

**Readopt with amendment He-E 801.01 through 801.03, effective 2-8-03 (Document # 7823), cited and to read as follows:**

CHAPTER He-E 800 MEDICAL ASSISTANCE

PART He-E 801 ~~HOME AND COMMUNITY BASED CARE FOR THE ELDERLY AND CHRONICALLY ILL~~CHOICES FOR INDEPENDENCE PROGRAM

He-E 801.01 Purpose. The purpose of the rules contained in He-E 801 is to describe the requirements for eligibility and the services provided through the ~~home and community based care for the elderly and chronically ill~~Choices for Independence (HCBC-ECICFI) program.

He-E 801.02 Definitions.

(a) “Activities of daily living” (ADLs) means activities such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, and monitoring and supervision of medications.

~~—— (b) “Agency directed personal care services” means services provided by a licensed home health agency or another qualified agency with a limited license as described in RSA 151:2 b, III, and in accordance with the support plan described in He E 801.05.~~

(b) “Annual aggregate Medicaid cost” means the total Medicaid costs for nursing facility residents, combining both the initial Medicaid payments and quarterly supplemental payments.

(c) “Average aggregate payment” means the value of the annual aggregate Medicaid cost of nursing facility services divided by the number of paid Medicaid bed days in nursing facilities.

~~—— (e) “Assistance with nutrition, hydration, and meal preparation” means preparation of the meal, arranging food, including cutting up or mashing the food, filling the individual’s fork or spoon, encouraging the individual to eat or drink, and feeding the individual as specified in the care plan.~~

~~—— (d) “Assistance with personal appliances” means cleaning dentures, cleaning hearing aids, cleaning glasses, and assisting with the application of some types of braces, splints, slings and prostheses as specified in the care plan.~~

~~—— (e) “Assistance with self administration of oral and topical medication” means:~~

~~(1) Reminding the individual regarding the timing and dosage of the medication, and to take his or her medication as written on the medication container;~~

~~(2) Placing the medication within reach of the individual;~~

~~(3) Assisting the individual with opening the container;~~

~~(4) Assisting the individual by steadying shaking hands; and/or~~

~~(5) Observing the individual take the medication and recording the same in the individual’s record.~~

~~—— (f) “Assistance with toileting and toileting hygiene” means:~~

- ~~(1) Assistance with the use of the toilet, commode, bedpan or urinal;~~
- ~~(2) Assistance with the use of products related to hygiene care, such as incontinence briefs or pads;~~
- ~~(3) Assistance with cleaning after elimination;~~
- ~~(4) Assisting the individual with cleaning after instances of vomiting, diarrhea, and incontinence;~~
- ~~(5) Assistance with ostomy care in a long-term, well-healed, trouble-free ostomy, such as assisting in application of the stoma bag; and/or~~
- ~~(6) Assistance with catheter care as specified in the support plan and provided by a trained provider.~~

~~——(g) “Assisted living” means a range of services in an environment where each individual has access to:~~

- ~~(1) A congregate dining room; and~~
- ~~(2) Medical and social supports and supervision, including:
  - ~~a. Home health aide services;~~
  - ~~b. Personal care assistance;~~
  - ~~c. Environmental accessibility adaptations;~~
  - ~~d. 24-hour per day supervision;~~
  - ~~e. Periodic evaluations; and~~
  - ~~f. Transportation to non-medical services.~~~~

~~——(h) “Assistive technology devices” are practical equipment products meant to assist individuals with activities of daily living and instrumental activities of daily living which allow the individuals more independence, including:~~

- ~~(1) Alternative and augmentative communication aids for purposes of communicating with caregiver and health providers;~~
- ~~(2) Custom seating and positioning;~~
- ~~(3) Custom fabrication of seating;~~
- ~~(4) Memory aids;~~
- ~~(5) Mobility aids;~~
- ~~(6) Transfer aids; or~~

~~(7) Electronic aids for daily living.~~

~~——(i) “Assistive technology support services” means those services that are intended to help individuals in the selection, acquisition and use of assistive technology devices, as described in He-E 801.08 (c).~~

~~——(j) “Average annual costs” means the net Medicaid expenditures for services provided through the HCBC ECI program.~~

~~——(k) “Basic personal care and grooming” means washing/bathing, hair care, including shampooing, care of nails, dental and oral hygiene, skin and foot care, shaving, application of make-up, and/or dressing as specified in the care plan.~~

~~——(l) “Broker” means the coordinator designated by the division of elderly and adult services who has the primary responsibility for managing and overseeing an individual’s environmental accessibility adaptation and assistive technology needs as described in the support plan.~~

~~——(m) “Care plan” means a written guide containing specific instructions on providing a defined service to an individual, that is developed and maintained by the service provider, based on the authorized DEAS support plan, and that defines the processes and outcomes of direct care.~~

