability to provide local services and supports to persons with developmental disabilities and their families;
· A comprehensive self-assessment of the Area Agency's current abilities and past performance;
· Input from a wide range of individuals, agencies, or groups who are either recipients, providers, or people who collaborate in the provision of services and supports;
· Documentation pertaining to Area Agency operations available regionally and at the Department; and
· Input from Department staff that have direct contact with and knowledge of Area Agency operations.

As noted above, each participant in the NH Developmental service system is afforded choice of service provider(s). An individual or guardian may select any person, any agency, or another Area Agency as a provider to deliver one or more of the services identified in the individual's Service Agreement. An Area Agency may not deny any willing and qualified provider. As a result, families have full choice of any qualified provider and they may add any new provider who meets the same qualifications; there are no obstacles to any willing and qualified provider to be selected to provide direct supports under this waiver.

Currently, the NH Developmental Services System currently utilizes in excess of 65 private developmental services agencies and hundreds of individual providers. All providers must comply with the rules pertaining to the service(s) offered and meet the provisions specified within the individual's Service Agreement.

Providers enter into a contractual agreement with the Area Agency which specifies the roles of the area agency and private services agency/provider in service planning, provision and oversight including:
· Implementation of the service agreement;
· Specific training and supervision required for the service providers;
· Compensation amounts and procedures for paying providers;
· Oversight of the service provision, as required by the service agreement;
· Documentation of administrative activities and services provided;

· Fiscal intermediary services provided by the area agency or private agency to facilitate the delivery of consumer-directed services;
· Quality assessment and improvement activities as required by rules pertaining to the service provided;
· Compliance with applicable laws and rules, including delegation of tasks by a nurse to unlicensed providers pursuant to RSA 326-B and He-M 1201;
· Family support service coordination provided by the area agency;
· Procedures for review and revision of the service agreement as deemed necessary by any of the parties; and
· Provision for any of the parties to dissolve the contract.

Individuals Prior Authorizations list all waiver services/procedure codes approved for that individual. No payments are made for any HCBS-DD waiver service without a current Prior Authorization. Payment for claims without an appropriate Prior Authorization would be denied by the MMIS.
Prior Authorizations are issued for a period not to exceed one year and are only issued by State QMRP staff who has determined LOC after the approval of the State BDS Liaison.
As noted earlier, there are multiple steps in the approval of a Prior Authorization for HCBC-IHS Waiver services.
The BDS utilizes databases which contain all budget and service information for every NH HBCS-IHS consumer. This information is maintained by BDS Liaisons and is verified for each request for a Prior Authorization by BDS QMRP staff.
In addition to the multiple programmatic tasks, BDS Liaisons also have substantial financial responsibilities including:
Annual Area Agency contract development
Review of service units for all HCBC-DD eligible individuals
Review of Area Agency revenues and expenses
Approving Area Agency requests for Prior Authorizations of HCBC-IHS services from the standpoint of available funds and appropriateness of proposed services
Approval of proposals for changes in individual budgets
Maintenance of a database of changes to Area Agency budgets and Prior Authorizations
Review of financial reports and audits from Area Agency.

BDS conducts periodic billing audits to confirm that no billing occurs without accurate "attendance/service provision" records indicating: date(s) of service, units of service, service provider, and the required contact notes/progress notes are complete. On those occasions where Medicaid payment has been made but service records are not adequate upon review/audit, recoupments are made.

**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.**

## 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:

## 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:

☐ **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:

Room and board are not allowable budget items and BDS ensures that Medicaid waiver funds are not used for Room and Board by requiring that a budget is submitted for each individual clearly delineating non-Medicaid revenues which are used to pay for Room and Board, typically, Social Security income. The Room and Board amount is clearly reflected in each individual's budget and it is subtracted from the amount total prior to the Medicaid funding amount being expressed.

