

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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

- A. The State of New Hampshire requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. Program Title:
Choices for Independence
- C. Waiver Number: NH.0060
- D. Amendment Number: NH.0060.R06.01
- E. Proposed Effective Date: (mm/dd/yy)
07/01/12
- Approved Effective Date: 07/01/12
Approved Effective Date of Waiver being Amended: 07/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment has the following purposes:

Purpose A. It makes the technical corrections described below to the service description of an existing service.

1. Adult Family Care:

1.A. Allow relatives who are not legally responsible for the participant to provide Adult Family Care when authorized by the Bureau of Elderly and Adult Services (BEAS). BEAS is finding that the most likely successful match of a participant and an Adult Family Care provider is when the participant and caregiver already have a relationship. These relatives must meet the same requirements as unrelated caregivers, including background checks and accountabilities. State law does not require the home of a family member to be licensed for that family member to provide care to a relative.

1.B. Clarify provider and caregiver roles. Oversight and management of the Adult Family Care service is provided through two avenues to assure participant health and welfare: Each participant has a case manager who is in regular contact to monitor participant satisfaction and service provision. In addition, BEAS has approved specific enrolled providers to act as oversight agencies for this service. These agencies evaluate caregiver adequacy, provide caregiver training, serve as the point of contact for caregiver trouble-shooting, and assist the caregiver in preparing to be licensed (when required) or make other preparations prior to the participant moving into the home. The current oversight agencies include agencies that are designated area agencies and oversee similar homes for other New Hampshire 1915(c) waivers, are licensed/certified to provide home care, and/or are otherwise approved by BEAS. It is most efficient for BEAS to work with these agencies and the case managers to manage this service, rather than with each individual caregiving home. Therefore, while the individual Adult Family Care homes are licensed as required by law, they do not independently enroll as Medicaid providers.

Purpose B. It revises several performance measures (PMs) in the following Appendices:

1. App. A - Administration and Operation: The frequency of data collection was changed from quarterly to monthly.

App. B - Eligibility: The change clarifies that the PM pertains to CFI participants, and is not a reference to managed care;

2. App. C - Qualified Providers: The change clarifies that the Bureau of Health Facilities confirms provider training when they review the file - not necessarily on the same date as a physical inspection.

3. App. D - Service Plan: Three changes are proposed:

3.A. Delete the d. 1 PM and add a similar PM to the Financial Accountability appendix.

3.B. Revise the d. 2 PM to more accurately reflect the monitoring expected of case managers.

3.C. Revise the e. 3 PM to remove the repetition of the word "provider" because that appears in the previous PM.

4. App. G - Participant Safeguards: Two changes are proposed:

4.A. Delete the a. 2 PM because it duplicates two other PMs that appear later in this Appendix. The intent of this PM is to measure events that seriously impact the well-being of participants and how well BEAS responds to those events. This is measured through the Sentinel Event PMs, already in place (the 5th and 6th under this Assurance). As described in the waiver document, BEAS follows two types of communications: "Sentinel Events" and what are called "Complaints and Incidents." Although a Complaint or Incident could include an event that indicates potential harm to a participant, that category is not the intended reporting mechanism for this purpose. 4.B. Revise what is now the a. 7 PM to clarify which mailing to participants will contain the Adult Protective Services brochure and that what is being measured is whether a brochure is enclosed in every such mailing.

5. App. I - Financial Accountability: Two changes are proposed:

5.A. Replace the a. 1 PM with two alternative PMs. The Medicaid Business Office (MBO) is unable to provide a count of correctly coded claims because many providers bill by a date span, or submit a claim more than once due to other errors. We are also unable to identify the volume of claims that are paid at less than the established rate, as the MMIS pays the lesser of the established rate or the billed amount. The following two alternative PMs are proposed to monitor denials of waiver service claims and their reasons:

The first PM will measure the occurrence of claim denials due to incorrect procedure codes or modifiers for the providers with the highest number of waiver service claims denials. There are currently about 300 providers enrolled to provide waiver services and approximately 170 submit claims in an average month. The current claims denial analysis measures the top 10 such providers and in November 2012, providers with as few as 42 denials were included in the top 10. The fiscal agent has agreed to expand that analysis to include more providers, effective in December 2012, to ensure we see a full picture of the occurrence of denials due to procedure code errors.

The second PM will measure provider performance over time by identifying providers whose billing practices result in a high number of denials for waiver service claims. A provider who experiences a prolonged period of denied payments may choose to discontinue participation in the program, which could affect access to care. By reaching out to providers who are having trouble we could improve their practices and reduce the chances of them disenrolling.

5.B. Add a new PM proposed to identify the number of participants to whom a significant percentage of services were provided outside of what services are authorized by BEAS. Since the bulk of services are provided as ordered and authorized, it seems most appropriate to identify those that are not.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	QI a.i.
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	QI a.i.a.
<input checked="" type="checkbox"/> Appendix C – Participant Services	C-1/C-3, QI a.i.c.2.

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	QI a.i.d.1, d.2 & e.3
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input type="checkbox"/> Appendix F – Participant Rights	
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	QI a.i.2, a.i.7
<input type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	QI a.i.1, 2 & 3
<input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

This Amendment includes changes to the specified performance measures in the following Appendices:

A. PM# a.i: The incidence of data aggregation and analysis was changed from annually to quarterly.

B. PM #a.i.a: The word "enrollees" was changed to "participants" to clarify that this pertains to all CFI participants, not only those enrolled in managed care.

C. PM #a.i.c.2: The word "inspection" was changed to "review" to reflect that looking for provider training confirmation is not necessarily tied to a provider inspection.

D. PM #a.i.d.1: The measure regarding number and percent of services provided in accordance with the care plan was removed. A new PM was added to Appendix I, to address the relationship between what is authorized and what is paid.

D. PM #a.i.d: What was PM #2 was changed to reflect that service monitoring is required of case managers, and their performance of this monitoring is verified during on site file reviews.

D. PM #a.i.e.3: The words "and providers" were removed because this is addressed in the prior PM.

G. PM #a.i.2: This PM was deleted because the monitoring of events that seriously impact the well-being of participants and how well BEAS responds to those events, is addressed in PMs 5 and 6 (now 4 and 5) under this Assurance.

G. PM #a.i.7 (now 6): The language in this PM was changed to more accurately identify the letter being referenced, and to clarify that we are measuring whether or not every such letter carries an APS brochure.

I. PM #a.i: The amendment replaces the two PMs initially proposed with three alternate PMs.

The first PM will measure the occurrence of claim denials due to incorrect procedure codes or modifiers for the providers with the highest number of waiver service claims denials. There are currently about 300 providers enrolled to provide waiver services and approximately 170 submit claims in an average month. The current claims denial analysis measures the top 10 such providers and in November 2012, providers with as few as 42 denials were included in the top 10. The fiscal agent has agreed to expand that analysis to include more providers, effective in December 2012, to ensure we see a full picture of the occurrence of denials due to procedure code errors.

The second PM will measure provider performance over time by identifying providers whose billing practices result in a high number of denials for waiver service claims. A provider who experiences a prolonged period of denied payments may choose to discontinue participation in the program, which could affect access to care. By reaching out to providers who are having trouble we could improve their practices and reduce the chances of them disenrolling.

The third PM will measure claims that are paid in excess of what services have been authorized. The original waiver document had a PM in Appendix D regarding claims being paid in accordance with the service plan. That was removed from that Appendix and modified to be clear that we are comparing paid claims to services

authorized after communication between the case manager and the BEAS nurse. This emphasizes the process in place: The first step is for the case manager to develop a person-centered care plan with the participant, and send the services selected to the BEAS nurse. The second step is for the nurse to either approve the list as submitted or request more information about the participant's needs. After this communication with the case manager, the nurse enters the authorization in the Options information system, which then sends an automated authorization to the provider. This revised PM is clear that the measure is the comparison of what the provider bills and is paid to what was authorized.

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

1. Request Information (1 of 3)

A. The State of New Hampshire requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Choices for Independence

C. Type of Request: amendment

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

3 years 5 years

Waiver Number: NH.0060.R06.01

Draft ID: NH.01.06.01

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/12

Approved Effective Date of Waiver being Amended: 07/01/12

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 in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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.

I. Goal: The Choices for Independence program (CFI) seeks to enable eligible seniors and adults with disabilities to choose and access covered services in NH communities that will allow them to postpone or avoid institutional placements.

II. Objectives:

1. Continue in long term care system rebalancing efforts and increase reliance upon community based rather than institutional services, in partnership with the statewide ServiceLink Resource Center (SLRC) network, the New Hampshire Aging and Disability Resource Center model.

2. Meet federal and state cost effectiveness requirements and determine clinical eligibility in a consistent manner. The clinical standards and complete process are in the administrative program rule (He-E 801), which also describes services and provider requirements for the waiver program. An administrative rule has the force of law and is used in any type of program training, monitoring or enforcement.

Clinical eligibility and initial cost effectiveness are in 801.04 as follows:

(a)(1) A registered nurse employed or designated by the department shall:

- a. Conduct an on-site, face-to-face visit with the applicant;
- b. Perform a clinical assessment of the applicant; and
- c. Develop a list of identified needs with the applicant;

(2) The applicant shall sign the following:

- a. The identified needs section of the assessment, indicating his or her agreement or disagreement with the identified needs;
- b. A consent for participation in the CFI program, including whether or not he or she has a preference of a case management agency;
- c. An authorization for release of information; and

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

(b) For each applicant who meets the clinical eligibility requirements, a registered nurse employed or designated by the department shall estimate the costs of the provision of home-based services by identifying medical and other services, including units, frequencies, and costs, that would meet the needs identified in the assessment in (a)(1) above in order to determine if services that meet the applicant's needs can be provided at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services.

4. Support individual choice and preference of services through person-centered planning: After the RN identifies an individual's needs based on the assessment data, the case manager creates a comprehensive care plan with the individual, using person-centered planning techniques. Training on person-centered planning is available for staff and providers to ensure a consistent understanding.

5. Respond to participant preferences/need, service availability, demographic, and budgetary changes. The aging population is increasing as a percentage of the overall state population. US Census of 2010, data shows that 13.5% of NH's population is 65 years of age or older. The NH Office of Energy & Planning projects this proportion to grow to 20% by 2020, and over 25% by 2025. Providers' reports of difficulty hiring adequate staff with appropriate skills led to the development of Personal Care Services, for which employees are not individually licensed but are trained by licensed/certified agencies. In addition, some Program participants have expressed interest in directing their care and services. BEAS will work with stakeholders to explore program change and development ideas.

6. Ensure that covered services are consistently of a high quality and provided by qualified providers. CFI providers enroll directly with the Medicaid Program and submit claims through the MMIS. Scheduled IT changes will link care plans and MMIS payment authorization.

III. Structure and Roles:

The Program is directed and managed by the Bureau of Elderly and Adult Services (BEAS), of the Division of Community Based Care Services (DCBCS). DCBCS, part of the single state Medicaid agency, includes the Bureaus of Behavioral Health and Developmental Services. The Medicaid Business Office (MBO) within the single state agency works with the Medicaid Fiscal Agent to enroll providers. Whenever a provider requests enrollment to provide waiver services, the MBO sends the provider's enrollment information to the BEAS Quality Manager, who conducts a QA review of 100% of enrolling providers before enrollment and ensures only approved providers are listed in the Options system.

Registered nurses employed, contracted or trained and approved by BEAS conduct every clinical assessment. BEAS employs and contracts with RNs, and trains RNs employed by community providers, ensuring that every assessment is consistently completed. Enrolled case management agencies use the information from the assessment and work with participants to develop a person-centered comprehensive care plan. BEAS-approved and enrolled providers serve participants in their homes or other community settings. SLRCs provide options counseling to individuals and families and, if the individual chooses to apply for Medicaid, the SLRC assists with the application process.

The non-federal portion of institutional and community based long-term care expenses is shared by DHHS and County Governments. This provides the Counties with an equal incentive to support community based care. The County role is limited to a financial relationship and includes the exchange general Program information as requested, and does not include program administration.

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/HID.
- 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:
1. **Administrative rules:** Operation of the Program requires DHHS to maintain an administrative rule that defines all eligibility, service and provider requirements. The administrative rulemaking process includes a public hearing before a rule goes before the Rules Committee, and the Committee meeting itself is public.
 2. **Budget authorization by the Legislature:** The process through which DHHS explains its proposed budget for the Program includes testimony to the Legislature, which is open to the public.
 3. **ServiceLink Resource Centers (SLRCs):** There are SLRC offices in every county of the state. Individuals, family members and caregivers can stop in or call with any questions or concerns about community based care, including care provided through the Program. SLRCs hold public educational sessions on a variety of topics, including Medicare, Medicaid, caregiving, and healthy living. The SLRC network received the Community Partner of the Year Award from AARP New Hampshire, in 2011.
 4. **Case Managers:** Case managers are enrolled providers that are responsible for communicating with each participant at least every 30 days to assess his/her satisfaction with the services being provided, and the adequacy of those services. Case managers report any problems identified to BEAS and meet with BEAS routinely. BEAS meets with case management agencies about every six weeks.
 5. **Listening Sessions:** In 2008, BEAS collaborated with the State Committee on Aging and the Institute on Disability at UNH, to conduct seventeen community listening sessions throughout the State to hear what seniors and local service providers thought about the transformation efforts taking place in the long term care services system, and to provide an opportunity to voice ideas and concerns about what is or is not working well for older people and adults with disabilities. The listening sessions were held as part of the Systems Transformation Grant work plan as a means of public outreach and comment. BEAS used the findings from these sessions in its renewal application of the State Plan on Aging. A survey on the State Plan on Aging was also available for completion on the BEAS website.
 7. **"Aging Issues:"** This newsletter is published by BEAS and the NH State Committee on Aging (SCOA) three times per year, to provide information about aging, health and services to the public and to encourage engagement by the public. Aging Issues is included as an insert in the Senior Beacon (circulation: 20,000), and an additional 13,700 copies are distributed through a mailing list maintained by BEAS.
 8. **Public Conferences:** The public is invited to attend various topic-focused conferences throughout the state on a regular basis. Examples include:
 - a. Approximately 250 people attended the New Hampshire Abuse Prevention Conference, "Supporting Elders: Prevention, Planning and Possibilities", held in 2011, in West Lebanon. The conference was presented by the Office of the State Long-Term Care Ombudsman (OLTCO) and BEAS-Adult Protective Services.
 - b. Annual Conference on Aging: Every year BEAS engages sponsors to hold this conference for the public. The theme for the 2011 Conference was "Connecting the Community," and it was attended by over 820 individuals. Attendees complete surveys, the results of which identify topics of common interest or concern and are used in planning future conferences or other public forums.
 9. **Area Committees on Aging (ACOA's):** ACOA's are independent local advocacy groups comprised of older adults, service providers and other members of the public who share a common interest in issues that affect older adults.

ACOA meeting schedules and locations are published in "Aging Issues" and through local channels.

10. Provider Meetings: BEAS is in regular contact with providers of several services at which time providers may share Program improvement ideas. When possible, BEAS staff participate in provider association meetings to discuss provider concerns and Program-related issues. In addition to more general contacts, BEAS formed a Choices for Independence (CFI) Focus Group in 2009. We invited providers and participants to discussions about the program. The Focus group included providers of the following services: home health services (including Aide, Nursing and Homemaking), personal care services, adult medical day services, case management services, adult family care services, and case management services. The other members were an individual who uses personal care services and a representative of the Association of Counties.

11. SCOA: The State Committee on Aging is committed to enhancing community based services and meets with DHHS every month.

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:

Toumpas

First Name:

Nicholas

Title:

Commissioner

Agency:

New Hampshire Department of Health and Human Services

Address:

129 Pleasant Street

Address 2:

City:

Concord

State:

New Hampshire

Zip:

03301

Phone:

(603) 271-9445

Ext:

TTY

Fax:

(603) 271-4912

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone: Ext: TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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: Toumpas
 Title: _____
 Attachment #1: Nicholas
 Agency: _____
Transition Plan Commissioner

 Address: _____
 Specify the transition plan for the waiver: New Hampshire Department of Health and Human Services
 Address 2: 129 Pleasant Street
 City: N/A
 State: Concord
Additional _____
 Zip: New Hampshire
 Phone: _____
Needed 03301
 Fax: _____
Information (603) 271-9445 Ext: _____ TTY
 E-mail: _____
(Optional) (603) 271-4912

Provide additional needed information for the waiver (optional): ntoumpas@dhhs.state.nh.us

Every CFI participant has a case manager. Case managers must be in contact with participants at a minimum of every 30 days. The case manager must have a face-to-face meeting with the participant at least every 60 days, or more often if needed.