~~——(d) “Bureau” means the department’s bureau of elderly and adult services (BEAS).~~

~~——(e) “Care plan” means a written guide:~~

~~(1) Developed and maintained by the service provider in consultation with the participant, his or her legal representative, if any, or both;~~

~~(2) Developed as a result of an assessment process;~~

~~(3) Based on the participant’s comprehensive care plan; and~~

~~(4) Containing specific instructions on providing a defined service to the participant.~~

~~(f) “Case management agency” means an agency that is licensed in accordance with RSA 151:2, I(b), and enrolled as a New Hampshire Medicaid provider to provide targeted case management services to CFI participants in accordance with He-E 805.~~

~~(g) “Case manager” means an individual employed by, or contracted with, a case management agency who provides services in accordance with He-E 805.~~

~~——(n) “Case manager” means the division of elderly and adult services staff member or a contracted provider who is licensed in accordance with RSA 151, and who has the primary responsibility to assess the individual’s needs, develop a support plan in conjunction with a registered nurse and locate, coordinate and monitor the services described in this rule.~~

~~——(o) “Chronic illness” means an illness, which has one or more of the following characteristics:~~

~~(1) Is permanent;~~

- ~~(2) Leaves residual disability;~~
- ~~(3) Is caused by non-reversible, pathological alteration;~~
- ~~(4) Requires special training of the individual for rehabilitation; or~~
- ~~(5) Might be expected to require a long period of supervision, observation or care.~~

~~——(p) “Congregate care services” means a range of services provided in congregate care units, including:~~

- ~~(1) Supervision, assistance with activities of daily living and instrumental activities of daily living;~~
- ~~(2) Transportation to non-medical services;~~
- ~~(3) Medication reminders; and~~
- ~~(4) Any other supportive activity as specified in the individual care plan or which promotes and supports health and wellness, dignity, and autonomy that are provided in designated congregate care housing units as specified by the department.~~

~~——(q) “Congregate care unit” means a private, apartment-like setting that meets the criteria specified by the United States Department of Housing and Urban Development at 24 CFR 700.105.~~

~~——(r) “Consumer-directed services” means consumer-directed services as defined in RSA 161-I: 2, II.~~

~~——(s) “Direct care” means any of the following services provided:~~

- ~~(1) Assistance in eating;~~
- ~~(2) Supervision in:
  - ~~a. Getting in and out of bed;~~
  - ~~b. Dressing;~~
  - ~~c. Getting to the bathroom;~~
  - ~~d. Bathing/shampooing;~~
  - ~~e. Grooming; and~~~~
- ~~(3) Reminders to take medication.~~

~~——(t) “Environmental accessibility adaptations” means those physical adaptations to the home which are either necessary to ensure the health, welfare and safety of individuals or which enable them to function more independently in the home, thereby avoiding institutionalization.~~

~~\_\_\_\_\_ (u) “Essential household services” means those services that are necessary to maintain a home to ensure the health, safety, and welfare of individuals, including:~~

- ~~(1) Meal planning and preparation;~~
- ~~(2) Paying bills;~~
- ~~(3) Shopping for groceries, clothing or other items with funds provided by the individual;~~
- ~~(4) Doing laundry;~~
- ~~(5) Performing light housekeeping tasks, including:
 
  - ~~a. Washing dishes;~~
  - ~~b. Dusting;~~
  - ~~c. Vacuuming;~~
  - ~~d. Sweeping;~~
  - ~~e. Wet mopping floors;~~
  - ~~f. Cleaning kitchen and bathroom fixtures; and~~
  - ~~g. Emptying wastebaskets; and~~~~
- ~~(6) Doing errands.~~

~~\_\_\_\_\_ (h) “Choices for Independence (CFI)” means a system of long-term care services provided in a home care or mid-level residential facility and provided under Section 1915(c) of the Social Security Act to participants who meet the eligibility requirements in He-E 801. This term is also known as home and community-based care for the elderly and chronically ill (HCBC-ECI).~~

~~(i) “Comprehensive care plan” means an individualized plan described in He-E 805.05(c) that is the result of a person-centered process that identifies the strengths, capacities, preferences, and desired outcomes of the participant.~~

~~(j) “Home-based services” means long term care services provided to an individual either in a private home setting or in a mid-level residential facility, including CFI services, case management services, and the following Medicaid State Plan services: personal care attendant, home health aide, home health nursing, physical therapy, occupational therapy, speech therapy, adult medical day, and private duty nursing.~~