Room and Board payments are made from individual's income by the individual or guardian directly to the agency or entity providing residential services.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.***Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.**Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: ICF/IID**

| 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 | 46455.82 | 9140.00 | 55595.82 | 143200.00 | 11796.00 | 154996.00 | 99400.18 |
| 2 | 46265.17 | 9368.00 | 55633.17 | 146780.00 | 12091.00 | 158871.00 | 103237.83 |
| 3 | 46641.31 | 9602.00 | 56243.31 | 150450.00 | 12394.00 | 162844.00 | 106600.69 |
| 4 | 46761.07 | 9843.00 | 56604.07 | 154211.00 | 12703.00 | 166914.00 | 110309.93 |
| 5 | 46928.49 | 10089.00 | 57017.49 | 158067.00 | 13021.00 | 171088.00 | 114070.51 |

## 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: |
| | | ICF/IID |
| Year 1 | 5000 | |
| Year 2 | 5200 | |
| Year 3 | 5400 | |
| Year 4 | 5600 | |
| Year 5 | 5800 | |

## 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.

Average derived from MMIS for period ending June 30, 2014

## 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:

Derived from MMIS for period ending June 30, 2014

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:

Derived from MMIS for period ending June 30, 2014

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:

Calculated using the current actual NH private ICF/IID daily rate

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:

Derived from MMIS for period ending June 30, 2014

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services | |
|---|---|
| Community Participation Services | |

| Waiver Services | |
|---|---|
| Residential Habilitation/Personal Care Services | |
| Respite | |
| Service Coordination | |
| Supported Employment | |
| Assistive Technology Support Services | |
| Community Support Services (CSS) | |
| Crisis Response Services | |
| Environmental and Vehicle Modification Services | |
| Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services | |
| Specialty 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 |
|---|---|---|---|---|---|---|
| **Community Participation Services Total:** | | | | | | 55240380.00 |
| Community Participation Services | 15 minutes | 2379 | 6000.00 | 3.87 | 55240380.00 | |
| **Residential Habilitation/Personal Care Services Total:** | | | | | | 122903738.10 |
| Residential Habilitation/Personal Care Services | Day | 2145 | 313.00 | 183.06 | 122903738.10 | |
| **Respite Total:** | | | | | | 2549760.00 |
| Respite | 15 minutes | 1245 | 800.00 | 2.56 | 2549760.00 | |
| **Service Coordination Total:** | | | | | | 11298346.80 |
| Service Coordination | Month | 3830 | 12.00 | 245.83 | 11298346.80 | |
| **Supported Employment Total:** | | | | | | 7173249.20 |
| Supported Employment | 15 Minutes | 481 | 3242.00 | 4.60 | 7173249.20 | |
| **Assistive Technology Support Services Total:** | | | | | | 785229.72 |
| | | | GRAND TOTAL: | | | 232279078.32 |
| | | | Total Estimated Unduplicated Participants: | | | 5000 |
| | | | Factor D (Divide total by number of participants): | | | 46455.82 |
| | | | Average Length of Stay on the Waiver: | | | 314 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Assistive Technology Support Services | 1/2 Hour | 478 | 66.00 | 24.89 | 785229.72 | |
| **Community Support Services (CSS) Total:** | | | | | | 4593422.70 |
| Community Support Services (CSS) | 15 Minutes | 562 | 1329.00 | 6.15 | 4593422.70 | |
| **Crisis Response Services Total:** | | | | | | 1345428.00 |
| Crisis Response Services | 15 Minutes | 90 | 2248.00 | 6.65 | 1345428.00 | |
| **Environmental and Vehicle Modification Services Total:** | | | | | | 1278810.00 |
| Environmental Modification - Vehicle | Each | 24 | 1.00 | 13720.00 | 329280.00 | |
| Environmental Modification - Home | Each | 186 | 1.00 | 5105.00 | 949530.00 | |
| **Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services Total:** | | | | | | 22380556.30 |
| PDMS - Specialty Services | 1/2 Hour | 22 | 15.00 | 58.65 | 19354.50 | |
| PDMS - Day | Hour | 330 | 1500.00 | 12.40 | 6138000.00 | |
| PDMS - Emod | Each | 33 | 1.00 | 4425.00 | 146025.00 | |
| PDMS - Respite | Hour | 187 | 194.00 | 9.52 | 345366.56 | |
| PDMS - CSS | Hour | 99 | 331.00 | 20.97 | 687165.93 | |
| PDMS - SEP | Hour | 110 | 750.00 | 13.92 | 1148400.00 | |
| PDMS - Service Coordination | Month | 391 | 11.00 | 174.31 | 749707.31 | |
| PDMS - PCS | Day | 380 | 300.00 | 114.60 | 13064400.00 | |
| PDMS - Atech | 1/2 Hour | 55 | 60.00 | 24.89 | 82137.00 | |
| **Specialty Services Total:** | | | | | | 2730157.50 |
| Specialty Services | 1/2 Hour | 2450 | 19.00 | 58.65 | 2730157.50 | |
| | | | | **GRAND TOTAL:** | | 232279078.32 |
| | | | | **Total Estimated Unduplicated Participants:** | | 5000 |
| | | | | **Factor D (Divide total by number of participants):** | | 46455.82 |
| | | | | **Average Length of Stay on the Waiver:** | | 314 |