He-E 805.05 Required Case Management Services:

- (d) The designated case manager shall monitor the services provided to a participant, as follows:
 - (1) Conduct the case management contacts required for each participant, as follows:
 - a. Case management contacts shall include no less than one monthly telephonic contact and one face-to-face contact every 60 days; and
 - b. Each case management contact shall be documented in a contact note;
 - (2) Ensure that services are adequate and appropriate for the participant's needs, and are being provided, as described in the comprehensive care plan;
 - (3) Ensure that the participant is actively engaging in the services described in the comprehensive care plan;
 - (4) Ensure that the participant is satisfied with the comprehensive care plan; and
 - (5) Identify any changes in the participant's condition, discuss these changes with the participant in order to determine whether changes to the comprehensive care plan are needed, and make changes to the comprehensive care plan as needed.

Additionally, participants are able to contact their case manager whenever needed. The administrative rule requires, at He-E 805.04 (e): "Case management agencies shall maintain access to a toll free number for all participants served and respond to calls as follows:

- (1) Responses to calls received on Monday through Friday shall be made within 24 hours; and
- (2) Responses to calls received on Saturdays, Sundays and holidays shall be made within 48 hours."

When a waiver applicant is found eligible, s/he is told the names of the participating case management agencies and asked if s/he prefers a specific agency. If the applicant does not have a preference, the agency is assigned through a rotation

process. Applicants and participants are also told that they may change their case management service provider at any point.

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.

Division of Community Based Care Services (DCBCS), Bureau of Elderly and Adult Services (BEAS)
(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

The NH Department of Health and Human Services (DHHS) is the single state Medicaid agency. As required by RSA 151-E, DHHS has adopted administrative rules, He-E 801 (Choices for Independence), which directs BEAS within DHHS in the administration of the waiver program. He-E 801 describes clinical eligibility standards, the eligibility process, service definitions and requirements, and provider requirements. It also includes the requirement of a comprehensive care plan developed by the case manager and participant using a person-centered planning process.

The Commissioner of Health and Human Service retains the ultimate authority over all of NH's HCBS waivers. BEAS is responsible for CFI waiver operations, under the direct supervision of DHHS Associate Commissioner, including waiver program monitoring.

- 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.

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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.:

BEAS contracts with and monitors ServiceLink Resource Centers (SLRCs), non-profit agencies established under RSA 151-E:5, located in each county to provide information, outreach, resource development and education to Participants, caregivers, providers and the general public. Trained Options Counselors at SLRCs assist individual consider what services and programs, including local programs may be free to the public as well as Medicaid-funded programs, may best meet their needs. If a person decides to apply for Medicaid-funded long term care services, the Options Counselor can facilitate the application process. BEAS has sole authority over level of care and waiver eligibility decisions.

The contracted Medicaid fiscal agent performs provider recruitment and training, and screens providers applying to the Medicaid Program. In 2012, Affiliated Computer Services (ACS, owned by Xerox) will become the fiscal agent, replacing HP Enterprise Services. The fiscal agent conducts the initial review of each provider application and provides guidance to providers that are seeking to enroll. Once the fiscal agent has confirmed that an enrollment application is complete and correctly filled out, it forwards the materials to the Medicaid Business office (MBO) for review and a decision. The MBO is responsible for executing provider agreements and approving enrollment, and obtains BEAS' approval of providers seeking enrollment to provide waiver services.

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:

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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:

	▲ ▼
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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:

BEAS is responsible for directly monitoring the performance of the SLRCs. The Medicaid Business Office (MBO) is responsible for directly monitoring the Medicaid fiscal agent, which is currently HP and will soon be ACS. The MBO provides BEAS with regular performance reports.

Additional assessments, both ongoing and periodic, are performed by other entities within the Single State Medicaid Agency/DHHS including:

1. Surveillance and Utilization Review Services within the Office of Improvement and Integrity, which assists BEAS in the assessment of waiver providers; and
2. The Office of Program Support, Bureau of Health Facilities, which conducts licensing and certification reviews of licensed service providers.

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:

BEAS monitors the SLRCs through the following actions:

1. BEAS reviews and approves the work plans that SLRCs establish at the beginning of the contract cycle, and monitors workplan updates to demonstrate progress, adjustments to goals, task, deliverables, and timeline every quarter during the contract period.
2. Each SLRC is required to monitor specified performance measures and report to BEAS during the contract period.
3. BEAS approves and monitors contract budgets and quarterly program expenses for each SLRC.
4. BEAS representatives and regional SLRC programs meet as a statewide network to share information, review data, and plan for continued quality improvement of the SLRC network.
5. On a bi-annual basis BEAS conducts contract site reviews. The review focuses primarily on contract and administrative rule compliance as well as a general financial review. Strengths and weaknesses as well as opportunities for improvement are identified through an evaluation of the various steps completed by the BEAS review team.

The Medicaid Business Office (MBO) reports to BEAS each month about its oversight of the Fiscal Agent, currently HP. This reports includes the following domains:

1. Claims processing, including graphical representation of financial information, for example: expenditures, amounts refunded or recouped, claims suspended, and insurance premium payouts, as well as claims processing information, such as volume submitted by paper or electronic means;
2. Provider services activity, including Call Center inquiry statistics, provider grievances filed, calls, visits and workshops helped by provider representatives, provider enrollments and disenrollments by provider type, and an analysis of the claims denials for the month;
3. System activities including modification hours spent in response to project requests from the DHHS and system availability statistics by function and in comparison to the contractual requirements; and
4. Organizational chart.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
 In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of Medicaid System Status reports that were submitted on time and in the correct format. N = The number of reports that were submitted on time and in the correct format. D = The total number of reports required.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

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

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

The Commissioner of Health and Human Service retains the ultimate authority over all waiver operations. As required by RSA 151-E, and pursuant to RSA 541-A, the Department has adopted administrative rules that define how the waiver program operates and the program's requirements and limitations. Administrative rule, He-E 801, Choices for Independence Program, defines eligibility criteria and process, covered services and provider qualifications.

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.
BEAS receives the status report from the Medicaid Business Office (MBO) on a monthly basis and reviews it for indications of program dysfunction, such as an increase in claims denials or provider requests for assistance. If there is an increase in such indicators, BEAS works directly with the MBO to determine the appropriate follow up action, and who will take that action. Documentation of the discovery of a problem, the subsequent collaboration with the MBO, the action decided upon and the responsible party, the result(s) of the action taken, and the result of follow-up oversight is maintained by the waiver manager, who is the individual responsible for managing the waiver document.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No
- Yes

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

	<input type="button" value="▲"/> <input type="button" value="▼"/>
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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 a group 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 waiver target group, check each of the subgroups in the selected target group 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
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	18	64	
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Individuals must require assistance due to a chronic medical diagnosis and/or frailty associated with aging, including Alzheimer’s Disease or other types of dementia, and meet clinical eligibility requirements established in RSA 151-E:3 I. Individuals who would otherwise require the services of an IMD, and are of the age of 21 through 64 (per 1905 (a) 28 (B) of the Act), or who would otherwise require the services of a psychiatric residential treatment facility as defined in 42 CFR 483.352, are not eligible.

RSA 151-E:3 states the following:

I. A person is medicaid eligible for nursing facility services if the person is:

(a) Clinically eligible for nursing facility care because the person requires 24-hour care for one or more of the following purposes, as determined by registered nurses appropriately trained to use an assessment tool and employed by the department, or a designee acting on behalf of the department:

(1) Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;

(2) Restorative nursing or rehabilitative care with patient-specific goals;

(3) Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or

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

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

- Not applicable. There is no maximum age limit
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other

Specify:

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

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

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:

Each prospective participant is clinically evaluated by an RN employed, contracted or trained by the State, using a standardized assessment instrument, to determine if s/he is clinically eligible and to identify the individual's needs. The resulting assessment form is sent to the Bureau of Elderly and Adult Services (BEAS) where an RN employed or contracted by BEAS drafts a preliminary list of services that would address the participant's identified needs. Using the service rates in use at the time, this RN estimates the cost of the preliminary list of services, and this cost is compared to the cost of facility care. The RN uses the results of this comparison to determine whether the individual's needs can be met through the Program within the institutional cost limit.

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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

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

If a Participant's condition or circumstances change after being accepted to the Program, an RN employed, contracted or trained by the State conducts a clinical reassessment of his/her functional needs. The Case Manager and/or RN talks with the Participant about how his/her needs can be met, including what informal or community supports may be available.

Additional Program services may be authorized if they are required to maintain the participant's health and safety. There is no standard amount of additional services that may be authorized. Rather, an authorization is made after consideration of other supports available to the individual and the period of time when the additional services are needed, such as if additional services are needed until the Participant moves to another living arrangement. Additional services are considered for authorization based on the Participant's clinical needs and living environment, with the foremost goal of preserving health and safety. Through the risk assessment process and Elder-Wrap meetings, BEAS engages community partners and the Participant in the planning and delivery of appropriate services. The Elder-Wrap process brings together professionals from various community service organizations and provider agencies and case managers to discuss specific challenges they have in common, with the purpose of developing solutions they can effect as a team.

Other safeguard(s)

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3909
Year 2	4053
Year 3	4202
Year 4	4359
Year 5	4522

- 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	

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

Appendix B: Participant Access and Eligibility

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

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):
- Not applicable. The state does not reserve capacity.
 - The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

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

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.
 - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. **Allocation of Waiver Capacity.**
- Select one:*
- Waiver capacity is allocated/managed on a statewide basis.
 - Waiver capacity is allocated to local/regional non-state entities.

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

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

The waiver provides for the entrance of all applicants who are found eligible though the eligibility process identified in He-E 801. Enrollment is effective as soon as the eligibility process is completed and the applicant is found eligible. There is no waiting list for this Program.

The requirements for the waiver program are described at He-E 801.03, and the process is at He-E 801.04, as follows:

801.03 (a) An individual shall be eligible to receive CFI services if he or she meets all of the following requirements:

- (1) Submits a signed and dated application, as defined in He-W 601.17, to the department;
- (2) Is at least 18 years of age;

- (3) Has been determined financially eligible as either categorically needy or medically needy;
- (4) Meets the clinical eligibility requirements for nursing facility care in RSA 151-E:3, I(a), namely, the person requires 24-hour care for one or more of the following purposes, as determined by registered nurses appropriately trained to use an assessment instrument and employed by the department, or a designee acting on behalf of the department:
 - a. Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;
 - b. Restorative nursing or rehabilitative care with patient-specific goals;
 - c. Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or
 - d. Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence;
- (5) Requires the provision of at least one CFI waiver service, as documented in the identified needs list, and receives at least one CFI waiver service at least monthly;
- (6) Is determined by a registered nurse employed or designated by the department to require CFI waiver services that can be provided at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services; and
- (7) Has chosen, or whose legal representative has chosen, by signing the application in (1) above, CFI services as an alternative to institutional care.

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

(c) While receiving care as a resident in a nursing facility, an individual shall not be eligible for coverage of CFI services listed in He-E 801.12(b).

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

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

- (1) Services described in He-E 801.12(b) shall not be provided while the participant is in the facility, except for services that have been prior authorized for the purpose of enabling the participant to transition back to his or her community; and
- (2) The participant's clinical eligibility shall be maintained until such time that an eligibility redetermination is conducted in accordance with He-E 801.07 and the participant is determined ineligible.

He-E 801.04 Eligibility Determination.

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

- (1) A registered nurse employed or designated by the department shall:
 - a. Conduct an on-site, face-to-face visit with the applicant;
 - b. Perform a clinical assessment of the applicant; and
 - c. Develop a list of identified needs with the applicant;
- (2) The applicant shall sign the following:
 - a. The identified needs section of the assessment, indicating his or her agreement or disagreement with the identified needs;
 - b. A consent for participation in the CFI program, including whether or not he or she has a preference of a case management agency;
 - c. An authorization for release of information; and

d. An authorization for release of protected health information;

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

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

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

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

(b) For each applicant who meets the clinical eligibility requirements, a registered nurse employed or designated by the department shall estimate the costs of the provision of home-based services by identifying medical and other services, including units, frequencies, and costs, that would meet the needs identified in the assessment in (a)(1) above in order to determine if services that meet the applicant's needs can be provided at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services, pursuant to He-E 801.03(a)(6), and does not exceed the cost limits described in He-E 801.09.

(c) The applicant shall be determined eligible for the CFI program if it is determined that the applicant meets the financial eligibility requirements described in He-W 600, the clinical eligibility requirements of He-E 801.03(a)(4), and the other eligibility requirements in He-E 801.03.

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

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

(2) The eligibility start date.

(e) Upon a determination of ineligibility, because the applicant does not meet the eligibility requirements of He-E 801.03 or because required information is not received pursuant to (a)(6) above, the applicant or his or her legal representative shall be sent a notice of denial, including:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

- §1634 State
- SSI Criteria State
- 209(b) State

2. Miller Trust State.

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

- No
- Yes

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

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

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)
- Specify percentage:
- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- 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 (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 4)

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 4)

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:

	<input type="button" value="▲"/> <input type="button" value="▼"/>
--	--

- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of the FBR, which is less than 300%

Specify percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable (see instructions)

The following standard under 42 CFR §435.121

Specify:

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

▲
▼

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

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

Select one:

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

Specify:

▲
▼

Appendix B: Participant Access and Eligibility

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

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-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:

Registered nurse holding a NH license who is employed, contracted or trained by BEAS to perform clinical assessments.

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

Individuals must require assistance due to a chronic medical diagnosis and/or frailty, such as Alzheimer's Disease or other types of dementia, and meet clinical (level of care) eligibility requirements established in RSA 151-E:3 I, which are: To be clinically eligible for Medicaid coverage of long term care, a person must require 24-hour care for one or more of the following purposes: medical monitoring and nursing care; restorative nursing or rehabilitative care; medication administration requiring medical or nursing intervention; or assistance with two or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence. (RSA 151-E:3) The Medical Eligibility Determination (MED) instrument is used for every applicant to long term care, including institutional and community based services. Individuals who would otherwise require the services of an IMD, and are of the age of 21 through 64, are not eligible, (per 1905 (a) 28 (B) of the Act), or who would otherwise require the services of a psychiatric residential treatment facility as defined in 42 CFR 483.352, are not eligible.

- 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 registered nurse visits the applicant/participant in his/her home (or hospital if the applicant is receiving acute care) and completes the MED. The completed MED is sent to BEAS and is reviewed by an RN employed or contracted by the Medicaid Agency, who determines clinical eligibility for admission to the waiver program.

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

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):
- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
 - The qualifications are different.
- Specify the qualifications:*

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

Current status information is constantly available to all RNs electronically through two Department-developed and maintained information systems: The Options Information system that is maintained by BEAS, and the eligibility system of record, the NewHeights (NHts) system, which is maintained by another Departmental unit. NHts displays each participant's status in the application process. The Options Information produces monthly and quarterly reports to show the timeliness of renewal reviews.

- 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:

Medical records are retained by the Department and case management agencies.

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**
 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new participants who received a LOC determination prior to the initiation of waiver services. N = The number of new enrollees whose LOC was established in Options prior to receipt of services. D = The Number of participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

All applications and redeterminations are processed through the Options Information System. System edits require confirmation of LOC prior to LTC eligibility being effective.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of waiver participants who received an annual redetermination of eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation. N = Number of participants whose LOC was determined within 12 months of the prior LOC. D = Number of participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monthly reports are produced by the DHHS-operated case tracking system, Options, that show how many re-evaluations were due and how many were completed.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	

		<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of participants' initial/annual LOC determinations made with instruments that were completed as required by the state. N = Number of LOC determinations made with the required forms. D = Number of participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

BEAS LTC Unit staff review every LOC instrument received for completeness. RNs employed/contracted by DHHS review and confirm that each document was completed as required by the state.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = []
<input type="checkbox"/> Other Specify: []	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: []
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: []
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
 Number and percent of participants' LOC determinations made by a qualified evaluator. N = Number of LOC determinations made by a qualified evaluator D = Number of participants

Data Source (Select one):

Other
 If 'Other' is selected, specify:
Confirmation through the Board of Nursing that only licensed registered nurses are employed or contracted to perform LOC determinations.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Eligibility cannot be determined unless all clinical data is received. If information is missing, appears inaccurate or is inadequate, BEAS obtains additional information prior to making an eligibility decision. The Quality Assurance Manager produces monthly and quarterly reports about all indicators, and regularly convenes a quality assurance workgroup to review these reports. As individual problems are identified they are addressed by the Long Term Care Unit, waiver manager and Quality Assurance Manager. If an evaluator repeatedly submits poorly completed assessment forms, additional training is offered and, if necessary, no further assessments are assigned to that evaluator. Documentation of problems identified, action taken to correct the problems and the results of those actions is retained by the waiver manager.