~~\_\_\_\_\_ (v) “Home and community based care for the elderly and chronically ill” (HCBC-ECI) means a system of long term care services, as defined in He E 801 and provided under a waiver of Section 1902(a)(10) and 1915(c) of the Social Security Act for individuals who are elderly or who have a disability or chronic illness, in a non-institutional setting.~~

~~\_\_\_\_\_ (w) “Indirect care” means non-medical care provided to individuals to prevent institutionalization and includes any of the following services:~~

- ~~(1) Meal preparation;~~
- ~~(2) Changing bed linens;~~
- ~~(3) Doing laundry essential to the individual's comfort or health;~~
- ~~(4) Arrangement of furniture and/or medical supplies for the individual's safety;~~
- ~~(5) Paying bills;~~
- ~~(6) Shopping; and~~
- ~~(7) Doing light cleaning.~~

~~——(x) “Informed consent” means the process by which the individual or his or her representative, makes decisions regarding health care services, after demonstrating an understanding of available options and their potential risks and consequences.~~

~~——(y) “Instrumental activities of daily living” (IADL’s) means activities performed on a regular basis, including, but not limited to:~~

- ~~(1) Doing laundry;~~
- ~~(2) Cleaning;~~
- ~~(3) Managing money;~~
- ~~(4) Shopping;~~
- ~~(5) Using transportation;~~
- ~~(6) Correspondence;~~
- ~~(7) Making telephone calls;~~
- ~~(8) Obtaining and keeping appointments;~~
- ~~(9) Socializing; and~~
- ~~(10) Recreation.~~

~~——(z) “Intermediary services” means intermediary services as defined in RSA 161-I, VII.~~

(k) “Legal representative” means one of the following individuals, duly appointed or designated in the manner required by law to act on behalf of another individual, and who is acting within the scope of his/her authority:

- (1) An attorney;
- (2) A guardian or conservator;

(3) An agent acting under a power of attorney;

(4) An authorized representative acting on behalf of an applicant in some or all of the aspects of initial and continuing eligibility in accordance with He-W 603.01; or

(5) A representative acting on behalf of another individual pursuant to RSA 161-I, Personal Care Services.

~~(aa)~~(l) “Legally responsible relative” means “legally responsible relative” as defined in RSA 161-I:2, VIII. In this rule, the only applicable legally responsible relative shall be the participant’s spouse.

(m) “Licensed practitioner” means:

(1) Medical doctor;

(2) Physician’s assistant;

(3) Advanced practice registered nurse;

(4) Doctor of osteopathy;

(5) Doctor of naturopathic medicine; or

(6) Anyone else with diagnostic and prescriptive powers licensed by the appropriate New Hampshire licensing board.

(n) “Long term care service plan” means a list of health and supportive care services which:

(1) Is determined by the registered nurse employed or designated by the bureau;

(2) Is based on the participant’s needs as identified in the clinical assessment process;

(3) Specifies the CFI services and the frequency, duration and scope of the CFI services to be provided to the participant; and

(4) Authorizes reimbursement to service providers.

(o) “Medicaid bed days” means the total unduplicated number of days of nursing facility care that were paid for by the Medicaid program in a 12 month period.

~~(ab) “Mid-level care” means care provided in an assisted living facility, congregate housing program, or residential care facility under the HCBC ECI program.~~

~~(ac) “Mobility assistance” means accompanying the individual as he or she moves from one location to another, opening doors, handing the individual his or her cane or walker, pushing a wheelchair, or another type of assistance as specified in the care plan.~~

~~(ad)~~(p) “Other qualified agencies” means those entities authorized by DHHS certified in accordance with RSA 161-I and He-P 601 to offer personal care services and/or intermediary services in accordance with rules adopted pursuant to RSA 541-A.

~~—— (ae) “Personal care services” means non-medical, hands-on services that assist eligible individuals to maintain themselves in a community setting.~~

~~—— (af) “Representative” means a person who is:~~

~~(1) Duly appointed or designated in the manner required by law to act on behalf of another individual;~~

~~(2) Acting within the scope of his/her authority pursuant to state law;~~

~~(3) One of the following:~~

~~a. An attorney;~~

~~b. A guardian or conservator;~~

~~c. An agency acting under a power of attorney;~~

~~d. An authorized representative acting on behalf of an individual in some or all of the aspects of initial and continuing eligibility; or~~

~~e. A representative acting on behalf of an individual pursuant to RSA 161-I, Personal Care Services.~~

~~—— (ag) “Support plan” means a written guide of health and supportive care services which:~~

~~(1) Is determined by the individual and/or his/her representative, the case manager, and the registered nurse designated by DEAS;~~

~~(2) Is approved by a physician or by an advanced registered nurse practitioner;~~

~~(3) Specifies the frequency, duration and scope of the HCBC-ECI services to be provided to the individual, based on the covered services described in this rule; and~~