## 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 |
|---|---|---|---|---|---|---|
| **Community Participation Services Total:** | | | | | | 56726460.00 |
| Community Participation Services | 15 minute | 2443 | 6000.00 | 3.87 | 56726460.00 | |
| **Residential Habilitation/Personal Care Services Total:** | | | | | | 126169711.56 |
| Residential Habilitation/Personal Care Services | Day | 2202 | 313.00 | 183.06 | 126169711.56 | |
| **Respite Total:** | | | | | | 2617344.00 |
| Respite | 15 minutes | 1278 | 800.00 | 2.56 | 2617344.00 | |
| **Service Coordination Total:** | | | | | | 11599242.72 |
| Service Coordination | Month | 3932 | 12.00 | 245.83 | 11599242.72 | |
| **Supported Employment Total:** | | | | | | 7359011.00 |
| Supported Employment | 15 Minutes | 493 | 3245.00 | 4.60 | 7359011.00 | |
| **Assistive Technology Support Services Total:** | | | | | | 806585.34 |
| Assistive Technology Support Services | 1/2 Hour | 491 | 66.00 | 24.89 | 806585.34 | |
| **Community Support Services (CSS) Total:** | | | | | | 4730217.15 |
| Community Support Services (CSS) | 15 Minutes | 577 | 1333.00 | 6.15 | 4730217.15 | |
| **Crisis Response Services Total:** | | | | | | 1377773.60 |
| Crisis Response Services | 15 Minutes | 92 | 2252.00 | 6.65 | 1377773.60 | |
| **Environmental and Vehicle Modification Services Total:** | | | | | | 1304335.00 |
| Environmental Modification - Vehicle | Each | 24 | 1.00 | 13720.00 | 329280.00 | |
| | | | | | **GRAND TOTAL:** | 240578900.71 |
| | | | | | **Total Estimated Unduplicated Participants:** | 5200 |
| | | | | | **Factor D (Divide total by number of participants):** | 46265.17 |
| | | | | | **Average Length of Stay on the Waiver:** | 314 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Environmental Modification - Home | Each | 191 | 1.00 | 5105.00 | 975055.00 | |
| **Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services Total:** | | | | | | 26898501.59 |
| PDMS - Specialty Services | 1/2 Hour | 26 | 15.00 | 58.65 | 22873.50 | |
| PDMS - Day | Hour | 396 | 1500.00 | 12.41 | 7371540.00 | |
| PDMS - Emod | Each | 40 | 1.00 | 4425.00 | 177000.00 | |
| PDMS - Respite | Hour | 224 | 194.00 | 9.75 | 423696.00 | |
| PDMS - CSS | Hour | 119 | 331.00 | 20.97 | 825987.33 | |
| PDMS - SEP | Hour | 132 | 750.00 | 13.92 | 1378080.00 | |
| PDMS - Service Coordination | Month | 496 | 11.00 | 174.31 | 951035.36 | |
| PDMS - PCS | Day | 455 | 300.00 | 114.65 | 15649725.00 | |
| PDMS - Atech | 1/2 Hour | 66 | 60.00 | 24.89 | 98564.40 | |
| **Specialty Services Total:** | | | | | | 989718.75 |
| Specialty Services | 1/2 Hour | 1125 | 15.00 | 58.65 | 989718.75 | |
| | | | | **GRAND TOTAL:** | | 240578900.71 |
| | | | | **Total Estimated Unduplicated Participants:** | | 5200 |
| | | | | **Factor D (Divide total by number of participants):** | | 46265.17 |
| | | | | **Average Length of Stay on the Waiver:** | | 314 |