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

Long Term Supports and Services (LTSS) Options Counselors at the SLRCs receive comprehensive training and supervision by BEAS concerning the importance of each applicant being accurately informed about his/her ability to choose community based care.

SLRC LTS Options Counselors conduct standardized education of each applicant concerning:

1. The fact that CFI services are available as an alternative to institutional care.
2. The range of available long term care services.
3. The appeal process if the application is denied.

Each applicant must sign a form that states that s/he is choosing community based services instead of institutional services. A new copy of the same form is reviewed and signed at each reassessment.

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

Forms are developed and retained by the Department.

Appendix B: Participant Access and Eligibility

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

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

1. At each NH DHHS District Office (DO) and at each ServiceLink Resource Center (SLRC), at least one of which is accessed by every applicant in the application and redetermination processes, there is a large poster that is prominently displayed. It shows a symbol for sign language, low vision, hard of hearing, and speaking impairment and announces in large print that assistance is available at no cost to the individual. The individual indicates his/her needs by pointing to the appropriate block.
 2. Every DO and SLRC has equipment available for use by applicants and participants during the application and redetermination process. This includes:
 - a. Pocket-talker: These small, battery-operated devices are used by people who are hard of hearing and make it possible for them to hear the person with whom they are speaking.
 - b. CCTV device: This enables magnification of documents for reading by people with low vision. (not all SLRCs have a CCTV)
 - c. Videophones: The State Office and the SLRCs have videophones that provide access to video relay services for sign language.
 - d. Language Line: The Language Line is available at all DOs and SLRCs and provides translation of all languages for people whose primary language is not English.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Medical Day Services
Statutory Service	Home Health Aide
Statutory Service	Homemaker
Statutory Service	Personal Care
Statutory Service	Respite
Other Service	Adult Family Care
Other Service	Adult In-Home Services
Other Service	Community transition services
Other Service	Consolidated services
Other Service	Environmental accessibility services
Other Service	Home-Delivered Meals
Other Service	Non-Medical Transportation
Other Service	Personal Emergency Response System
Other Service	Residential Care Facility Services
Other Service	Skilled Nursing
Other Service	Specialized Medical Equipment Services
Other Service	Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Medical Day Services

Service Definition (Scope):

Adult medical day programs provide a protective environment for impaired or isolated Participants who are at risk of institutionalization. Services include an array of social and health care services and provides day-time respite for primary caregivers. Services are furnished on a regularly scheduled basis, for one or more days per week. Meals provided as part of this service shall not constitute a "full nutritional regimen." Transportation services are not included in this service and are not included in the reimbursement for this service.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Medical Day

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Medical Day Services

Provider Category:

Agency

Provider Type:

Adult Medical Day

Provider Qualifications

License (specify):

Adult Medical Day, RSA 151:2

Certificate (specify):

Other Standard (specify):

▲
▼

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

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

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

Service Type:
 Statutory Service ▼

Service:
 Home Health Aide ▼

Alternate Service Title (if any):

▲
▼

Service Definition (Scope):
 Services defined in 42 CFR 440.70, that are provided in addition to home health aide services furnished under the approved State Plan. Home health aide services under the waiver differ in provider type (including provider training and qualifications) from home health aide services in the State Plan. The difference from the State Plan is that the employing agency is licensed by the State to direct or provide therapeutic services in accordance with administrative rule He-P 809.

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

▲
▼

- Service Delivery Method (check each that applies):**
- Participant-directed as specified in Appendix E
 - Provider managed

- Specify whether the service may be provided by (check each that applies):**
- Legally Responsible Person
 - Relative
 - Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

RSA 151:2-b

Certificate (specify):

Other Standard (specify):

Home Health Aides are individually licensed

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureaus of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Service Definition (Scope):

Non hands-on general household services, such as light cleaning or meal preparation, provided by homemakers who are employed, trained and supervised by licensed home health agencies.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

Home Health, RSA 151:2-b

Certificate (specify):

[Empty text box with scroll arrows]

Other Standard (specify):

[Empty text box with scroll arrows]

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

[Empty text box with scroll arrows]

Service Definition (Scope):

Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the State Plan. This service includes a range of services to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance, such as with activities of daily living, including eating, bathing, dressing, and personal hygiene, or cuing to prompt a participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services including skilled or nursing care and medication administration are allowed to the extent permitted by law. Personal care services may be provided outside of the participant's home. When authorized by BEAS, based on clinical necessity documented in the comprehensive care plan, personal care services may be used to accompany the participant to access necessary services. Personal care services do not include transportation. Personal care aides may furnish and bill separately for transportation if they meet the State qualifications for transportation services, whether medical transportation under the State Plan or non-medical transportation under the waiver.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
 Service Name: Personal Care

Provider Category:

Agency ▼

Provider Type:

Other Qualified Agencies (OQA)

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

OQA: RSA 161 (OQA certification)

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Elderly and Adult Services certifies OQAs

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
 Service Name: Personal Care

Provider Category:

Agency ▼

Provider Type:

Agencies licensed by the State under RSA 151:2 for home care

Provider Qualifications

License (specify):

RSA 151:2

Certificate (specify):

Other Standard (specify):

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

Appendix C: Participant Services

C-1/C-3: 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):

Service Definition (Scope):

Direct and indirect care provided to participants unable to care for themselves, furnished on a short term basis because of the absence of, or need for relief of, the usual caregiver(s). Services may be provided in the Participant's home, in a licensed residential care facility or in a nursing facility.

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

Services are limited to the equivalent of 20, 24 hour days of care per state fiscal year/participant. Services are provided in units of time that are determined appropriate by the caregiver and case manager.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Facilities licensed by the State to provide Residential Care Services

Provider Qualifications
License (specify):
Residential care, RSA 151:2
Certificate (specify):

Other Standard (specify):

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Agencies certified by the State as Other Qualified Agencies

Provider Qualifications
License (specify):

Certificate (specify):
OQA, RSA 161:1
Other Standard (specify):

Verification of Provider Qualifications
Entity Responsible for Verification:
BEAS
Frequency of Verification:
Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Facilities licensed by the State as Nursing Facilities

Provider Qualifications

License (specify):

Nursing Facilities, RSA 151:2

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agencies licensed by the State under RSA 151:2 for home care

Provider Qualifications

License (specify):

RSA 151:2-b, He-P 809 and He-P 822

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureaus of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Family Care

Service Definition (Scope):

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	BEAS approves providers to provide caregiver oversight. AFC homes meet the requirements established in law.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Family Care

Provider Category:

Agency

Provider Type:

BEAS approves providers to provide caregiver oversight. AFC homes meet the requirements established in law.

Provider Qualifications

License (specify):

RESIDENTIAL CARE AND HEALTH FACILITY LICENSING laws:

RSA 151:2 as follows:

II. This chapter shall not be construed to require licensing of the following:

(b) Facilities maintained or operated for the sole benefit of persons related to the owner or manager by blood or marriage within the third degree of consanguinity.

151:9 as follows:

VIII. The commissioner of the department of health and human services shall establish a program, by rule, to certify facilities that provide services to fewer than 3 individuals, beyond room and board care, in a residential setting, as an alternative to nursing facility care, which offers residents a home-

like living arrangement, social, health, or medical services, including, but not limited to, medical or nursing supervision, medical care or treatment by appropriately trained or licensed individuals, assistance in daily living, or protective care.

Certificate (specify):

RESIDENTIAL CARE AND HEALTH FACILITY LICENSING laws:

151:9 as follows:

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

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult In-Home Services

Service Definition (Scope):

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

Home Health or Homemaker RSA 151:2-b

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community transition services

Service Definition (Scope):

One-time set-up expenses for an individual who transitions from an institution to his/her own home or apartment in the community. Expenses must be reasonable and necessary for an individual to establish his or her basic living arrangement. Expenses may include security deposits required to obtain a lease, essential furnishings, including but not limited to bedding, pots and pans, dishes, cutlery, deposits to ensure utility access, or one-time cleaning costs prior to occupancy.

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

Services must be prior authorized by BEAS and are limited to \$1000/person per transition. This limit is independent of other service limits. This service does not include payment for rent.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	All qualified providers, including providers enrolled to provide Consolidated or Personal Care services.

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Community transition services

Provider Category:

Individual ▾

Provider Type:

All qualified providers, including providers enrolled to provide Consolidated or Personal Care services.

Provider Qualifications

License (specify):

Certificate (specify):

OQA: RSA 161:1

Other Standard (specify):

Potential providers must be approved by BEAS and be an enrolled provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

BEAS

Frequency of Verification:

Prior to service delivery

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:

Consolidated services

Service Definition (Scope):

Services that are linked to provide supportive care to participants in community and residential care settings to help the individual achieve and maintain independence and well being. Services may include transportation to non-medical appointments, personal care services, housekeeping, general supervision, and social programs to promote health and well-being. Services are planned and provided in a person-centered manner.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Other Qualified Agency (OQA)
Agency	Residential Care
Agency	Agency licensed by the State under RSA 151:2, for home care services

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Consolidated services

Provider Category:

Agency

Provider Type:

Other Qualified Agency (OQA)

Provider Qualifications

License (specify):

Certificate (specify):

RSA 161-1

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

BEAS

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consolidated services

Provider Category:

Agency

Provider Type:

Residential Care

Provider Qualifications

License (specify):

Residential care RSA 151:2

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Licensing and Certification

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consolidated services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

RSA 151:2

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Licensing and Certification

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

Environmental accessibility services

Service Definition (Scope):

Physical adaptations to the Participant's home, required by the comprehensive care plan, which are necessary to ensure the health, welfare and safety of the Participant or which will enable the Participant to function with greater independence and, without which, the Participant would require institutionalization. Services may include the installation of grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric equipment or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the health and welfare of the Participant. Adaptations or improvements that are of general utility, add to the square footage of the home, or are not of direct medical or remedial benefit to the Participant, such as carpeting, roof repair, or air conditioning, are not included in this service.

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

Services must be prior authorized by BEAS, and are limited to a one-time \$15,000/Participant. This limitation is applied to this service independently of specified limits on other services (e.g.: Specialized Medical Services).

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Environmental Accessibility Adaptations

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental accessibility services

Provider Category:

Individual ▼

Provider Type:

Environmental Accessibility Adaptations

Provider Qualifications

License (specify):

Providers must be licensed if the work to be completed requires licensure.

Certificate (specify):

Other Standard (specify):

Potential providers must be:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

1. Prior to enrollment:

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

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home-Delivered Meals

Service Definition (Scope):

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	All qualified nutrition providers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

All qualified nutrition providers

Provider Qualifications

License (specify):

Nutrition

Certificate (specify):

[Empty text box with scroll arrows]

Other Standard (specify):

[Empty text box with scroll arrows]

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Food Protection or, in towns that self-inspect, by the Health Inspector

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

Service Definition (Scope):

Non-Medical Transportation is authorized to enable participants to gain access to community services and resources, as specified in the comprehensive care plan. This service is offered in addition to medical transportation required within the State Plan under 42 CFR 431.53, Assurance of Transportation, and services under 440.170(a), Any Other Medical Care or Remedial Care Recognized Under State Law and Specified by the Secretary, and does not replace them. Transportation services under the waiver are offered in accordance with the participant's comprehensive care plan. Whenever possible, family, friends, neighbors, or community agencies that can supply this service without charge are utilized. Transportation is not covered as a separate service when it is included in another service.

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

[Empty text box with scroll arrows]

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-Medical Transportation

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Non-Medical Transportation

Provider Qualifications

License (specify):

All drivers must be at least 18 years of age and have a valid and current driver's license.

Certificate (specify):

Other Standard (specify):

The following providers may enroll in the NH Title XX Program to provide Non-Medical Transportation:

- (1) Home Health Care Agencies enrolled as NH Medicaid providers and licensed in accordance with RSA 151:2 and He-P 809;
- (2) Home Care Service Agencies enrolled as NH Medicaid providers and licensed in accordance with RSA 151:2 and He-P 822;
- (3) Other Qualified Agencies enrolled as NH Medicaid providers and certified in accordance with RSA 161-I and He-P 601; or
- (4) Agencies under contract with BEAS to provide community based services, which include the provision of transportation, funded by the Older Americans' Act or the Social Services Block Grant.

For every vehicle, providers must provide documentation of car insurance for a minimum of \$100,000 per passenger per occurrence and \$300,000 per occurrence.

Verification of Provider Qualifications

Entity Responsible for Verification:

BEAS

Frequency of Verification:

Upon enrollment and periodically thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

Personal Emergency Response System

Service Definition (Scope):

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

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Emergency response system providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Individual ▼

Provider Type:

Emergency response system providers

Provider Qualifications

License (specify):

▼

Certificate (specify):

▼

Other Standard (specify):

Must be established emergency response business

Verification of Provider Qualifications

Entity Responsible for Verification:

BEAS

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Residential Care Facility Services

Service Definition (Scope):

Supportive services provided in a licensed facility, including: Assistance with activities of daily living and incidental activities of daily living; Personal care; 24 hour supervision; Incontinence management; Dietary planning; Non-emergency transportation to/from medical and non-medical services and activities; and any other activities that promote and support health and wellness, dignity and autonomy within a community setting. Residential care facility residents do not have their own, lockable living units. When a participant chooses residential care services, the selection of service provider is guided by the amenities offered at the different locations. Some providers have more single rooms and others have more shared rooms, so the participant's choice of provider may involve whether s/he wants his/her own room or would like a shared bedroom and bathroom. Shared bedrooms do not accommodate more than two people. Personal care, transportation and other services listed above as part of this service are included in the rate paid to the provider and are not separately billed.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Care Facility

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Residential Care Facility Services

Provider Category:

Agency

Provider Type:

Residential Care Facility

Provider Qualifications

License (specify):

Residential Care, RSA 151:2
 Certificate (specify):

Other Standard (specify):

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

Skilled Nursing

Service Definition (Scope):

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

RSA 151:2

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment Services

Service Definition (Scope):

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

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

Purchases must be prior authorized by the Bureau of Elderly and Adult Services, and are limited to lifetime total of \$15,000 per participant. This limit is applied to this service independently of specified limits on other services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable medical equipment and supply providers enrolled as Title XIX providers.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment Services

Provider Category:

Agency

Provider Type:

Durable medical equipment and supply providers enrolled as Title XIX providers.

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Title XIX Fiscal Agent

Frequency of Verification:

At enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)

Service Definition (Scope):

Services provided by a licensed agency in apartments located in publicly funded apartment buildings that include: Personal care services, including assistance with activities of daily living and instrumental activities of daily living; Supervision; Medication reminders; and other supportive activities as specified in the

comprehensive care plan or which promote and support health and wellness, dignity and autonomy within a community setting. This service was renamed to avoid conflict with a new state law. Personal care, medication reminders and other services identified as part of this service are included in the rate paid to the provider and can not be separately billed.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)

Provider Category:

Agency ▼

Provider Type:

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

Provider Qualifications

License (specify):

RSA 151:2-b

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

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

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. Do not complete item C-1-c.

As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.

As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

As an administrative activity. Complete item C-1-c.

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

NH enrolls private agencies that are licensed as case management providers and enrolled to provide targeted case management services in accordance with the approved State Plan and NH administrative rules. They develop and monitor the participant's comprehensive care plan.

Appendix C: Participant Services

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

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

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

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

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

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

No. The State does not conduct abuse registry screening.

Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

BEAS is responsible for maintaining the state-wide abuse registry. The first tier of enforcement is the law, RSA 161-F:49, which states that "All employers of programs which are licensed, certified, or funded by the

department to provide services to individuals shall be required before hiring a prospective employee, consultant, contractor, or volunteer who may have contact with individuals to submit his or her name, for review against the registry to determine whether the person is on the registry." This law also directs the Department in what actions it must take to investigate and then notify the potential employer. The second tier of enforcement is the review conducted by the Department. This review identifies entities that would be expected to file inquiries but have not done so and leads to direct communication with those entities to confirm their awareness of the law and to determine if inquiries should have been filed.

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Facility Type	
Residential Care Facilities	

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

Participants select residential care facilities based upon the type of setting they prefer. The options range from small facilities that had been private homes to larger facilities that were built for the purpose of providing residential care. Also, there are homes in rural areas and in urban areas, allowing participants to choose the type of location that they prefer. The popularity of these facilities in NH led to increased development. Overall, about half of the 144 facilities licensed by the Bureau of Health Care Facilities to provide residential or supported residential care are enrolled waiver providers, and generally serve a mix of waiver participants and privately paying individuals. The licensed facilities that are enrolled to serve waiver participants range in size from three residents to 156 residents. There are seven facilities that are licensed to serve 100 or more individuals and two of them only accept privately paying residents. About 38 waiver participants live in the remaining five enrolled facilities. Just about a quarter of the facilities that are licensed to serve 50 – 99 residents are enrolled waiver providers, and about half of the facilities licensed to serve fewer than 50 residents are enrolled.

Moving into a residential care home provides participants with ready access to community events and medical appointments as well consistent oversight to ensure adequate nutrition and medication compliance, and personal care assistance as needed. These settings are much less isolating than living in a separate apartment or home and relying upon paid workers for assistance and interaction. In 2010, BEAS conducted a survey of enrolled residential care facilities and learned the following:

1. They named the following as their most positive "selling points": Home-like settings with professional staff, good locations, cost-efficient dementia care, and quality of life.
2. The most frequent community events or locations to which the facilities provide transportation for residents are libraries, senior centers and for attendance at town band performances.
3. The most frequent community resources that come into the facilities for the residents are Church services, singing groups, support groups, medical service professionals, and individuals providing stretching/strengthening classes.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Emergency Response System	<input type="checkbox"/>
Residential Care Facility Services	<input checked="" type="checkbox"/>
Adult Family Care	<input type="checkbox"/>
Home-Delivered Meals	<input type="checkbox"/>
Adult In-Home Services	<input type="checkbox"/>
Environmental accessibility services	<input type="checkbox"/>
Consolidated services	<input type="checkbox"/>
Community transition services	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)	<input type="checkbox"/>
Specialized Medical Equipment Services	<input type="checkbox"/>
Home Health Aide	<input type="checkbox"/>
Personal Care	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Adult Medical Day Services	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>

Facility Capacity Limit:

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

Scope of Facility Standards. 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	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>

Standard	Topic Addressed
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

N/A

Appendix C: Participant Services

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

- d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

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

- 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.*

- 6. 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.

Relatives or legal guardians may be employed, if qualified, by an enrolled provider and paid to furnish the following waiver services when the services are authorized by BEAS: Adult Family Care; Adult In Home Care, Adult Medical Day, Community Transition, Home Health Aide, Homemaker, Non-medical Transportation; Respite, Skilled Nursing, Shared Housing, and Supportive Housing. Personal Care services may not be provided by a guardian but may be provided by relatives who are not legally responsible for the participant. Payment is made through enrolled providers and not directly to relatives/legal guardians. The enrolled provider ensures that employees are qualified and that payment is made only for services rendered. Documentation requirements are the same for family and non-family providers. Case managers are in regular, monthly contact with the participant to ensure that services are adequate and appropriate.

- Other policy.

Specify:

[Empty text box with scroll arrows]

- 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:

Provider requirements for all services are specified in He-E 801, which is available to the public electronically or on paper by request. The Medicaid fiscal agent refers to that rule whenever a new provider requests enrollment. All applicant providers that meet the specified criteria are enrolled. All providers must be registered to do business in NH and licensed or certified as required by law.

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
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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 providers that are listed in the Options Information System as available for specific waiver services are determined to be qualified as

defined by the waiver at the time of enrollment. N = Providers whose qualifications have been confirmed. D = All enrolled waiver providers.

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

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

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

Performance Measure:
 Number and percent of providers, by provider type, continuing to meet applicable licensure/certification requirements following enrollment. N = Number of providers, by provider type, continuing to meet applicable requirements following enrollment. D = The total number of providers, by provider type.

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

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-Assurance:** *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Environmental Accessibility Adaptation providers whose qualifications were reviewed prior to enrollment in the Options Information System. N = The number of EAA providers whose qualifications were confirmed pre-enrollment. D = The number of new EAA providers.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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collection/generation <i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: The Medicaid Fiscal Agent will communicate with the Department prior to enrolling the provider.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

Performance Measure:

The number and percent of enrolled Environmental Accessibility Adaptation providers whose qualifications were reviewed annually. N = The number of EAA providers annually reconfirmed. D = The total number of EAA providers.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Confidence Interval = <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>
<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>
	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="▲"/> <input type="button" value="▼"/>

Performance Measure:

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

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: The Bureau of HHealth Facilities conducts licensing inspections.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

- 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.

There are multiple parties that report their findings to BEAS, including the Bureau of Health Facilities Licensing if they identify any problems or concerns during a licensing inspection or reinspection, Adult Protective Services Social Workers if they identify any problems or concerns during their interactions throughout the state and case managers if they identify any problems or concerns during their routine participant or provider contacts.

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 various Bureaus within the Department work closely together to ensure that all Bureaus that might have involvement are notified when a provider is identified as substandard by any Bureau, and to collaborate on resolution of provider issues. If the Bureau responsible for licensing is considering decertifying or revoking the license of any provider, BEAS receives advance notification. Because most Bureaus are co-located, interactions are frequently informal. Agency staff meet when a problem is identified that requires joint follow-through. When a provider is found to not meet requirements during a licensing inspection, the process defined in the licensing rules is followed, which may include the establishment of a corrective action plan, imposition of fines and license revocation. Throughout the process, BEAS is kept informed and the Bureaus collaborate on a Departmental workplan to ensure that license revocation is a last resort. When appropriate, BEAS has assigned a Protective Services Social Worker to also conduct one or more visits to provide additional participant safety oversight during this time. If the Bureau of Health Facilities were to consider revoking the provider's license, BEAS would work with the case managers of the affected participants to ensure that appropriate care-transfer arrangements are made for necessary services to remain in place. Once the provider's license was revoked, BEAS would remove the provider name from the Options Information System database and would inform the MMIS Fiscal Agent to terminate the provider's Medicaid enrollment status.

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The State imposes additional limits on the amount of waiver services.

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

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

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Comprehensive Care Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager (qualifications specified in Appendix C-1/C-3)**
- Case Manager (qualifications not specified in Appendix C-1/C-3).**

Specify qualifications:

Case managers are employed by agencies that are licensed by NH DHHS, and are enrolled in the NH Medicaid Program to provide Targeted Case Management services under the Medicaid State Plan. The services provided by these case managers are directed by the Administrative Rule: He-E 805, Targeted Case Management Services, and the qualifications are as follows:

805.02 Definition: "Case manager" means an individual employed by, or contracted with, a case management agency who:

- (1) Meets the qualifications described in He-E 805.06;
- (2) Is responsible for the ongoing assessment, person-centered planning, coordination and monitoring of the provision of services included in the comprehensive care plan; and
- (3) Does not have a conflict of interest.

805.06 Qualification Requirements for Case Managers.

(a) Case managers employed by case management agencies shall have the following minimum requirements:

- (1) Have demonstrated knowledge of the local service delivery system and the resources available to participants;
- (2) Have demonstrated knowledge of the development and provision of integrated, person-centered services; and
- (3) Have a degree in a human-services related field and one year of supervised experience, or a combination of training and experience that provides the knowledge base required in (1) and (2) above.

(b) Case manager supervisors employed by case management agencies shall have the following minimum requirements:

- (1) Have a bachelor's level degree; or
 - (2) Be a registered nurse with 2 years of related experience.
- (c) Case management agencies shall not employ individuals who:

- (1) Have a felony conviction;
- (2) Have been found to have abused, neglected or exploited an individual based on a protective investigation completed by the BEAS in accordance with He-E 700 and an administrative hearing held pursuant to He-C 200, if such a hearing is requested; or
- (3) Are listed in the state of NH central registry of abuse, neglect or exploitation pursuant to RSA 169-C: 35 or the BEAS state registry pursuant to RSA 161-F:49.

Social Worker.

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

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

	▲ ▼
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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.

(a) The Long Term Supports and Services (LTSS) Options Counselors at the SLRC explain the full array of long term supports and services that are available to each applicant and/or family or caregiver, and learn the applicant's preferences and needs. Participant rights are also explained.

(b) The applicant/participant is encouraged by the LTSS Options Counselors to identify everyone who s/he would like present at discussions and planning meetings. When the case manager makes the appointment with the applicant or participant to create or discuss the comprehensive care plan, the case manager asks if there is anyone who the applicant/participant would like to have at the plan 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):

(a) When an individual has applied for CFI, or annually for participants, a Registered Nurse employed, contracted or trained by the Department conducts a clinical assessment at the person's residence, using a standardized instrument. In addition to identifying the individual's clinical status, his/her needs are identified through this process. The fact that the individual has freedom of choice of provider is explained. This freedom of choice includes the selection of the case management agency and the ability to change case managers at any point. (He-E 801.04)

(b) In addition to the clinical assessment, a comprehensive assessment is conducted by the case manager. After the Department has determined that the applicant meets, or the participant continues to meet, the level of care and is eligible for CFI, the individual is referred to the case manager requested or, if a specific case management agency was not requested, a referral is made to the agency next in rotation. The participant is notified in writing of this referral and is informed of the agency's name and contact information. Within 15 days of referral, the case manager meets with the participant and any others identified by the participant. As part of participant-centered planning, the case manager first seeks to understand the participant's preferences, support system and lifestyle. To the extent

possible and preferred by the participant, ongoing sources of support are encouraged to continue. Services available through the Program are identified when needed to fill needs that are not already being met. The case manager continues to use a person-centered approach throughout the comprehensive assessment. This assessment includes:

1. Biopsychosocial history;
2. Functional ability, including activities of daily living and instrumental activities of daily living;
3. Living environment, including the participant's in-home mobility, accessibility and safety;
4. Social environment, including social/informal relationships and supports, activities and interests, such as avocational and spiritual;
5. Self-awareness, or the degree to which the participant is aware of his/her own medical condition(s), treatment(s), and/or medication regime;
6. Risk, including the potential for abuse, neglect, or exploitation by self or others, as well as health, social or behavioral issues that may indicate a risk;
7. Legal status, including guardianship, legal system involvement, and availability of advance directives, such as durable power of attorney;
8. Community participation, including the participant's need or expressed desire to access specific resources, such as the library, educational programs, restaurants, shopping, and medical providers; and
9. Any other area(s) identified by the participant as being important to his or her life. (He-E 805.05)

(c) The case manager reviews the services available through the waiver with the participant.

(d) The case manager and participant discuss how the participant's needs and preferences as identified through the assessment process can be best met through a combination of waiver and non-waiver services. When the participant's preferred services are identified, the case manager sends a request for those services to BEAS electronically for review by an RN employed by BEAS. The RN reviews the information sent by the case manager and the clinical information to see if the requested services are consistent with the identified needs. The RN then responds electronically with an approval or a request for additional information, or a recommendation for a different service to be discussed with the participant. The case manager then reviews the R.N.'s response with the participant. After agreement by all parties has been reached concerning which services are preferable and appropriate, the participant selects the service providers. This information is sent to BEAS and the RN authorizes the services. System-generated authorizations are automatically sent to the selected providers. (He-E 801.06)

(e) Case managers do not provide other direct services to the same participant. The case manager coordinates services, and assists the participant in arranging for services and activities outside of the Medicaid Program. They also work with the participant and providers concerning scheduling preferences.

(f) The case manager and the participant determine how often the participant and case manager will meet, within guidelines established by the Department, to monitor service delivery and participant satisfaction. (He-E 805.05)

(g) They also discuss how the participant can contact the case manager between meetings if s/he has questions or concerns, and that the comprehensive care plan can be adjusted if the participant finds that the services are not addressing his/her needs and preferences, or if his/her needs change. (He-E 805.04) The plan is reviewed with the nurse at least annually, or more often at the request of the participant, family or guardian, case manager, or when the participant's needs change. A complete clinical assessment is conducted as part of the review. (He-E 801.07)

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.

Both the RN and the case manager are responsible for assessing potential risks through participant interviews. These assessments include reviewing conditions in the home that may be unsafe, health conditions and the participant's ability to manage them safely, relationships with family, caregivers and significant others, and an evaluation of the potential for the participant to be the victim of abuse, neglect, exploitation, or self neglect.

BEAS is in the process of implementing a CFI Risk Management Protocol to consistently guide CFI applicants, participants and family members in determining the amount and types of risks involved in their current community living arrangements or in their transitions from nursing homes to community living. This protocol includes a list of

potential risk factors, their definitions, options considered and plans to mitigate identified risks. The protocol also includes a self-assessment which provides potential applicants and current participants opportunities to compare their assessments with CFI staff and to decide whether community based care or nursing home care is preferable and would be the more successful living arrangement.

The Department's Adult Protective Services (APS) receives and responds to reports of abuse, neglect, exploitation and self-neglect of incapacitated adults 18 and over, in accordance with RSA 161-F: 42-57, the Adult Protection Law. APS uses a Structured Decision Making™ (SDM™) system, developed with the National Council on Crime and Delinquency (NCCD) with funding from CMS. The Department is using tools and techniques from that project to add structure to the assessments conducted by nurses and case managers.

Another important risk assessment and mitigation resource is the Elder-Wrap system. This is a system of workgroups that are organized on a regional basis and include professionals from multiple provider types. These groups are convened regularly and as needed in all areas of the state. By including a wide range of professionals, the groups are able to identify solutions to unusual and complex issues affecting the health and welfare of participants.

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.

Long Term Supports and Services (LTSS) Options Counselors at the SLRCs receive training and supervision by BEAS to ensure they are current on all Program services, service availability and provider qualifications. This enables them to provide preliminary information for the participant to consider.

All providers that have been approved to provide waiver services are identified in the Options Information System, a database maintained by the Department. Case managers have direct access to this database, giving them current information about provider availability and allowing them to accurately inform participants about their choices of providers. Case managers are responsible to inform participants of all providers available in their geographical areas, to encourage participants to choose, and to inform participants of how they can change providers after the initial selection.

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):

Case managers communicate electronically with the BEAS RN concerning the participant's needs and requested services. If the need for the requested service is not clear initially, the RN requests additional information from the case manager and, if necessary, from the participant's medical provider. Services are electronically authorized through the Options Information System, which limits the authority to authorize services to BEAS RNs. The Options Information System also provides information to case managers. It is programmed to limit the access of each case manager to only the relevant participant's information.

This provides consistent and clear communication between RNs and case managers about service authorizations. Services may be initiated only after the Options Information System has generated and electronically transmitted the authorization established in the system by the RN.

Appendix D: Participant-Centered Planning and Service Delivery

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

- h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Ⓒ Every three months or more frequently when necessary

- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (check each that applies):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers monitor the implementation of the comprehensive care plan and participant health and welfare through direct communication with participants, as required by administrative rule He-E 805.05(d), which states:

The designated case manager shall monitor the services provided to a participant, as follows:

(1) Conduct the case management contacts required for each participant, as follows:

- a. Case management contacts shall include no less than one monthly telephonic contact and one face-to-face contact every 60 days; and
- b. Each case management contact shall be documented in a contact note;

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

Case management performance is monitored by BEAS' annual site visits that include record reviews.