~~(4) Authorizes reimbursement to service providers.~~

~~—— (ah) “Specialized medical equipment services” means those devices, controls or appliances that are specified in the support plan, and which enable individuals to increase their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live.~~

~~—— (ai) “Transfer assistance” means weight bearing and non-weight bearing assistance, such as steadying the individual, which is provided on an individual basis as specified in the care plan.~~

~~—— (aj) “Universal precautions” means a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and other bloodborne pathogens when providing first aid or health care.~~

(a) ~~Every New Hampshire Medicaid-eligible individual shall~~ An individual shall be eligible to receive ~~HCBC-ECICFI~~ services if he/she:

(1) Submits a signed and dated application, as defined in He-W 601.17, to the department;

~~(1)~~(2) Is at least 18 years of age;

~~(2)~~(3) ~~Meets the categorical and medical eligibility requirements for nursing facility service coverage as specified in He-W 658.06 and the level of care requirements as specified in He-W 590~~ 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;

~~(3) Would require long term nursing facility institutional placement in accordance with He-W 590, but not placement in an intermediate care facility for persons with mental retardation or in intermediate care facility for persons with mental illness, unless HCBC-ECI services are provided;~~

~~(4) Meets the following appropriateness of care criteria as determined by the division of elderly and adult services (DEAS):~~

~~a. The individual is residing in a setting that is free of readily observable hazards where the services included in the support plan can be provided without compromising the individual's or the provider's health or safety;~~

~~b. Formal and/or informal supports are available; and~~

~~c. Services contained in the support plan are available from providers who meet the requirements of He-E 801.09;~~

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

~~(4) Is determined by a registered nurse employed or designated by the department to require services that can be provided at a cost that is the same as, or lower than the Medicaid cost of nursing facility services; and~~

~~(5) The cost of HCBC ECI services, combined with an allowance for acute care costs in accordance with 42 CFR 441.302, is less than the average annual payment for nursing facility services as determined in accordance with He-W 593;~~

~~(6) Is not an inpatient of a hospital or a nursing facility (NF) except that respite care involving the temporary placement of an individual in a NF may be provided as a component service of HCBC ECI services;~~

~~(7) Has needs that can be met with community services at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services;~~

~~(8) If the cost of the services offered through the HCBC ECI program in He-E 801.03(a)(7) is higher than the average per diem Medicaid cost of nursing facility care in New Hampshire, the option of receiving HCBC ECI services shall not be offered to the individual;~~

~~(9) Pays to the department of health and human services (DHHS) the monthly cost share payment, determined in accordance with He-E 801.06, toward the cost of HCBC ECI services;~~

~~(10)(5) Has chosen, or whose legal representative has chosen, with the demonstration of informed consent by signing the application in He-E 801.04, HCBC ECI/CFI services as an alternative to institutional care.;~~

~~(11) Has approved, or his or her representative has approved, with the demonstration of informed consent, the support plan described in He-E 801.05, and the support plan has been approved by a physician or an advanced registered nurse practitioner; and~~

~~(12) Has signed, or whose representative has signed, an authorization to release information.~~

~~(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) If an individual is a resident of a nursing facility, that individual shall not be eligible to receive CFI services while in the nursing facility.~~

**Repeal He-E 801.04, effective 2-8-03 (Document # 7823), to read as follows:**

~~He-E 801.04 Initial Level of Care Screening.~~

~~(a) DEAS shall conduct an initial level of care screening for each applicant to the HCBC ECI program by reviewing medical and social information for the purpose of establishing that the applicant's primary need for NF level of care is in accordance with He-W 590.02, and He-E 801, and not based on criteria established for services described in He-M 426 or He-M 517.~~

~~—(b) Requests for the initial level of care screening shall be submitted to DEAS by the referring party in accordance with He W 590.11. The referring party may attach any other relevant information to the patient care referral form required in He W 590.11, and shall supply additional information if necessary for DEAS to establish the applicant's primary need for NF level of care.~~

~~—(c) If the initial level of care screening results in DEAS approval of the applicant's primary need for NF level of care, the registered nurse designated by DEAS shall then:~~

~~(1) Notify the referring party that the applicant has been found eligible for HCBC ECI services pending the on-site evaluation referred to in (2) below and the development of the support plan described in He E 801.05; and~~

~~(2) Conduct a preadmission on-site medical and psychosocial evaluation by meeting with the applicant for purposes of determining the applicant's eligibility for the HCBC ECI program, including identified informal and family and community support services.~~

~~—(d) If the initial level of care screening results in DEAS denying the applicant's primary need for HCBC ECI services, DEAS shall notify the referring party in writing of the denial, and include in the notice the reason for the denial.~~

**Adopt He-E 801.04 to read as follows:**

He-E 801.04 Clinical Eligibility Determination for CFI Services.