## 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 |
|---|---|---|---|---|---|---|
| **Community Participation Services Total:** | | | | | | **58978800.00** |
| Community Participation Services | 15 minute | 2540 | 6000.00 | 3.87 | 58978800.00 | |
| **Residential Habilitation/Personal Care Services Total:** | | | | | | **131211916.20** |
| Residential Habilitation/Personal Care Services | Day | 2290 | 313.00 | 183.06 | 131211916.20 | |
| **Respite Total:** | | | | | | **2721792.00** |
| Respite | 15 minutes | 1329 | 800.00 | 2.56 | 2721792.00 | |
| **Service Coordination Total:** | | | | | | **12062386.44** |
| Service Coordination | Month | 4089 | 12.00 | 245.83 | 12062386.44 | |
| **Supported Employment Total:** | | | | | | **7657551.00** |
| Supported Employment | 15 Minutes | 513 | 3245.00 | 4.60 | 7657551.00 | |
| **Assistive Technology Support Services Total:** | | | | | | **837797.40** |
| Assistive Technology Support Services | 1/2 Hour | 510 | 66.00 | 24.89 | 837797.40 | |
| **Community Support Services (CSS) Total:** | | | | | | **4918770.00** |
| Community Support Services (CSS) | 15 Minutes | 600 | 1333.00 | 6.15 | 4918770.00 | |
| **Crisis Response Services Total:** | | | | | | **1437676.80** |
| Crisis Response Services | 15 Minutes | 96 | 2252.00 | 6.65 | 1437676.80 | |
| **Environmental and Vehicle Modification Services Total:** | | | | | | **1358895.00** |
| Environmental Modification - Vehicle | Each | 25 | 1.00 | 13720.00 | 343000.00 | |
| Environmental Modification - Home | Each | 199 | 1.00 | 5105.00 | 1015895.00 | |
| **Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services Total:** | | | | | | **27947331.20** |
| PDMS - Specialty Services | 1/2 Hour | 27 | 15.00 | 58.65 | 23753.25 | |
| PDMS - Day | | | | | 7669380.00 | |
| | | | **GRAND TOTAL:** | | | **251863073.54** |
| | | | **Total Estimated Unduplicated Participants:** | | | **5400** |
| | | | **Factor D (Divide total by number of participants):** | | | **46641.31** |
| | | | **Average Length of Stay on the Waiver:** | | | 290 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Hour | 412 | 1500.00 | 12.41 | | |
| PDMS - Emod | Each | 41 | 1.00 | 4425.00 | 181425.00 | |
| PDMS - Respite | Hour | 233 | 194.00 | 9.75 | 440719.50 | |
| PDMS - CSS | Hour | 124 | 331.00 | 20.97 | 860692.68 | |
| PDMS - SEP | Hour | 137 | 750.00 | 13.93 | 1431307.50 | |
| PDMS - Service Coordination | Month | 487 | 11.00 | 174.31 | 933778.67 | |
| PDMS - PCS | Day | 474 | 300.00 | 114.65 | 16303230.00 | |
| PDMS - Atech | 1/2 Hour | 69 | 60.00 | 24.89 | 103044.60 | |
| **Specialty Services Total:** | | | | | | 2730157.50 |
| Specialty Services | 1/2 Hour | 2450 | 19.00 | 58.65 | 2730157.50 | |
| | | | | **GRAND TOTAL:** | | 251863073.54 |
| | | | | **Total Estimated Unduplicated Participants:** | | 5400 |
| | | | | **Factor D (Divide total by number of participants):** | | 46641.31 |
| | | | | **Average Length of Stay on the Waiver:** | | 290 |