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
 - 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 comprehensive care plans that address all of the participant's assessed needs and perceived risks. N = The number of comprehensive care plans that address all of the participant's assessed needs and perceived risks. D = The total number of care plans included in the QA review.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participants' comprehensive care plans that address personal goals. N = The number of participants' service plans that address personal goals. D = Total number of plans included in the QA review.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		+/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of records containing documentation by the case managers, that the comprehensive care plans (CCP) contain required elements, including documentation of participant contact and service oversight, in accordance with the state's policies. N = The number of CCPs with evidence described above. D = The total number of CCPs included in the QA review.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of records containing documentation by the case managers, that changes were made to the comprehensive care plans (CCP) in response to changes in the participant's needs or preferences. N = The number of CCPs with evidence described above. D = The total number of CCPs included in the QA review.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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/percent of comprehensive care plans (CCPs) with documentation by the case manager of his/her review, CCP revision if needed and CCP approval at least annually. N = The number of CCPs with evidence of having been reviewed at least annually and either revised during that time or found to not need revision. D = The total number of comprehensive care plans included in the QA review.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 comprehensive care plans containing documentation of service monitoring to determine that services were provided in accordance with the comprehensive care plan, including amount, type and frequency. N = The number of CCPs with evidence described above. D = The total number of plans included in the QA review.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

The number and percent of participants whose records contain a freedom of choice form that specified choice was offered between institutional care and

waiver services. N = The number of files with documentation of choice of community based care. D = The total number of records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> [Dropdown]	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

The number and percent of comprehensive care plans that show evidence of the participant having had a choice of providers. N = The number of comprehensive care plans showing evidence of choice of provider D = The total number of comprehensive care plans included in the QA review

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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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):		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly		
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly		
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly		
<input type="checkbox"/> Other Specify: <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="text-align: right;">▲</td> </tr> <tr> <td style="text-align: right;">▼</td> </tr> </table>	▲	▼	<input checked="" type="checkbox"/> Annually
▲			
▼			
	<input type="checkbox"/> Continuously and Ongoing		
	<input type="checkbox"/> Other Specify: <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="text-align: right;">▲</td> </tr> <tr> <td style="text-align: right;">▼</td> </tr> </table>	▲	▼
▲			
▼			

Performance Measure:

The number and percent of comprehensive care plans that contain documentation of the participant being informed about his/her ability to choose services. N = The number of comprehensive care plans containing documentation that information about choice was provided to the participant. D = The total number of comprehensive care plans included in the QA review.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

The Quality Assurance Manager monitors and reports quarterly on each assurance. These reports are discussed with the waiver administrator, the Division of Community Based Care Quality Manager and the Long Term Care unit managers, and follow-up action is planned as needed.

Reports of the results of the annual site reviews of case management files are shared with the agencies, accompanied by additional observations and recommendations for improvement, and are then posted on the Department website for public review. BEAS follows up with agencies concerning recommended improvements.

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.

Following the QA program evaluation, the review team conducts an exit interview with each case management agency. The interview is followed by a written report that contains the findings and recommendations and is sent to the case management agency. The provider may add a response to the report prior to it being posted on the DHHS website. The provider makes changes to their operations as needed and directed by the report's recommendations.

Areas noted as needing improvement are given extra attention at the next QA program evaluation to see if the agency made improvements. If the documentation by a particular case manager is found to be consistently sub-standard, the case management agency must submit a corrective action plan to address the case manager's performance to BEAS for approval. If the problem continues, that case manager may be taken out of rotation and not assigned any additional participants. Each step taken by BEAS is documented in the QA program evaluation outcome documentation. When a plan of correction is required as a result of the review, BEAS monitors the provider's progress with the plan. If improvement is determined by BEAS to not be satisfactory, a focused review may be done on site to evaluate the status of the provider's corrective actions and to create a revised corrective action plan for the provider, which may include additional reporting for BEAS for progress monitoring.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

Long Term Supports and Services (LTSS) Options Counselors at the SLRCs receive comprehensive training and supervision by BEAS. The standardized education provided to each applicant includes the appeal process if the applicant's application is denied. Case managers also provide this information.

Every notice of decision from the Department that contains a denial of service or eligibility includes instructions about how to request an appeal. They state:

If you do not agree, you have the right to appeal this decision. To request a fair hearing, contact the Administrative Appeals Unit (AAU) within thirty (30) days of the date of this notice, (He-C 200). If you are currently receiving waiver services and wish to continue them during the appeal process you have 15 (15) days from the date on this notice to file your appeal. Please send written request for a fair hearing, including a copy of this notice to the AAU to:

Department of Health and Human Services
Administrative Appeals Unit
105 Pleasant Street, Main Building
Concord, NH 03301-3857
(603) 271-4292

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.

(a) The Bureau of Elderly and Adult Services (BEAS) included a process through which applicants or participants who disagree with a service authorization decision can request reconsideration from BEAS in the recently readopted program rule at He-E 801.06. The rule states that this process is apart from the appeal process and does not interfere with the individual's right to a Fair Hearing.

(b) An applicant or participant who disagrees with a service authorization may request a reconsideration of the

service authorization by submitting a written request to BEAS within 30 days of the service authorization. The request must include an explanation of the reason why a specific service authorization should be changed, including any supporting documentation. The request is reviewed by a BEAS RN and a written notice is sent to the applicant or participant, or his or her representative, of the decision to maintain or change the original service authorization, including the reason.

(c) Requesting a service authorization reconsideration does not affect in any way an applicant's or participant's right to appeal a disputed service authorization in accordance with He-C 200, which is clearly stated in the rule and the notice.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The State operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

There are two levels of critical events: Sentinel Events and what the Department has named "complaints and incidents."

Within the Department, the Division of Community Based Care Services (DCBCS) is responsible for implementing the DHHS Sentinel Event Protocol, which identifies the types of critical events that must be reported by providers (including case managers) to include: an unanticipated death or permanent loss of function, not related to the natural course of an individual's illness or underlying condition; Homicide or suicide of any individual receiving Department funded care, treatment or services, who had been discharged from a Department funded program or facility within 72 hours of the event; Sexual assault or rape of any individual receiving Department funded care, treatment or services by another client or employee of any Department funded program or facility where there is an act that was witnessed or there is sufficient clinical evidence obtained by the provider to support allegation of nonconsensual sexual contact; Unauthorized departure of an individual receiving Department funded services, from a facility providing care, resulting in death or permanent loss of function; Medication error that results in death, paralysis, coma, or other permanent loss of function; Delay or failure to provide Department funded provider services that result in death or permanent loss of function; Abuse as a result of the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one individual by another; Neglect as a result of the failure to provide the goods and services necessary to avoid physical harm, mental anguish or mental illness; Assault of or by a client of the provider that results in the injury of the person or another person of such severity that medical attention is required; Arson resulting in property loss.

Written information is forwarded to the DCBCS Deputy Director or designee within 72 hours of the event by completing the Sentinel Event reporting form. Further, licensed providers must adhere to licensing requirements, such as reporting to DHHS, Bureau of Health Facilities, within 72 hours, the occurrence of an unusual event or an unexplained absence.

The Adult Protection law, RSA 161-F:42-57, requires that any individual who believes that an incapacitated adult is being abused, neglected, exploited, or is self-neglecting must report this to the DHHS Case management Supervisors review a sample of case files to assure the accuracy of the assessment and monitoring processes, and the appropriateness of service plans.

Complaints and incidents are received, and responses are coordinated by the DCBCS, Bureau of Elderly and Adult Services (BEAS) Quality Manager. Incidents are defined as: An occurrence or event that interrupts normal procedures, including a serious injury or other event threatening the health or safety of a client. Reportable incidents include the following:

1. seizures resulting in hospitalization and occurring while in paid services or on agency premises;
2. injuries and/or accidents occurring while in paid services or on provider's premises, and/or if a Choices for Independence recipient, in the recipient's own home and medical attention was necessary;
3. assaults or illegal behavior occurring while in paid services or on the provider's premises and/or if a Choices for Independence recipient, in the recipient's own home;
4. incarceration due to charges brought; e.g., arson, theft, break-in, property damage, while in paid services or on the provider's premises, and/or if a Choices for Independence recipient, in the recipient's own home; and,
5. unauthorized departure/missing person occurring while in residential settings with 24-hour supervision, excluding homeless shelters.

BEAS issued written guidance on how complaints and incidents will be recorded, investigated and resolved. The Quality Manager is responsible to follow up with the involved providers to ensure appropriate resolutions and to provide a written report of complaints and incidents on a monthly or quarterly basis to the DCBCS Deputy Director. The process for submitting a complaint is as follows:

- 1) A complaint and/or incident report pertaining to BEAS may be made in person or by telephone, letter, fax, email, or Web Mail.
- 2) A complaint and/or incident report received by BEAS, from any point of entry, will be forwarded to the quality management manager.
- 3) The quality management manager will document the complaint or incident report by entering the report into the Complaint & Incident Log. The log shall include the following information:
 - The reporter's name, address, and telephone number;
 - Date of complaint/incident and a brief description of the event;
 - If an incident is being reported, whether or not the incident is client-related;
 - In cases where the reporter does not contact BEAS directly, the name and telephone number of the person referring the complaint/incident; and

- Whether the complaint/incident is considered opened or closed.

4) The quality management manager will determine if BEAS is the appropriate bureau to handle the complaint/incident report.

a) If BEAS is not the appropriate agency to handle the complaint/incident the quality management manager will forward the complaint/incident to the correct DHHS agency via the DHHS network and document this information on the BEAS Complaint and Incident Log.

b) If BEAS is the appropriate agency to handle the complaint/incident the BEAS quality management manager will proceed to step 5 of this section.

5) The quality management manager will send an email notification within the DHHS network to the unit administrator overseeing the BEAS administrative unit in which the complaint/incident has been alleged. The email will include all known information regarding the complaint/incident and request that a Complaint – Incident Record form be initiated.

6) The unit administrator or quality management manager will utilize the Complaint – Incident Record form to conduct an investigation of the complaint/incident in a systematic way. At a minimum the individual investigating the complaint/incident will document on this form:

- A summary of the issues presented, including dates;
- The names, addresses, telephone numbers, and/or other pertinent contact details regarding the reporter and any other individuals interviewed and/or investigated;
- A summary of the investigatory findings, a proposed determination of whether the allegations are founded or unfounded, and an explanation of why such determination was made;
- A list of all documents and/or evidence reviewed; and
- The proposed resolution, and, if appropriate, any actions taken.

7) Following the investigation the reporter will be notified regarding the resolution of the complaint/incident. The unit administrator or quality management manager will document this communication on the BEAS Complaint – Incident Record form. Information communicated will be in keeping with issues of confidentiality as outlined in Procedures (D) – Confidentiality. If a BEAS employee has questions or concerns regarding confidentiality or how to respond to a reporter following the resolution of a complaint/incident, the employee should confer with the unit's supervisor and/or BEAS attorneys. If the reporter is unhappy with the resolution of the complaint/incident s/he may, within 10 working days, submit a request in writing for further review by the bureau administrator.

8) The completed Complaint – Incident Record form will be sent to the quality management manager. The following will be attached to the form:

- Any related correspondence, research, and/or documentation that the unit administrator deems necessary to be included in the complaint/incident report;
- A report of any access or service delivery practices, business practices, or policies and procedures that will be revised as a result of the investigation.

9) The quality management manager will review the Complaint – Incident Record form for all conclusions, actions taken, and documentation forwarded from the unit administrator. The quality management manager will use this information to update the Complaint & Incident Log.

10) At the end of each month the quality management manager will compile a complaint and incident report for the bureau administrator. The report will include a description of each complaint/incident logged and its status (opened or closed). For closed investigations the report will include any findings resulting from the investigation, as well the investigation's determinations and resolution. The quality management manager reports this information to the bureau administrator.

11) For complaint/incident reports that span more than one month, the quality management manager will employ a tickler system to ensure that progress is made in regard to complaint/incident resolution.

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.

Every participant is informed about rights during the application process by the RN performing the assessment, and is re-informed by case managers as services are being planned or are in place. This information includes whom to

call if they have a complaint or concern, or if they believe they are being abused, neglected or exploited. Residents of licensed residential facilities are informed, and the facility posts the information in a public location, concerning their rights and the availability of the Office of Long Term Care Ombudsman if they have any concerns or believe their rights are being violated. Case managers evaluate the participant's circumstances and statements for any sign of abuse, neglect or exploitation during each of their contacts. All participant education includes the distribution of written contact information for the Office of the Long Term Ombudsman for residents of facilities, or the Adult Protection program for people living in independent settings.

- 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 DHHS Commissioner assigns responsibility to either the individual DCBCS Bureau or Quality Improvement Administrator, or to the Office of Improvement and Integrity (OII) to conduct an internal review of an event. An interim report regarding the event must be submitted to the Commissioner's Office within ten business days. A final report is then submitted to the Commissioner from the designated DCBCS representative in the time frame specified by the Commissioner. It will contain a full explanation of the actions leading up to and contributing to the event.

- 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.

Upon receipt of the final review report, the BEAS Interim Director and Waiver Program Manager review the findings and implement pertinent action plans as agreed upon to improve operational practices and systems. The action plan shall describe risk reduction strategies and include a strategy for the organizations, both 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 2)

- a. **Use of Restraints or Seclusion. (Select one):**

The State does not permit or prohibits the use of restraints or seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The use of restraints or seclusion 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 or Seclusion.** 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 or 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).

Participants are served in several different types of locations: their own homes, apartments in congregate or other apartment buildings, in the homes of their family or caregivers, and in licensed facilities. Of all these locations, restraints may be used only in emergencies and only in Licensed Assisted Living Residence/Residential Care and Supported Residential Care facilities (ALR-RCs and ALR-SRCs), and then only in accordance with licensing standards.

Licensing standards restrict the use of restraints in licensed facilities to emergencies, and when ordered by a physician as part of a treatment plan, as defined by the state law governing resident rights. The use of restraints is a last resort action and, if restraints are used, the facility is required to provide detailed reporting to the Department. Further, the rule also requires that staff are trained in the correct use of any restraints, to ensure resident safety.

This State Law is RSA 151:21, IX: "The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records."

The licensing rules, He-P 804.14 (for ALR-RCs) and He-P 805.14 (for ALR-SRCs), contain restrictions on what restraints may be used under what circumstances, and reporting requirements in the event restraints are used. In both cases, chemical, mechanical and physical restraints are defined in the rule. He-P 804.14, states the following:

(h) Physical or chemical restraints shall only be used in the case of an emergency, pursuant to by RSA 151:21, IX.

(i) Immediately after the use of a physical or chemical restraint, the resident's licensed practitioner, guardian or agent, if any, and the department shall be notified of the use of restraints.

(j) The use of all mechanical restraints, as defined in He-P 804.03(ai), shall be prohibited.

(k) An ALR-RC may use door alarm systems that notify personnel when a resident leaves the ALR-RC, provided that the alarm does not stop the resident from free movement in or out of the ALR-RC.

He-P 805.14 states the following:

(h) Physical or chemical restraints shall only be used in the case of an emergency, pursuant to by RSA 151:21, IX.

(i) Immediately after the use of a physical or chemical restraint, the resident's guardian or agent, if any, and the department shall be notified of the use of restraints.

(j) The ALR-SRHC shall: (1) Have policies and procedures on: a. What type of emergency restraints may be used; b. When restraints may be used; and c. What professional personnel may authorize the use of restraints; and (2) Provide personnel with education and training on the limitations and the correct use of restraints.

(k) The use of mechanical restraints shall be allowed only as defined under He-P 805.03(ai).

(l) The following methods of mechanical restraints shall be prohibited: (1) Full bed rails; (2) Gates, if they prohibit a resident's free movement throughout the living areas of the ALR-SRHC; (3) Half doors, if they prohibit a resident's free movement throughout the living areas of the ALR-SRHC; (4) Geri chairs, when used in a manner that prevents or restricts a resident from getting out of the chair at will; (5) Wrist or ankle restraints; (6) Vests or pelvic restraints; or (7) Other similar devices that prevent a resident's free movement.

State law RSA 161-F:42, includes in the purpose of the Adult Protection Program: "the philosophy that whenever possible an adult's right to self-determination should be preserved, and that each adult should live in safe conditions and should live his own life without interruption..." This law includes mandatory reporting, which obligates anyone who suspects that someone is being abused or neglected, including being restrained or secluded, to report their suspicions to DHHS. This pertains to adults in all settings.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Bureau of Health Facilities Licensing is responsible for licensing inspections and reinspections of residential care facilities, approving their policies and procedures concerning restraints, receiving the reports of restraint use, and imposing any applicable fines. The information is shared with BEAS. BEAS is responsible for protective investigations and oversight of the Adult Protection law. Further, case managers evaluate the participant's status during every contact.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

- 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:

	▲ ▼
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- The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

State law, RSA 151.21, "Patient Bill of Rights," prohibits the use of restrictive interventions except in the case of defined emergencies within certain settings.