(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 using an assessment instrument reviewed and approved pursuant to RSA 151-E:3, I(a) and III; and

c. Develop a list of identified needs for the applicant;

(2) The applicant shall sign the following:

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

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

c. An authorization for release of information; and

d. An authorization for release of protected health information; and

(3) The department shall identify specific types, units, frequencies, and costs of medical and other services to meet the needs identified in the assessment, which do not exceed the cost

limits described in He-E 801.07, along with the types of providers that will furnish the services.

(b) 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.

(c) Within the 30 day period in (b) 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 requesting the information.

(d) A licensed practitioner may request that the department extend the deadline in (b) above.

(e) If the information required by (b) above is not received by the date specified in the notice, or as extended by the department in accordance with (d) above, clinical eligibility shall be denied.

(f) The applicant shall be determined clinically eligible if it is determined that the applicant meets the financial eligibility requirements described in He-W 600 and the clinical eligibility requirements of He-E 801.03 and 801.04.

(g) 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; and

(2) The eligibility start date.

(h) Upon a determination of ineligibility, because the applicant does not meet the eligibility requirements of He-E 801.03 and 801.04 or because required information is not received pursuant to (e) 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.

**Readopt with amendment He-E 801.10, effective 2-8-03 (Document # 7823), and renumber as He-E 801.05, cited and to read as follows:**

He-E 801.~~1005~~ Eligibility Redetermination.

~~\_\_\_\_\_ (a) Eligibility redeterminations for continued home and community based care services shall be completed at least annually for every individual to determine the continued need and appropriateness of HCBC ECI services as initially determined pursuant to He E 801.~~

~~\_\_\_\_\_ (b) Individuals who no longer meet the eligibility criteria for HCBC ECI services as described in He E 801 shall have their HCBC ECI services terminated as follows:~~

~~(1) Payment for services provided to individuals failing to satisfy the medical requirements of the eligibility redetermination for continued HCBC ECI services shall be terminated within 60 calendar days of the date of the notice described below; and~~

~~(2) Written notices of termination indicating the last date of coverage shall be sent by DEAS to the case manager, the individual or individual's representative and to the attending physician.~~

~~\_\_\_\_\_ (c) Notice of service coverage termination shall include:~~

~~(1) The reason for the service coverage termination;~~

~~(2) Information concerning the individual's right to appeal pursuant to He C 200;~~

~~(3) An explanation that continued payments for HCBC ECI services shall be authorized, if medical assistance has been continued, until a hearing decision has been made, provided that the hearing is requested within 10 days of the date of the service coverage termination letter; and~~

~~(4) An explanation that if the individual appeals pursuant to He C 200, and the DEAS decision is upheld, service coverage shall cease 60 calendar days from the date of the notice of service coverage termination or 30 calendar days from the date of the hearing decision, whichever is later.~~

\_\_\_\_\_ (a) Each participant shall be subject to a clinical eligibility redetermination at least annually.

\_\_\_\_\_ (b) The redetermination shall be conducted in accordance with He-E 801.04.

\_\_\_\_\_ (c) Upon a redetermination of eligibility, the identified needs list and service authorizations shall be updated as necessary by the department registered nurse.

\_\_\_\_\_ (d) If a participant is determined ineligible, the department shall terminate CFI services as follows:

(1) Payment for services shall be terminated 30 calendar days from the date of the notice described in (2) below, unless an appeal has been filed within 10 calendar days of the date of the notice; and

(2) A written notice of service coverage termination shall be sent to the participant, or his or her legal representative, and the participant's case manager, including:

a. The reason and legal basis for the service coverage termination;

b. The date that service coverage shall be terminated, absent the filing of an appeal;

c. Information concerning the participant's right to appeal pursuant to He-C 200, as follows:

1. The participant shall have 30 calendar days to file an appeal, otherwise the department's decision shall be final; and
2. If the participant files an appeal within 10 calendar days of the date of the notice of service coverage termination, continued payments for CFI services shall be authorized until 30 calendar days after a hearing decision has been made.

(e) The annual redetermination schedule shall not preclude earlier redetermination, reevaluation, or changes to the identified needs list and service authorizations.

~~(d) For each individual receiving HCBC ECI services, DEAS shall review expenditures and the utilization of HCBC ECI services to ensure program compliance.~~

**Adopt He-E 801.06 to read as follows:**

He-E 801.06 Request for Clinical Redetermination After Clinical Denial.