## 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 |
|---|---|---|---|---|---|---|
| **Community Participation Services Total:** | | | | | | 61347240.00 |
| Community Participation Services | 15 minute | 2642 | 6000.00 | 3.87 | 61347240.00 | |
| **Residential Habilitation/Personal Care Services Total:** | | | | | | 136483311.96 |
| | 1/2 Hour | 2382 | 313.00 | 183.06 | 136483311.96 | |
| | | | | **GRAND TOTAL:** | | 261861974.06 |
| | | | | **Total Estimated Unduplicated Participants:** | | 5600 |
| | | | | **Factor D (Divide total by number of participants):** | | 46761.07 |
| | | | | **Average Length of Stay on the Waiver:** | | 290 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Residential Habilitation/Personal Care Services | | | | | | |
| **Respite Total:** | | | | | | **2830336.00** |
| Respite | 15 minutes | 1382 | 800.00 | 2.56 | 2830336.00 | |
| **Service Coordination Total:** | | | | | | **12546179.88** |
| Service Coordination | Month | 4253 | 12.00 | 245.83 | 12546179.88 | |
| **Supported Employment Total:** | | | | | | **7971018.00** |
| Supported Employment | 15 Minutes | 534 | 3245.00 | 4.60 | 7971018.00 | |
| **Assistive Technology Support Services Total:** | | | | | | **872294.94** |
| Assistive Technology Support Services | 1/2 Hour | 531 | 66.00 | 24.89 | 872294.94 | |
| **Community Support Services (CSS) Total:** | | | | | | **5115520.80** |
| Community Support Services (CSS) | 15 Minutes | 624 | 1333.00 | 6.15 | 5115520.80 | |
| **Crisis Response Services Total:** | | | | | | **1497580.00** |
| Crisis Response Services | 15 Minutes | 100 | 2252.00 | 6.65 | 1497580.00 | |
| **Environmental and Vehicle Modification Services Total:** | | | | | | **1408350.00** |
| Environmental Modification - Vehicle | Each | 26 | 1.00 | 13720.00 | 356720.00 | |
| Environmental Modification - Home | Each | 206 | 1.00 | 5105.00 | 1051630.00 | |
| **Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services Total:** | | | | | | **29059984.98** |
| PDMS - Specialty Services | 1/2 Hour | 29 | 15.00 | 58.65 | 25512.75 | |
| PDMS - Day | Hour | 428 | 1500.00 | 12.41 | 7967220.00 | |
| PDMS - Emod | Each | 43 | 1.00 | 4425.00 | 190275.00 | |
| PDMS - Respite | Hour | 243 | 194.00 | 9.75 | 459634.50 | |
| PDMS - CSS | Hour | 128 | 331.00 | 20.97 | 888456.96 | |
| | | | | **GRAND TOTAL:** | | **261861974.06** |
| | | | | **Total Estimated Unduplicated Participants:** | | **5600** |
| | | | | **Factor D (Divide total by number of participants):** | | **46761.07** |
| | | | | **Average Length of Stay on the Waiver:** | | 290 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| PDMS - SEP | Hour | 143 | 750.00 | 13.93 | 1493992.50 | |
| PDMS - Service Coordination | Month | 507 | 11.00 | 174.31 | 972126.87 | |
| PDMS - PCS | Day | 493 | 300.00 | 114.65 | 16956735.00 | |
| PDMS - Atech | 1/2 Hour | 71 | 60.00 | 24.89 | 106031.40 | |
| **Specialty Services Total:** | | | | | | 2730157.50 |
| Specialty Services | 1/2 Hour | 2450 | 19.00 | 58.65 | 2730157.50 | |
| | | | | **GRAND TOTAL:** | | 261861974.06 |
| | | | | **Total Estimated Unduplicated Participants:** | | 5600 |
| | | | | **Factor D (Divide total by number of participants):** | | 46761.07 |
| | | | | **Average Length of Stay on the Waiver:** | | 290 |