Only Licensed Assisted Living Residence/Residential Care and Supported Residential Care facilities may use restraints in the case of an emergency, pursuant to RSA 151:21, IX, described above. The licensing rules, He-P 804.14 and 805.14, also described above include restrictions on what restraints may be used in an emergency. Inspections by the Bureau of Health Facilities Licensing monitor the use of restrictive interventions and is responsible for imposing any applicable fines if such interventions are used improperly.

The Adult Protective law, RSA 161-F:42, includes in the purpose of the Adult Protection Program: "the philosophy that whenever possible an adult's right to self-determination should be preserved, and that each adult should live in safe conditions and should live his own life without interruption..." This law includes mandatory reporting, which obligates anyone who suspects that someone is being abused or neglected, including being restrained or secluded, to report their suspicions to DHHS.

- 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:

Within the Department, the Bureau of Health Facilities Licensing inspects for improper use of restraints during inspections and reinspections. BEAS is responsible for oversight of the Adult Protection law. Case managers evaluate the participant's status during every contact.

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.

The Bureau of Health Facilities Licensing monitors medication management through its annual inspections of any provider where medication administration is performed. Monitoring is done through reviews of the provider's documentation.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

(a) Periodic licensing or certification reinspections by the Bureau of Health Facilities Licensing include whether the documentation in the medical records meets the requirements in He-P 805.17, described below. Findings, and any subsequent action planned by the Bureau of Health Facilities Licensing are reported to BEAS. Case managers may also review medical records when they go to the facility to see the participant. Any irregularities identified by case managers are reported to BEAS and to the Bureau of Health Facilities Licensing. The provider is instructed on the necessary corrective action.

(b)& (c) A reinspection by the Bureau of Health Facilities Licensing after a brief interval determines whether the provider has taken the necessary corrective action(s). If the provider has not taken the corrective action, the Bureau of Health Facilities Licensing may impose a fine or revoke the facility's license. The Bureau of Health Facilities Licensing involves BEAS throughout this process to ensure participant safety and to assist with discharge planning if necessary.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication administration is allowed in home care settings in accordance with the Nurse Practice Act (NPA), directed by the Board of Nursing, and in licensed or certified settings as allowed by applicable administrative rules.

The NPA allows limited nurse delegation for medication by non-medical personnel, generally family members. Medication may not be administered in participants' private homes by non-medical waiver providers.

In licensed Residential Care Homes and Supported Residential Health Care Homes, as monitored by the Bureau of Health Facilities Licensing, medication is managed as directed by administrative rules He-P 804 and 805, respectively. These rules allow self-administration, self-administration with supervision, self-directed administration, and administration by a licensed nurse, medication nursing assistant as defined by law and any other individual as defined by law. Personnel who are not licensed must complete, at a minimum, a four-hour medication administration supervision education program that covers both prescription and non-prescription medications. The education must be provided by a licensed nurse or pharmacist, or someone who has been trained by a licensed nurse or pharmacist.

He-P 804.17 and 805.17 address how medication is managed and administered, which medications may be administered, how facilities must manage changes in medications or dosing amounts, how facilities must accommodate self-administration, and how medications are stored. These rules direct that only a pharmacist may make changes to prescription medication container labels. If the prescribing professional changes the dose of a medication, if the facility staff can not obtain a new prescription label, the container must be clearly and specifically marked, the medication record must be updated and there are specific time periods in which

the facility must obtain a new label.

These rules also direct facilities on how to manage over the counter and PRN medications. Although Supported Residential Health Care Homes may manage controlled substances, the rule defines how these medications must be secured at all times.

These rules direct facilities on how to address medication needs when the resident is going to be absent from the facility for a period of time, and that they must provide the remaining medications to any resident who is discharged.

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:

The Bureau of Health Facilities Licensing

(b) Specify the types of medication errors that providers are required to *record*:

Home Health agencies must report errors as follows:

He-P 809.16, Medications:

(10) Develop and implement a system for reporting to the client's prescribing, licensed practitioner any:

- e. Observed adverse reactions to medication; and
- f. Side effects, or medication errors such as incorrect medications.

(11) Develop and implement a system for reporting to the client's prescribing, licensed practitioner any:

- a. Observed adverse reactions to medication; or
- b. Side effects, or medication errors such as incorrect medications;

In addition, medication errors are considered "unusual incidents" and must be reported as follows:

He-P 809.14 Duties and Responsibilities of All Licensees (o) Licensees shall contact the department in writing within 3 business days to report an unusual incident.

For residential care facilities, similar requirements are found at:

a. He-P 804.17, Medication Services: (c)(4) Report to the resident's licensed practitioner any adverse reactions and side effects to medications or medication errors, such as incorrect medications, within 24 hours of the adverse reaction or medication error, including documentation in the resident's file.

b. He-P 805.17, Medication Services: (as) The licensee shall develop and implement a system for reporting any observed adverse reactions to medication and side effects, or medication errors such as incorrect medications, within 24 hours of the adverse reaction or medication error. (at) The written documentation of the report in (as) above shall be maintained in the resident's record.

(c) Specify the types of medication errors that providers must *report* to the State:

Any error, such as incorrect medications, or adverse reaction that results in The unanticipated death of a resident; an injury that requires treatment by a licensed practitioner; or other circumstances that resulted in the notification and/or involvement of law enforcement.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Compliance by the licensed residential care facility is monitored during licensing reinspections by the Bureau of Health Facilities Licensing. Findings, and any subsequent action planned, are reported by the Bureau to the Bureau of Elderly and Adult Services. Further, case managers review medication management when they see the Participant and report any irregularities to BEAS and to the Bureau of Health Facilities Licensing.

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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 comprehensive care plans that show documentation of the participant having been assessed for risk. N = Number of comprehensive care plans with a completed risk assessment profile. D = Number of plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

The number and percent of participants surveyed who report they are treated with respect and dignity, and that paid service providers do not yell at them or take their things. N = The number of participants who report they are treated with respect and dignity and have not experienced theft by providers. D = The total number of participants surveyed with the Participant Experience Survey.

Data Source (Select one):

Participant/family observation/opinion

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		+/- 5%, (also, 95% is the confidence level.)
<input checked="" type="checkbox"/> Other Specify: For the most recent survey, the Department contracted with the University to conduct the interviews.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px;"> ▲ ▼ </div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px;"> ▲ ▼ </div>
	<input checked="" type="checkbox"/> Other Specify: Every other year	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: For the most recent survey, the Department contracted with the University to conduct the initial analysis.	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every other year

Performance Measure:

Number and percent of participants (or family or guardian) who reported they received information about how to report if they experience or suspect abuse, neglect or exploitation. N = The number of participants/family/guardian who reported they received information about how to report if they experience or suspect abuse, neglect or exploitation. D = The total number of participants interviewed.

Data Source (Select one):

Participant/family observation/opinion

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, (also, 95% is the confidence level.)
<input checked="" type="checkbox"/> Other Specify: For the most recent survey, the Department contracted with the University of NH to conduct the interviews.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Every other year	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: For the most recent survey, the Department contracted with the University to conduct the initial analysis.	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other

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

Performance Measure:
 Number and percent of Sentinel Event reports that were reviewed in accordance with the State's policies. N = Number of Sentinel Event reports that were reviewed in accordance with the State's policies. D = Total number of Sentinel Event reports.

Data Source (Select one):
 Critical events and incident reports
 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of action plans developed in response to Sentinel Event reports for which BEAS took the appropriate action within the prescribed timeframe. N = Number of action plans developed in response to Sentinel Event reports for which BEAS took the appropriate action within the prescribed timeframe. D = Total number of action plans that were BEAS' responsibility.

Data Source (Select one):

Critical events and incident reports

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of case manager assignment letters sent to participants with an Adult Protective Services brochure about identifying and reporting abuse, neglect and exploitation enclosed. N = Number of case manager assignment letters sent to participants with an Adult Protective Services brochures enclosed. D = Total number of notices of case manager assignment letters sent to participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report from the Options database about the number of letters sent and information from DHHS Bureau of Data Management concerning the number of brochures enclosed.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

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

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

Additional discovery activities include:

1. Phone calls by BEAS RNs to participants, on a random basis, during which the participant is asked about his/her satisfaction with the services being provided and about his/her well-being.

2. Regularly scheduled meetings with all case managers to discuss program issues so that systemic or regional problems are identified and resolved.

3. BEAS protocol that directs all Adult Protective Services social workers and intake staff to screen all reports of neglect, abuse or exploitation to determine if the alleged victim or perpetrator is a waiver participant and, if the alleged victim or perpetrator is a waiver participant, to immediately report this information to the Adult Protective Services Administrator and the BEAS QA Manager, who inform the waiver manager and the BEAS Director. The QA manager and waiver manager are kept informed throughout the investigation and, if appropriate, the case manager is also involved.

4. The Elder Wrap system through which, on a regional basis, professionals from multiple disciplines meet to discuss unmet needs and individuals whose needs may require a non-traditional approach for them to remain independent in the community. These meetings are scheduled as needed and ensure that all possible avenues and service combinations are considered.

5. Cross-Bureau meetings are held within the Division of Community Based Care Services to ensure that each program area is aware of initiatives and issues experienced by other program areas. This meeting includes professionals from BEAS, the Bureau of Behavioral Health, including the unit that addresses homelessness, the Bureau of Developmental Services, and the State psychiatric hospital. Additional program areas within DHHS are included as needed. This allows BEAS to be aware of changes occurring elsewhere in DHHS that may impact waiver participants or providers.

6. In addition, case management agencies have quality management responsibilities defined in the program rule, He-E 805, as follows:

He-E 805.10 Quality Management

(a) On a quarterly basis, case management agencies shall conduct a participant record review to evaluate the delivery of services identified in the comprehensive care plan to ensure that participants' needs are being met in the community, and shall document the results of the review in a quarterly quality management report, including:

- (1) The number of records reviewed;
- (2) A summary of the review results;
- (3) A description of any deficiencies identified;
- (4) The remedial action taken and/or planned to address the deficiencies identified in (3) including the dates action was taken or will be taken; and
- (5) A summary of unmet service needs.

(b) On a quarterly basis, case management agencies shall conduct a review of all reported complaints,

incidents, and sentinel events related to the delivery of services identified in the comprehensive care plan, and shall document the results of the review in a quarterly quality management report, including:

- (1) The number of reported complaints, incidents and sentinel events;
- (2) A summary of the review results;
- (3) A description of the deficiencies identified; and
- (4) The remedial action taken and/or planned to address the deficiencies identified in (3) including the dates action was taken or will be taken.

(c) Case management agencies shall plan and take any remedial action necessary to address deficiencies in service delivery identified in the quarterly quality management reports in (a) and (b) above.

(d) Case management agencies shall retain the quarterly quality management reports in (a) and (b) above for 2 years and make them available to the department upon request.

b. Methods for Remediation/Fixing Individual Problems

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

If the identified problem is related to abuse, neglect or exploitation, the Adult Protective Services unit follows protocols and timeframes required by law. Problems are resolved in accordance with state laws and policies. Actions taken are documented in the Adult Protective Service database and confidential records. The QA and waiver managers and the Adult Protective Services administrator are kept informed of the status. The QA and waiver managers maintain documentation in the participant's record, and general/non-participant-specific information is retained in the QA files and waiver management files.

If the identified problem is not related to abuse, neglect or exploitation, BEAS' first step upon discovering a problem is to determine what parties are involved or should be involved, such as the participant's family or guardian, Adult Protective Services, the Bureau of Health Facilities Licensing, and/or the case management agency. The QA manager, waiver manager, BEAS Director, and other managers and involved parties collaborate to develop a preliminary action plan. If needed, BEAS schedules an Elder-Wrap meeting or contacts involved service providers. Problems are resolved based on the participant's individual needs and may include changes to service authorizations, changes in providers involved, increased direct contact with and oversight of the participant by an Adult Protective Services social worker and/or case manager, or other actions. Each action taken is documented in the participant's record and general/non-participant-specific information is retained in the QA files and waiver management files. Information about problems identified and either their resolution or continued status is included in the quarterly QA report.

If the problem involves inappropriate action or lack of action by a provider, the Bureau of Health Facilities Licensing also retains documentation. The action plan will include the intervals at which the team will reconvene to review the status of the problem resolution. The plan would also identify, approximately, at what point the problem would be considered resolved and what actions may trigger revising the action plan or taking emergency action. If the action plan results in resolution, the case manager would continue to monitor the participant's well-being and would be alert to signs of the problem recurring. If the problem were not resolved in what is determined an appropriate time period, the team would determine what additional alternative actions are needed. If necessary to protect the participant, a temporary admission to an appropriate facility, such as a nursing facility or the state psychiatric hospital, may be recommended to the participant/participant's guardian.

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

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.

BEAS has implemented a multi-faceted approach to monitor and improve service quality within the Choices for Independence (CFI) program, placing emphasis on preserving the rights, health and safety of participants while encouraging provider development and skills improvement. This is achieved through collaboration with both internal and external stakeholders, as well as internal quality improvement exercises.

BEAS has had the benefit of active engagement by various stakeholders in program development and monitoring. These workgroups, with their different members and focus of attention, provide a broad perspective to BEAS. The results of their monitoring are provided to the Quality Management Team who uses the information to determine if there are program-wide trends or concerns and, if these are identified, to plan follow-up action to resolve the concerns.

The stakeholder groups that provide this meaningful feedback are listed below:

I. BEAS Quality Management Team: This team meets quarterly and consists of the BEAS Quality Manager, the DCBCS Quality Improvement Director, the waiver manager, long term care nursing supervisors, the Community Services Policy & Program Development Administrator, the Business Systems Administrator, and, as needed, the Adult Protective Services Administrator. The foci of the workgroup are the CFI performance measures and the results of the QA reports. This group determines which performance measures provide the best reflection of the waiver program, how the information will be obtained and by whom, and how often the results will be reported and reviewed. This information is organized into a Quality Assurance Workplan, which contains specific actions to be taken by team members.

II. DCBCS Quality Leadership team: This team, which meets monthly, designates a quarterly meeting to review CFI performance measures and consists of the BEAS Quality Manager, the DCBCS Quality Improvement Director, the waiver manager, the Community Services Policy & Program Development Administrator, and others as needed. The BEAS Quality Management team has developed program reports that show key metrics of waiver operations, such as application processing time. These reports are key to the ongoing monitoring and management of the waiver program. Key responsibilities are:

1. Developing and maintaining the quality management plan for CFI, including the establishment of performance measures;
2. Monitoring the performance measure reports generated to identify trends and the results of corrective actions taken; and
3. Identifying: New corrective actions required; Different performance measures that would be advantageous; and Policy and training needs for staff, providers or both.

III. The Risk Management Case Review Committee: This Committee includes the long term care nursing supervisors, the APS Administrator, the Community Services and Long Term Care Administrator, Adult

Protective Services Social Workers, and providers as deemed appropriate. Monthly reviews are case-specific and all systems of care that either are or could potentially be engaged to serve the participant. The waiver manager is informed if program changes are identified as necessary.

IV. The Case Management Services providers: BEAS brings together the management of the six agencies enrolled to provide targeted case management services to CFI participants several times per year. They discuss program policies and issues or problems they are seeing on a regional or statewide basis, or have been identified by the BEAS Quality Management Team. This is a good opportunity to compare strategies across agencies, and to identify best practices and opportunities for improvement.

V. DHHS Adult Protective Services (APS) Program: BEAS administers this program, which was established in law (RSA 161-F:42). BEAS employs APS Social Workers and managers to respond to reports of alleged abuse, neglect, self-neglect, and exploitation, to work with community providers to support incapacitated adults in the community and to educate the public about the signs of abuse, neglect, self-neglect, and exploitation, and about the mandatory reporting and the registry laws. The APS Administrator works with the waiver manager to ensure that all APS social workers and CFI case managers are informed about new initiatives available to support community living, program policies within both APS and CFI, and about any concerning trends being seen by either program area.

VI. The CFI Risk Management Protocol: A stakeholder group was established to develop an effective means to consistently guide CFI applicants, participants and family members in determining the amount and types of risks involved in their current community living arrangements or in their transitions from nursing homes to community living. A nationally known expert in the field, Suzanne Crisp, was engaged to guide the diverse group that included consumers, family members and caregivers, providers, health care professionals and program staff. The University of New Hampshire's (UNH) Institute on Disability (IOD) facilitated additional sessions through which consumers, family and caregivers of consumers, health care professionals, service providers, UNH and DHHS professionals drafted protocol initially implemented for the Community Passport program (MFP), and which is now being piloted for ongoing use throughout CFI.