(a) Within one year of a determination of clinical ineligibility per He-E 801.04(h) or a termination of service after redetermination per He-E 801.05(d), an individual may request clinical reconsideration for CFI services by submitting the following to the department:

(1) Supporting documentation, completed by the applicant's medical doctor, doctor of osteopathy, or advanced practice registered nurse (APRN), that substantiates a significant change in condition; or

(2) Supporting documentation, completed by the applicant's medical doctor, doctor of osteopathy, or advanced practice registered nurse (APRN), indicating new evidence of clinical eligibility not submitted with the original request for services.

(b) "Significant change in condition" means a decline in an applicant's condition that would not normally resolve itself without ongoing intervention by licensed medical providers and that impacts more than one area of the applicant's physical functioning or structure.

(c) After one year of an initial denial per He-E 801.04(h) or a termination of service after redetermination per He-E 801.05(d), an individual may reapply to the CFI program in accordance with He-E 801.04(a) without meeting the requirement in (a)(1) or (2) above.

**Repeal He-E 801.05, effective 2-8-03 (Document # 7823), to read as follows:**

~~He E 801.05 Support Plan.~~

~~(a) If the applicant meets the level of care requirement described in He E 801.04, the registered nurse designated by DEAS shall visit the applicant to determine if his or her needs can be met through provision of HCBC ECI services.~~

~~(b) If the registered nurse designated by DEAS determines that the applicant's service needs can be met through provision of HCBC ECI services, a support plan shall be developed.~~

~~——(c) Participants in the development of the support plan shall include the applicant or the applicant's representative, the registered nurse designated by DEAS, the case manager, and, if the applicant resides in a mid-level care setting, mid-level care providers. Community providers may also participate in the support plan development.~~

~~——(d) The support plan shall include the following information:~~

- ~~(1) The types and frequency of medical and other needed services;~~
- ~~(2) The types of providers that will furnish the identified services;~~
- ~~(3) Whether the services identified are available in the individual's community; and~~
- ~~(4) The cost of the services.~~

~~——(e) The following parties shall sign the support plan:~~

- ~~(1) The applicant or the applicant's representative;~~
- ~~(2) The applicant's physician or advanced registered nurse practitioner;~~
- ~~(3) The registered nurse designated by DEAS;~~
- ~~(4) The case manager; and~~
- ~~(5) The HCBC-ECI provider representative in the mid-level care setting.~~

~~——(f) The case manager shall:~~

- ~~(1) Make referrals on behalf of HCBC-ECI eligible individuals to the appropriate agencies identified in the support plan;~~
- ~~(2) Coordinate the services included in the support plan;~~
- ~~(3) Inform the individual and his/her family or representative of how services will be provided; and~~
- ~~(4) Monitor the progress of each individual receiving HCBC-ECI services, to ensure that the support plan is being met.~~

~~——(g) The individual shall be reevaluated annually as described in He E 801.10, by the registered nurse designated by DEAS and by the case manager, at which a time a determination shall be made as to the continued need for HCBC-ECI services.~~

~~——(h) If the individual continues to need HCBC-ECI services, the support plan that is in effect shall be reviewed and adjusted by DEAS as required.~~

~~——(i) The annual review schedule shall not preclude earlier reevaluation and changes to the support plan should the individual's condition warrant it. Every change to the support plan shall require prior approval by DEAS.~~

~~(j) If the registered nurse designated by DEAS determines that the applicant's needs cannot be met by HCBC ECI services, DEAS shall send a written notice of denial to the applicant or his/her representative.~~

~~(k) The notice of denial shall include:~~

~~(1) A statement regarding the reason for the denial;~~

~~(2) Information concerning the applicant's right of appeal pursuant to He-C 200; and~~

~~(3) An explanation that HCBC ECI applicants who are denied services and who choose to appeal this denial pursuant to He-C 200, shall not be entitled to Medicaid payments for HCBC ECI services pending the hearing decision.~~

**Adopt He-E 801.07 and 801.08 to read as follows:**

He-E 801.07 Cost Control Methodology.

(a) For each applicant or participant, the department shall conduct a cost comparison between the cost of the individual's home-based services and the average annual cost of the provision of services to a person in a nursing facility.

(b) The cost comparison in (a) above shall be conducted as part of the initial eligibility determination and redetermination, and at any other time when a participant's comprehensive care plan is adjusted or the services received by the participant change.

(c) The total cost of an individual's home-based services shall include the costs of the following services:

(1) CFI services identified in He-E 801.04(b)(3);

(2) Case management services provided in accordance with He-E 805; and

(3) The following Medicaid State Plan services:

a. Personal care attendant;

b. Home health aide;

c. Home health nursing;

d. Physical therapy;

e. Occupational therapy;

f. Speech therapy;

g. Adult medical day; and

h. Private duty nursing.

(d) Costs associated with services rendered for acute care needs shall not be included in the calculation in (c) above.