## 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 |
|---|---|---|---|---|---|---|
| **Community Participation Services Total:** | | | | | | 63808560.00 |
| Community Participation Services | 15 minute | 2748 | 6000.00 | 3.87 | 63808560.00 | |
| **Residential Habilitation/Personal Care Services Total:** | | | | | | 141926601.06 |
| Residential Habilitation/Personal Care Services | Day | 2477 | 313.00 | 183.06 | 141926601.06 | |
| **Respite Total:** | | | | | | 2942976.00 |
| Respite | 15 minutes | 1437 | 800.00 | 2.56 | 2942976.00 | |
| **Service Coordination Total:** | | | | | | 13047673.08 |
| Service Coordination | Month | 4423 | 12.00 | 245.83 | 13047673.08 | |
| | | | | **GRAND TOTAL:** | | 272185240.22 |
| | | | | **Total Estimated Unduplicated Participants:** | | 5800 |
| | | | | **Factor D (Divide total by number of participants):** | | 46928.49 |
| | | | | **Average Length of Stay on the Waiver:** | | 290 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Supported Employment Total:** | | | | | | 8284485.00 |
| Supported Employment | 15 Minutes | 555 | 3245.00 | 4.60 | 8284485.00 | |
| **Assistive Technology Support Services Total:** | | | | | | 906792.48 |
| Assistive Technology Support Services | 1/2 Hour | 552 | 66.00 | 24.89 | 906792.48 | |
| **Community Support Services (CSS) Total:** | | | | | | 5320469.55 |
| Community Support Services (CSS) | 15 Minutes | 649 | 1333.00 | 6.15 | 5320469.55 | |
| **Crisis Response Services Total:** | | | | | | 1556100.00 |
| Crisis Response Services | 15 Minutes | 104 | 2250.00 | 6.65 | 1556100.00 | |
| **Environmental and Vehicle Modification Services Total:** | | | | | | 1468015.00 |
| Environmental Modification - Vehicle | Each | 27 | 1.00 | 13720.00 | 370440.00 | |
| Environmental Modification - Home | Each | 215 | 1.00 | 5105.00 | 1097575.00 | |
| **Participant Directed and Managed Services (PDMS) formerly Consolidated Developmental Services Total:** | | | | | | 30193410.55 |
| PDMS - Specialty Services | 15 Minutes | 30 | 15.00 | 58.65 | 26392.50 | |
| PDMS - Day | Hour | 445 | 1500.00 | 12.41 | 8283675.00 | |
| PDMS - Emod | Each | 45 | 1.00 | 4425.00 | 199125.00 | |
| PDMS - Respite | Hour | 252 | 194.00 | 9.75 | 476658.00 | |
| PDMS - CSS | Hour | 134 | 331.00 | 20.97 | 930103.38 | |
| PDMS - SEP | Hour | 148 | 750.00 | 13.93 | 1546230.00 | |
| PDMS - Service Coordination | Month | 527 | 11.00 | 174.31 | 1010475.07 | |
| PDMS - PCS | Day | 512 | 300.00 | 114.65 | 17610240.00 | |
| PDMS - Atech | 1/2 Hour | 74 | 60.00 | 24.89 | 110511.60 | |
| **Specialty Services Total:** | | | | | | |
| | | | **GRAND TOTAL:** | | | 272185240.22 |
| | | | **Total Estimated Unduplicated Participants:** | | | 5800 |
| | | | **Factor D (Divide total by number of participants):** | | | 46928.49 |
| | | | **Average Length of Stay on the Waiver:** | | | 290 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | | | | | | 2730157.50 |
| Specialty Services | 15 Minutes | 2450 | 19.00 | 58.65 | 2730157.50 | |
| | | | | GRAND TOTAL: | | 272185240.22 |
| | | | | Total Estimated Unduplicated Participants: | | 5800 |
| | | | | Factor D (Divide total by number of participants): | | 46928.49 |
| | | | | Average Length of Stay on the Waiver: | | 290 |