This protocol includes a list of potential risk factors, their definitions, options considered and plans to mitigate identified risks. The protocol also includes a self-assessment, providing potential applicants and current participants opportunities to compare their views with CFI staff and to decide what care setting is preferable and would be the more successful living arrangement.

VII. DHHS Cross-Bureau Review team: This team consists of administrators and managers from all program areas, including the waiver programs, programs for the homeless, veterans' services, and conditions-specific programs. It was initially convened to encourage communication between units and the initial meetings concerned specific cases and has resulted in staff becoming more knowledgeable of other program areas and comfortable working with each other directly. The group continues to meet to discuss initiatives that are under consideration or trends being seen by the various program areas, providing a broad view of the service system for all staff involved.

VIII. The Sentinel Event Reporting and Review Process: DHHS established a Sentinel Event Reporting policy, with the latest revisions in September 2010, that requires the reporting of Sentinel events defined as: an unexpected occurrence involving the death or serious physical or psychological injury, or risk thereof, signaling the need for immediate investigation and response, or other serious event including, but not limited to the following:

1. An unanticipated death or permanent loss of function, not related to the natural course of an individual's illness or underlying condition, resulting from such causes including, but not limited to, a medication error, an unauthorized departure or abduction from a facility providing care, or a delay or failure to provide services.
2. Homicide or suicide.
3. Sexual assault or rape.
4. Abuse resulting in physical harm or mental anguish that seriously jeopardizes a person's health.
5. Neglect as a result of the failure to provide the services necessary to avoid physical or psychological injury that seriously jeopardizes a person's health.
6. High profile events, which may involve media coverage and/or police involvement.

The DCBCS Quality Improvement Director reviews Sentinel Event Reports with the DCBCS' Quality Leadership Team, based on trends and as requested by Division Directors.

IX. The Choices for Independence Focus Group: This group was established in 2009, to identify program weaknesses and opportunities for improvement. The group consists of consumers and providers, including case managers, and identified specific program topics to discuss. This group was directly involved in re-writing the CFI administrative rule. Their recommendations were integrated to the extent possible and BEAS was complimented on its collaborative approach at the public Legislative Rules Committee meeting.

X. DHHS LEAN: DHHS is using the LEAN process, a continuous quality improvement process that identifies waste or non-value added activity, to streamline operations. One LEAN project has been to improve the application process for Medicaid-covered long term care services, both community and facility based. The financial and clinical eligibility processes for long term care, formerly completed through two information systems, are now combined into one information system resulting in a more user-friendly and timely process for consumers and the staff.

XI. ServiceLink Resource Center (SLRC) Advisory Board: The SLRC Advisory Board meets quarterly and includes, caregivers, individuals receiving waiver and non-waiver services, service providers, and disability rights advocates. This group was most active during the State budget process and, in addition, discusses general trouble-shooting for the state-wide network of SLRCs.

XII. The Family Caregiver Support Program (FCGSP): The FCGSP provided family caregiver education and supports by offering caregiver education programs on topics such as Advanced Care Planning, the Dementia Friendly Home, Medicare and Medicaid Programs, an overview of the guardianship process for families, and available resources in the community. This program estimates that their services delay nursing home placement by an average of 577 days. The national award-winning NH Transitions in Caring program provided limited direct funding to family caregivers to support their ongoing caregiving.

XIII. The Legislative Budget Assistant (LBA): The LBA has completed performance audits of BEAS overall and the long term care program in particular. Their audits resulted in the identification of program areas requiring improvement and BEAS created and completed workplans to address each recommendation.

XIV. The State Council on Aging (SCOA): This statewide advisory board was established by law (RSA 161-F:7) and meets monthly to discuss issues related to community based care and BEAS operations. Members are appointed by the Governor and approved by the Governor's Council. SCOA is required to have members from each county, two Legislators, at least eight members who are aged 60 years or older, and no more than nine members of the same political party. Their responsibility is to assist DHHS with identifying problems relating to, or experienced by, the aging population of the state and assist with creating solutions.

XV. The Medical Care Advisory Committee (MCAC): This committee meets monthly to review the Medicaid Program as a whole, and frequently focuses on issues relating to the CFI program. The committee includes providers, professionals in the medical field, consumers and family members of caregivers of consumers.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Other Specify: ongoing and continuously

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.

System design change ideas are proposed by case managers, ServiceLink Resource Center management, BEAS long term care staff, the waiver manager, the BEAS Quality Manager, the DCBCS Quality Improvement Director, participants, and families or caregivers. The ideas are reviewed by the BEAS Quality Management Team, which determines which changes should be recommended and how the quality of the results will be monitored. The BEAS Director gives final approval of system design changes before the designated unit begins implementation.

Once a system change goal is identified and approved, the BEAS Quality Management Team develops the quality monitoring plan for that change. The plan will include what performance measures will be used to determine if the system change implementation plan has the desired effect, how and how often data for those measures will be gathered, how often the Team will review the results of the data gathering, and at what point the Team might determine whether: the plan should be modified, the plan resulted in the desired change, or, if the plan did not result in the desired change, whether the plan and design change should be re-evaluated.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The BEAS Quality Management Team evaluates the Quality Improvement Strategy. The BEAS Quality Manager reports the results of the performance measure reviews completed each quarter to the Team and the BEAS Director. This report, plus additional program information is discussed at the quarterly Quality Management Team meetings. If a problem is identified through the review process, the Team plans the corrective action, how the effectiveness of the corrective action will be measured and the associated timeframes. Problems identified, corrective action taken and the effectiveness of the corrective action are documented by the Quality Manager and maintained in the confidential Program Quality files and by the waiver manager.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All claims for CFI services are paid through the New Hampshire Medicaid MMIS and edits are applied to ensure that all billed services are covered, provided by properly enrolled providers, and rendered to individuals who were eligible on the dates of service. Service authorizations are maintained in the Options Information System and, when the new MMIS is implemented in 2012, there will be a direct feed from the Options Information System, which contains all authorization information, to the MMIS. This will ensure that only those services authorized by BEAS will be paid and will prevent payment of any service that is not authorized for the participant. Further, the SURS unit within the Department and the New Hampshire Attorney General Medicaid Fraud Unit provide the support necessary to pursue recoveries against any provider that bills incorrectly.

Currently, several services are prior authorized on an individual basis: Community transition services, Consolidated services, Environmental Accessibility Services and Specialized Medical Equipment. For these services, each request is evaluated by a nursing supervisor prior to authorizing the service. If a participant needs an environmental accessibility service, such as a ramp, the case manager coordinates an evaluation by a licensed occupational or physical therapist, and seeks bids from multiple potential service providers. This information is used by the nursing supervisor to support service authorization.

Waiver providers, like other Medicaid providers, are not required to have independent audits, in accordance with Subpart B of Circular No. A-133, at Section:--Audits§ __.200 Audit requirements, which states: (i) Medicaid. Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis.

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.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of waiver service claim denials from the providers with the highest number of claim denials, that are denied due to incorrect procedure codes and/or modifiers. N = Number of claims denied due to incorrect procedure codes and/or modifiers. D = Total number of claims denied for waiver services for the providers with the highest number of claims denied.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

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

	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of providers with a greater than 5% claims denial rate for waiver services more than two months in a row. N = providers with a greater than 5% claims denial rate for waiver services more than two months in a row. D = The total number of providers that billed during those months.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS-generated report and the denial analysis by the Medicaid Business Office

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participants who received 20% more services than what was approved by BEAS following communication with the participant's case manager. N = Number of participants who received 20% more services than what was approved by BEAS following communication with the participant's case manager. D = Total number of participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

BEAS is using software that combines and compares date from the MMIS and the Options Information System and generates a report of discrepancies between paid claims and authorizations.

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):
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> State Medicaid Agency		
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Waiver services are payable only to providers approved by BEAS and enrolled specifically to provide waiver services. Claims must be correctly completed with waiver-specific codes and modifiers, and the individual must have waiver eligibility on the dates of service. The activation of the new MMIS in 2012, will provide even greater control by automatically sending the authorizations in the BEAS Options information system to the MMIS, resulting in the denial of any claims for services not specifically authorized. Further, BEAS monitors overall program expenditures on a quarterly basis and investigates variations from projections.

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.

BEAS works closely with the Surveillance and Utilization and Review subsystem (SURS) unit in the Department’s Bureau of Improvement and Integrity. If a payment irregularity is identified through a BEAS review, all supporting documentation is forwarded to SURS, who initiates the appropriate further action, including payment recovery.

If it appears that a provider does not understand the program rules and requirements, BEAS provides individual training and considers the likelihood of other providers having similar misunderstandings. Additional provider training and written guidance targeted to specific issues is provided as needed.

- ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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

1-2: 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 Division of Community Based Care Services (DCBCS) establishes payment rates for waiver services in a manner to ensure access and to be comparable to the rates set for non-waiver services, as established by the Medicaid Agency. Public comment is accepted in the DCBCS budget process, and DCBCS works with provider associations for DCBCS to be informed of the actual cost of service delivery. The rate setting methodology for Home Health Aide and Skilled Nursing is described in the administrative rule for coverage of Home Health services, at He-W 553.07 and 553.08.

He-W 553.07: He-W 553.07 Payment for Services.

- (a) Reimbursement for home health services shall be based on the type of service delivered, and not on the credentials of the person providing the service.
- (b) To receive reimbursement for home health services, the provider shall:
 - (1) Verify that the recipient is eligible on the date the service is provided; and
 - (2) Submit claims for payment to the department's fiscal agent.
- (c) Skilled nursing services shall be reimbursed:
 - (1) A flat rate per unit of direct care time, prior to July 1, 2009;
 - (2) A flat rate per visit, on and after July 1, 2009; and
 - (3) At rates set by the department in accordance with RSA 161:4, VI(a), RSA 126-A:18-a, and He-W 553.08.
- (d) Home health aide services shall be reimbursed as follows:
 - (1) Home health aide visits composed of fewer than 8 units of direct care time shall be reimbursed:
 - a. A flat rate per unit of direct care time, prior to July 1, 2009;
 - b. A flat rate per visit, on and after July 1, 2009; and
 - c. At rates set by the department in accordance with RSA 161:4, VI(a), RSA 126-A:18-a, and He-W 553.08; and
 - (2) Home health aide visits composed of 8 or more units of direct care time shall be reimbursed a flat rate per unit of direct care time at a rate set by the department in accordance with RSA 161:4, VI(a), RSA 126-A:18-a, and He-W 553.08.

He-W 553.08 Rate Setting Methodology. The rate setting methodology for skilled nursing and home health aide services shall be as follows:

- (a) The rate setting methodology shall comply with the provisions of RSA 126-A:18-a and 126-A:18-b;
 - (b) The rates determined in accordance with the rate setting methodology shall be reduced in accordance with He-W 553.08(h), if such reduction is necessary in order to bring aggregated, estimated expenditures to the amount of the legislative appropriation;
 - (c) The payment rates for skilled nursing services and home health aide services shall be as shown in Table 553-1 for services performed on or after August 1, 2007 and prior to July 1, 2009;
- | Service | Aug 1, 2007 – Dec 31, 2008 | Jan 1, 2009 – June 30, 2009 |
|--|----------------------------|-----------------------------|
| Skilled Nursing | \$21.50/unit | \$22.18/unit |
| Home Health Aide visit of fewer than 8 units of direct care time | \$5.96/unit | \$6.14/unit |
| Home Health Aide visit of 8 or more units of direct care time | \$5.74/unit | \$5.74/unit |

- (d) On and after July 1, 2009, the per visit rates established for skilled nursing services, and for home health aide visits comprised of fewer than 8 units of direct care time, shall be calculated as follows:
 - (1) For each New England state, statewide Low Utilization Payment Adjustment (LUPA) rates for skilled nursing and home health aide visits shall be computed as follows:
 - a. The Medicare LUPA rates for the services in each county as of April 1 preceding the state fiscal year to which it applies shall be identified;
 - b. The county LUPA rates in (d)(1)a. above shall be multiplied by the percent of the population in the applicable county to arrive at weighted LUPA rates; and
 - c. The weighted LUPA rates for each county in (d)(1)b. above shall be added together to arrive at the statewide LUPA rates for each New England state;
 - (2) For each New England state, excluding New Hampshire, the state Medicaid rate for each service shall be identified by:
 - a. Taking the per visit payment rate in effect on April 1 of the preceding state fiscal year; or
 - b. Taking the per unit payment rate in effect on April 1 of the preceding state fiscal year and converting units to visits based on New Hampshire's use patterns of units per visit;
 - (3) For each New England state, excluding New Hampshire, the Medicaid rate in (d)(2) above shall be divided by

the LUPA rate in (d)(1) above to arrive at the Medicaid rate as a percent of the LUPA rate for each service;

(4) The percents in (d)(3) above for each New England state, excluding New Hampshire, shall be used to calculate the following measures of central tendency:

a. Mean (average);

b. Median; and

c. Mean (average) excluding the states with the highest and lowest percents;

(5) The 3 measures calculated in (d)(4) above shall be averaged and multiplied by New Hampshire LUPA rates as determined in (d)(1) above to create benchmark rates for skilled nursing and home health aide visits;

(6) Payment for skilled nursing visits shall be made at 105 percent of the benchmark rate in (d)(5) above; and

(7) Payment for home health aide visits shall be made at 105 percent of the benchmark rate in (d)(5) above;

(e) In interim years, when payment rates are not established according to the methodology in He-W 553.08(d), payment rates shall be established annually by increasing the base year payment rate by the most recent annual percentage increase in the home health market basket index published by the Centers for Medicare and Medicaid Services, at <http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/mktbskt-hha.pdf> as of April 1 preceding the state fiscal year to which it will be applied;

(f) The base year in (e) above for each service shall be the most recent state fiscal year for which rates were established in accordance with He-W 553.08(d);

(g) On a biennial basis beginning with state fiscal year 2010, if the New Hampshire Legislature specifies payment rate increases for skilled nursing and home health aide services, those rates of increase, rather than the rates set in accordance with (d) or (e) above, or (i) below, shall be applied as directed by the Legislature;

(h) On a biennial basis beginning with state fiscal year 2010, if the Legislature does not specify a payment rate increase for skilled nursing and home health aide services, the department shall take the following steps:

(1) The department shall project the estimated visits and units of skilled nursing and all home health aide services to be provided to the Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI) population;

(2) The ratesetting methodology in (d) above and (i) below shall be applied to the estimated visits and units in (h)(1) above to arrive at a total estimated expenditure for those services;

(3) The amount in (h)(2) above shall be added to the estimated expenditures for homemaker services to be provided to the HCBC-ECI population to arrive at a total estimated expenditure;

(4) If the amount in (h)(3) above exceeds the legislative appropriation in the HCBC-ECI home health budget line for the Bureau of Elderly and Adult Services, a proportionate discount factor shall be uniformly applied to skilled nursing and all home health aide services to bring the aggregate estimated expenditure to the amount of the appropriation;

(5) The rates calculated in accordance with (h)(4) above for each year of the biennium shall not be less than the rates in effect for the prior state fiscal year; and

(6) If the amount in (h)(3) above does not exceed the legislative appropriation in the HCBC-ECI home health budget line for the Bureau of Elderly and Adult Services, rates shall be those calculated in accordance with He-W 553.08(d) above and (i) below; and

(i) On and after July 1, 2009, the payment for home health aide visits of 8 or more units of direct care time shall be at rates set by the department in accordance with RSA 161:4, VI(a), RSA 126-A:18-a, and RSA 126-A:18-b.

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers bill the MMIS directly. Many providers use the supplied electronic software that enables them to bill electronically.

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.)*

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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.)*

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Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All provider billings are processed through the MMIS, which has claim edits and audits in place that limit the procedure codes that can be billed by CFI providers. Edits also ensure that payment is made only for Program-covered services rendered by qualified providers to participants who were Program-eligible on the date(s) of service. Enhanced automation in the new MMIS will link the service authorizations to the MMIS so that only claims for authorized services will be paid. Currently, environmental accessibility services, specialized medical services, community transition, and consolidated services require that a specific prior authorization be entered into the MMIS for claims payment, thus avoiding mis-payment.

- 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:

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- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.
- Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

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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: *Complete item I-3-e.*

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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:

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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.

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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.

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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:

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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.