(e) The average annual cost for the provision of services to a person in a nursing facility shall be calculated by adding the following amounts:

(1) The basic cost, determined by dividing the total annual aggregate Medicaid cost stated in the nursing facility budget line by the number of paid Medicaid bed days as specified in the HB-1 footnote for that budget year; and

(2) The average aggregate payment for supplemental Medicaid rates paid under the Medicaid Quality Incentive Program, as described in RSA 151-E:14 and 151-E: 15, divided by the number of paid Medicaid bed days.

(f) If the cost of an applicant's home-based services exceeds the average annual cost for the provision of services to a person in a nursing facility, the individual shall not be eligible for CFI services and shall be given notice and an opportunity to appeal in accordance with He-E 801.04(g).

(g) If the cost of an applicant's or a participant's home-based services exceeds 80% of the average annual cost for the provision of services to a person in a nursing facility, participation in the CFI program shall not be approved without the prior approval of the commissioner in accordance with He-E 801.08.

#### He-E 801.08 Commissioner Prior Approval Process.

(a) In accordance with RSA 151-E:11, II, no applicant or participant whose home-based services costs would be in excess of 80% of the average annual cost for the provision of services to a person in a nursing facility shall be approved for CFI participation without the prior approval of the commissioner.

(b) The prior approval process shall include the following:

(1) A review of the costs of the home-based services identified to meet the applicant's or the participant's needs;

(2) A review of the costs of nursing facility services at a nursing facility qualified to provide services, including any specialized services, that would be necessary for the proper care and treatment of the applicant or participant;

(3) A comparison of the amounts in (1) and (2) above;

(4) A review of the funds appropriated and made available to the bureau for long term care, including the CFI program, the current CFI program's expenditures to date, and the program's anticipated expenditures based on the actual and anticipated numbers of persons receiving CFI services; and

(5) A decision concerning the individual's participation in the CFI program that is consistent with the program management and cost controls described in RSA 151-E:11.

(c) If the commissioner approves the applicant's or the participant's participation in the CFI program, the bureau shall:

(1) Inform the applicant or participant in writing that services through the CFI program shall be provided or continued; and

(2) Inform the applicant or participant in writing that if the approval for services is discontinued in the future due to a determination that the services exceed what is allowed in RSA 151-E:11, the participant shall be informed in writing of the decision and the right to appeal the decision in accordance with He-E 801.04(g).

(d) If the commissioner does not approve the applicant's or the participant's participation in the CFI program, the bureau shall:

(1) Inform the applicant or participant in writing that services through the CFI program shall not be provided or continued; and

(2) Inform the applicant or participant in writing of the right to appeal the decision and the process to file an appeal in accordance with He-E 801.04(g) or 801.05(d).

**Readopt with amendment He-E 801.06, effective 11-21-08 (Document #9326), and renumber as He-E 801.09, to read as follows:**

He-E 801.~~06~~09 Post-Eligibility Computation of Cost of Care for ~~HCBC-ECICFI~~ Services.

(a) Except for individuals who reside in residential care facilities, the amount of income that an individual is liable to contribute toward the cost of his or her ~~HCBC-ECICFI~~ services shall be computed as follows:

- (1) The amount of the applicant or recipient's gross earned income as defined in He-W 601.81 shall be determined;
- (2) The employment expense disregard, as specified in He-W 654.18 for OAA or ANB recipients or the earned income disregard, as specified in He-W 654.15 for APTD recipients, shall be subtracted from the individual's gross earned income to obtain the individual's net earned income;
- (3) The total amount of the individual's unearned income, as defined in He-W 601.176, shall be added to the net earned income to determine the individual's net income;
- (4) The allowable deductions, as defined in He-W 654.20 and He-W 654.21, shall be subtracted from the individual's net income;
- (5) For the maintenance needs of the individual, 300% of the maximum SSI benefit for an eligible individual as determined in accordance with 20 CFR 416.410, adjusted by cost of living increases pursuant to 20 CFR 416.405 shall be subtracted from the amount in (4) above;
- (6) The cost of the following medical expenses incurred by the recipient that are not subject to third-party payment shall be subtracted from the amount in (5) above:
  - a. Health insurance premiums, including Medicare Part A, Part B, Part C, and Part D, coinsurance payments, and deductibles;

- b. Necessary and remedial care that would be covered by medical assistance except that allowable payment limits have been exceeded;
- c. Necessary and remedial care that is recognized by state law, but not covered by medical assistance; and
- d. Currently obligated, unpaid prior medical debt;

(7) The amount of any continuing SSI benefits, under section 1611 (e) (1) (E) and (G) of the Social Security Act, shall be subtracted from the amount in (6) above;

(8) The veterans affairs aid and attendance allowance shall be added to the amount in (6) or (7) above as required by 42 CFR 435.733 (c); and

(9) The result in (8) above shall be the amount of income for which the individual is liable to remit as payment toward the cost of his or her ~~HCBC-ECICFI~~ services.