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- 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 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:

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- 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:

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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:

- (a) & (b): County governments collect applicable taxes and other revenue.
- (c): The Department bills the counties for their portion of the non-federal share of expenditures and the counties send their payments to the Department.

The State Plan reflects the use of Pro-Share, in accordance with State Law.

State Law 167:18-a County Reimbursement of Funds; Limitations on Payments:

I. These expenditures shall in the first instance be made by the state, but each county shall make monthly payments to the state for the amounts due under this section within 45 days from notice thereof.

(a) Counties shall reimburse the state for expenditures for recipients for whom such county is liable who are eligible for nursing home care and are receiving services from a licensed nursing home, or in another New Hampshire setting as an alternative to a licensed nursing home placement and are supported under the Medicaid home and community-based care waiver for the elderly and chronically ill, as such waiver may be amended from time to time, to the extent of 100 percent of the non-federal share of such expenditures.

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs
- The following source(s) are used
Check each that applies:
 - Health care-related taxes or fees
 - Provider-related donations
 - Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Participants who live in residential settings are responsible for paying room and board from their income. This is paid directly to the residential care provider. The waiver payment is designated for 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:

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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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13740.81	12669.00	26409.81	42918.00	3617.00	46535.00	20125.19
2	13877.49	12923.00	26800.49	43776.00	3978.00	47754.00	20953.51
3	14017.98	13181.00	27198.98	44652.00	4376.00	49028.00	21829.02
4	14035.86	13445.00	27480.86	45545.00	4814.00	50359.00	22878.14
5	14036.06	13714.00	27750.06	46456.00	5295.00	51751.00	24000.94

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	3909		3909
Year 2	4053		4053
Year 3	4202		4202
Year 4	4359		4359
Year 5	4522		4522

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.

288

This is estimated based on a consistent history.

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:

The estimated FY 2012 values for users, units and cost for each waiver service were obtained by first obtaining the ratio of the service value to the overall actual from FY 2011. These ratios were then applied to

the budgeted values for FY2012, to obtain service specific values. Values for 'avg. units per user' and 'avg cost per unit' were carried forward from FY 2011. Cost values for FY 2013, were obtained by applying the overall 2.8% budgeted growth factor to each service. Similarly, 'users' were increased by the budgeted 2.6% and 'avg units per user' were increased by the budgeted 0.2%. Values for 'units' and 'avg cost per unit' were then calculated mathematically.

For each subsequent year (FY 2014 - 2017), the 'users' and 'total cost' for each service were then increased by 2.8% annually. 'Avg units per user' and 'unit cost' were carried forward and 'units' were calculated mathematically. The sum of the service specific costs result in the grand total costs.

- 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:

In FY 2009, the D' value from the 372 report was \$11,101. The estimate for FY 2010, based on the initial report is \$11,939. The average growth between FY 2008 and 2010(est) was then calculated at 2%, which was then applied to each successive year.

- 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:

Item J-1. The basis of these estimates is as follows:

In FY 2011, the actual G value was calculated by adding the total cost of nursing home care by the total number of unduplicated clients. Similar values were calculated for FY 2012 and 2013, based on budget figures, divided by unduplicated client counts, estimated by the 2011 ratio of unduplicated to average annual client counts. The average projected growth (also 2%) was then applied to each subsequent year.

- 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:

Detailed analysis of overall 2011 and 2012, State Plan services costs indicates that 49% of the total costs are attributed to institutional clients. Therefore, 49% of budgeted State Plan costs were used as the basis of FY 2012 and 2013 cost estimates. These values were divided by unduplicated client counts, estimated by the 2011, ratio of unduplicated to average annual client counts. The average projected growth (10%) was then applied to each subsequent year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Adult Medical Day Services	
Home Health Aide	
Homemaker	
Personal Care	
Respite	
Adult Family Care	
Adult In-Home Services	
Community transition services	
Consolidated services	
Environmental accessibility services	
Home-Delivered Meals	
Non-Medical Transportation	
Personal Emergency Response System	
Residential Care Facility Services	
Skilled Nursing	
Specialized Medical Equipment Services	
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)	

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
Adult Medical Day Services Total:						1262907.52
Adult Medical Day Services	day	280	91.60	49.24	1262907.52	
Home Health Aide Total:						6753516.72
Home Health Aide	15 min	755	1025.60	5.74	4444642.72	
Home Health Aide visit	visit	761	102.50	29.60	2308874.00	
Homemaker Total:						2760182.14
Homemaker	15 min	909	665.90	4.56	2760182.14	
Personal Care Total:						22236957.34
Personal Care	15 min	2157	2353.70	4.38	22236957.34	
Respite Total:						178446.51
Respite	15 min	82	1303.10	1.67	178446.51	
Adult Family Care Total:						166180.56
Adult Family Care	day	13	217.40	58.80	166180.56	
Adult In-Home Services Total:						398131.36
Adult In-Home Services	15 min	47	2406.50	3.52	398131.36	
Community transition services Total:						6800.00
Community transition services	transition	8	1.00	850.00	6800.00	
Consolidated services Total:						77072.26
Consolidated services	day	24	2.90	1107.36	77072.26	
GRAND TOTAL:						53712839.80
Total Estimated Unduplicated Participants:						3909
Factor D (Divide total by number of participants):						13740.81
Average Length of Stay on the Waiver:						288

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental accessibility services Total:						811910.00
Environmental accessibility services	occurrence	122	1.10	6050.00	811910.00	
Home-Delivered Meals Total:						1303447.99
Home-Delivered Meals	meal	924	202.10	6.98	1303447.99	
Non-Medical Transportation Total:						1276944.00
Non-Medical Transportation	trip	1438	111.00	8.00	1276944.00	
Personal Emergency Response System Total:						779992.29
Personal Emergency Response System	month	2297	9.90	34.30	779992.29	
Residential Care Facility Services Total:						8925623.85
Residential Care Facility Services	day	715	259.80	48.05	8925623.85	
Skilled Nursing Total:						4851987.45
Skilled Nursing	15 min	2233	24.10	90.16	4851987.45	
Specialized Medical Equipment Services Total:						233964.72
Specialized Medical Equipment Services	item	258	1.10	824.40	233964.72	
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care) Total:						1688775.10
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)	day	124	269.90	50.46	1688775.10	
GRAND TOTAL:						53712839.80
Total Estimated Unduplicated Participants:						3909
Factor D (Divide total by number of participants):						13740.81
Average Length of Stay on the Waiver:						288

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						1294480.21
Adult Medical Day Services	day	287	91.60	49.24	1294480.21	
Home Health Aide Total:						6943890.54
Home Health Aide	15 min	776	1025.60	5.74	4568268.54	
Home Health Aide visit	visit	783	102.50	29.60	2375622.00	
Homemaker Total:						2839131.24
Homemaker	15 min	935	665.90	4.56	2839131.24	
Personal Care Total:						22865818.91
Personal Care	15 min	2218	2353.70	4.38	22865818.91	
Respite Total:						184975.05
Respite	15 min	85	1303.10	1.67	184975.04	
Adult Family Care Total:						178963.68
Adult Family Care	day	14	217.40	58.80	178963.68	
Adult In-Home Services Total:						406602.24
Adult In-Home Services	15 min	48	2406.50	3.52	406602.24	
Community transition services Total:						6800.00
Community transition services	transition	8	1.00	850.00	6800.00	
Consolidated services Total:						80283.60
Consolidated services	day	25	2.90	1107.36	80283.60	
Environmental accessibility services Total:						831875.00
Environmental accessibility services	occurrence	125	1.10	6050.00	831875.00	
Home-Delivered Meals Total:						1340125.10
Home-Delivered Meals	meal	950	202.10	6.98	1340125.10	
Non-Medical Transportation Total:						1313352.00
Non-Medical Transportation					1313352.00	
GRAND TOTAL:						56245455.14
Total Estimated Unduplicated Participants:						4053
Factor D (Divide total by number of participants):						13877.49
Average Length of Stay on the Waiver:						288

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	trip	1479	111.00	8.00		
Personal Emergency Response System Total:						801724.77
Personal Emergency Response System	month	2361	9.90	34.30	801724.77	
Residential Care Facility Services Total:						10198610.27
Residential Care Facility Services	day	769	260.40	50.93	10198610.27	
Skilled Nursing Total:						4988877.38
Skilled Nursing	15 min	2296	24.10	90.16	4988877.38	
Specialized Medical Equipment Services Total:						240312.60
Specialized Medical Equipment Services	item	265	1.10	824.40	240312.60	
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care) Total:						1729632.56
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)	day	127	269.90	50.46	1729632.56	
GRAND TOTAL:						56245455.14
Total Estimated Unduplicated Participants:						4053
Factor D (Divide total by number of participants):						13877.49
Average Length of Stay on the Waiver:						288

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						1330563.28
Adult Medical Day Services	day	295	91.60	49.24	1330563.28	
Home Health Aide Total:						7140151.31
Home Health Aide					4697781.31	
GRAND TOTAL:						58903567.38
Total Estimated Unduplicated Participants:						4202
Factor D (Divide total by number of participants):						14017.98
Average Length of Stay on the Waiver:						288

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min	798	1025.60	5.74		
Home Health Aide visit	visit	805	102.50	29.60	2442370.00	
Homemaker Total:						2918080.34
Homemaker	15 min	961	665.90	4.56	2918080.34	
Personal Care Total:						23504989.68
Personal Care	15 min	2280	2353.70	4.38	23504989.68	
Respite Total:						189327.40
Respite	15 min	87	1303.10	1.67	189327.40	
Adult Family Care Total:						178963.68
Adult Family Care	day	14	217.40	58.80	178963.68	
Adult In-Home Services Total:						415073.12
Adult In-Home Services	15 min	49	2406.50	3.52	415073.12	
Community transition services Total:						6800.00
Community transition services	transition	8	1.00	850.00	6800.00	
Consolidated services Total:						83494.94
Consolidated services	day	26	2.90	1107.36	83494.94	
Environmental accessibility services Total:						780450.00
Environmental accessibility services	occurrence	129	1.00	6050.00	780450.00	
Home-Delivered Meals Total:						1378212.87
Home-Delivered Meals	meal	977	202.10	6.98	1378212.87	
Non-Medical Transportation Total:						1349760.00
Non-Medical Transportation	trip	1520	111.00	8.00	1349760.00	
Personal Emergency Response System Total:						824136.39
Personal Emergency Response System	month	2427	9.90	34.30	824136.39	
Residential Care Facility Services Total:						11643947.71
GRAND TOTAL:						58903567.38
Total Estimated Unduplicated Participants:						4202
Factor D (Divide total by number of participants):						14017.98
Average Length of Stay on the Waiver:						288

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Care Facility Services	day	826	261.10	53.99	11643947.71	
Skilled Nursing Total:						5127940.16
Skilled Nursing	15 min	2360	24.10	90.16	5127940.16	
Specialized Medical Equipment Services Total:						247567.32
Specialized Medical Equipment Services	item	273	1.10	824.40	247567.32	
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care) Total:						1784109.17
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)	day	131	269.90	50.46	1784109.17	
GRAND TOTAL:					58903567.38	
Total Estimated Unduplicated Participants:					4202	
Factor D (Divide total by number of participants):					14017.98	
Average Length of Stay on the Waiver:					288	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						1371156.74
Adult Medical Day Services	day	304	91.60	49.24	1371156.74	
Home Health Aide Total:						7336412.08
Home Health Aide	15 min	820	1025.60	5.74	4827294.08	
Home Health Aide visit	visit	827	102.50	29.60	2509118.00	
Homemaker Total:						3000065.95
Homemaker	15 min	988	665.90	4.56	3000065.95	
GRAND TOTAL:					61182308.29	
Total Estimated Unduplicated Participants:					4359	
Factor D (Divide total by number of participants):					14035.86	
Average Length of Stay on the Waiver:					288	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						24164778.86
Personal Care	15 min	2344	2353.70	4.38	24164778.86	
Respite Total:						193679.75
Respite	15 min	89	1303.10	1.67	193679.75	
Adult Family Care Total:						178963.68
Adult Family Care	day	14	217.40	58.80	178963.68	
Adult In-Home Services Total:						432014.88
Adult In-Home Services	15 min	51	2406.50	3.52	432014.88	
Community transition services Total:						6800.00
Community transition services	transition	8	1.00	850.00	6800.00	
Consolidated services Total:						86706.29
Consolidated services	day	27	2.90	1107.36	86706.29	
Environmental accessibility services Total:						878460.00
Environmental accessibility services	occurrence	132	1.10	6050.00	878460.00	
Home-Delivered Meals Total:						1416300.63
Home-Delivered Meals	meal	1004	202.10	6.98	1416300.63	
Non-Medical Transportation Total:						1387944.00
Non-Medical Transportation	trip	1563	111.00	8.00	1387944.00	
Personal Emergency Response System Total:						847227.15
Personal Emergency Response System	month	2495	9.90	34.30	847227.15	
Residential Care Facility Services Total:						12517948.63
Residential Care Facility Services	day	888	261.10	53.99	12517948.63	
Skilled Nursing Total:						5271348.66
Skilled Nursing	15 min	2426	24.10	90.16	5271348.66	
Specialized Medical Equipment Services Total:						253915.20
GRAND TOTAL:						61182308.29
Total Estimated Unduplicated Participants:						4359
Factor D (Divide total by number of participants):						14035.86
Average Length of Stay on the Waiver:						288

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment Services	item	280	1.10	824.40	253915.20	
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care) Total:						1838585.79
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)	day	135	269.90	50.46	1838585.79	
GRAND TOTAL:						61182308.29
Total Estimated Unduplicated Participants:						4359
Factor D (Divide total by number of participants):						14035.86
Average Length of Stay on the Waiver:						288

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Services Total:						1407239.81
Adult Medical Day Services	day	312	91.60	49.24	1407239.81	
Home Health Aide Total:						7541593.79
Home Health Aide	15 min	843	1025.60	5.74	4962693.79	
Home Health Aide visit	visit	850	102.50	29.60	2578900.00	
Homemaker Total:						3085088.06
Homemaker	15 min	1016	665.90	4.56	3085088.06	
Personal Care Total:						24834877.25
Personal Care	15 min	2409	2353.70	4.38	24834877.25	
Respite Total:						200208.28
Respite	15 min	92	1303.10	1.67	200208.28	
GRAND TOTAL:						63471065.15
Total Estimated Unduplicated Participants:						4522
Factor D (Divide total by number of participants):						14036.06
Average Length of Stay on the Waiver:						288

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Care Total:						191394.00
Adult Family Care	day	15	217.00	58.80	191394.00	
Adult In-Home Services Total:						440485.76
Adult In-Home Services	15 min	52	2406.50	3.52	440485.76	
Community transition services Total:						6800.00
Community transition services	transition	8	1.00	850.00	6800.00	
Consolidated services Total:						86706.29
Consolidated services	day	27	2.90	1107.36	86706.29	
Environmental accessibility services Total:						905080.00
Environmental accessibility services	occurrence	136	1.10	6050.00	905080.00	
Home-Delivered Meals Total:						1455799.06
Home-Delivered Meals	meal	1032	202.10	6.98	1455799.06	
Non-Medical Transportation Total:						1426128.00
Non-Medical Transportation	trip	1606	111.00	8.00	1426128.00	
Personal Emergency Response System Total:						870997.05
Personal Emergency Response System	month	2565	9.90	34.30	870997.05	
Residential Care Facility Services Total:						13462433.49
Residential Care Facility Services	day	955	261.10	53.99	13462433.50	
Skilled Nursing Total:						5419102.86
Skilled Nursing	15 min	2494	24.10	90.16	5419102.86	
Specialized Medical Equipment Services Total:						261169.92
Specialized Medical Equipment Services	item	288	1.10	824.40	261169.92	
Supportive Housing Services (formerly two services: Assisted Living and Congregate Care) Total:						1875961.51
Supportive Housing Services (formerly two	day		269.40	50.46	1875961.51	
GRAND TOTAL:						63471065.15
Total Estimated Unduplicated Participants:						4522
Factor D (Divide total by number of participants):						14036.06
Average Length of Stay on the Waiver:						288

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
services: Assisted Living and Congregate Care)		138				
GRAND TOTAL:						63471065.15
Total Estimated Unduplicated Participants:						4522
Factor D (Divide total by number of participants):						14036.06
Average Length of Stay on the Waiver:						288