(b) For individuals who reside in residential care facilities, the amount of income that the individual is liable to contribute toward the cost of his or her ~~HCBC-ECICFI~~ services shall be computed as follows:

(1) The amount of the applicant or recipient's gross earned income as defined in He-W 601.81 shall be determined;

(2) The employment expense disregard, as specified in He-W 654.18 for OAA or ANB recipients or the earned income disregard, as specified in He-W 654.15 for APTD recipients, shall be subtracted from the individual's gross earned income to obtain the individual's net earned income;

(3) The total amount of the individual's unearned income, as defined in He-W 601.176, shall be added to the net earned income to determine the individual's net income;

(4) The allowable deductions, as defined in He-W 654.20 and He-W 654.21, shall be subtracted from the individual's net income;

(5) The personal needs allowance as defined in He-W 654.17(b) shall be subtracted from the amount in (4) above;

(6) The cost of the following medical expenses incurred by the recipient that are not subject to third-party payment shall be subtracted from the amount in (5) above:

- a. Health insurance premiums, including Medicare Part A, Part B, Part C, and Part D, coinsurance payments, and deductibles;
- b. Necessary and remedial care that would be covered by medical assistance except that allowable payment limits have been exceeded;
- c. Necessary and remedial care that is recognized by state law, but not covered by medical assistance; and
- d. Currently obligated, unpaid prior medical debt;

(7) The amount of any continuing SSI benefits, under section 1611 (e) (1) (E) and (G) of the Social Security Act, shall be subtracted from the amount in (6) above;

(8) The veterans affairs aid and attendance allowance shall be added to the amount in (6) or (7) above as required by 42 CFR 435.733 (c); and

(9) The result in (8) above shall be the amount of income for which the individual is liable to remit as payment toward the cost of his or her ~~HCBC-EC~~CFI services.

**Readopt with amendment He-E 801.07, effective 2-8-03 (Document # 7823), to read as follows:**

He-E 801.~~07~~10 Covered Services and Requirements of Service Provision.

(a) CFI services shall be covered for eligible participants when:

(1) The services are provided as specified in the case management agency's comprehensive care plan;

(2) The services are provided in accordance with the service descriptions in He-E 801.12 through He-E 801.26; and

(3) Authorized by BEAS.

(b) CFI services shall include one or more of the following services:

(1) Adult family care services;

(2) Adult in home care services;

(3) Adult medical day services;

(4) Environmental accessibility adaptations;

(5) Home-delivered meals services;

(6) Home health aide services;

(7) Homemaker services;

(8) Non-medical transportation services;

(9) Personal care services;

(10) Personal emergency response system services;

(11) Residential care service;

(12) Respite services;

(13) Skilled nursing services;

(14) Specialized medical equipment services; and

(15) Supportive housing services.

~~(a) Home and community based care services shall be covered when they are determined to be a cost effective alternative to, and a means of preventing, institutionalization, and are provided as specified in the support plan.~~

~~(b) Home and community based care services shall include one or more of the following services:~~

~~(1) Adult in home care services;~~

~~(2) Adult medical day care services;~~

~~(3) Assisted living;~~

~~(4) Assistive technology services;~~

~~(5) Congregate care services;~~

~~(6) Environmental accessibility adaptations;~~

~~(7) Home delivered meals services;~~

~~(8) Home health aide services;~~

~~(9) Homemaker services;~~

~~(10) Nursing services;~~

~~(11) Personal care services;~~

~~(12) Personal emergency response system;~~

~~(13) Residential care service;~~

~~(14) Respite services; and~~

~~(15) Specialized medical equipment services.~~

**Readopt with amendment He-E 801.15, effective 2-8-03 (Document # 7823), renumbered as He-E 801.11, to read as follows:**

He-E 801.~~15~~11 Non-Covered Services.

(a) No service or item shall be covered though the CFI program if the service or item:

(1) Is covered through the Medicaid State Plan and the participant is eligible for that coverage;

- (2) Is covered through Medicare or any other insurance;
- (3) Is provided as a component of any other covered service;
- (4) Duplicates another service being provided to the participant;
- (5) Addresses needs being met by another paid or unpaid service; or
- (6) Is provided by a legally responsible relative.

~~(a)(b)~~ With the exception of respite care provided in an intermediate care facility or residential care facility, ~~all HCBC ECI payment for CFI~~ services shall exclude room and board.

~~(b)~~ Assistive technology services shall not include the actual purchase and cost of assistive technology devices.

~~(c)~~ The following shall be excluded from environmental accessibility adaptations:

- ~~(1) Improvements such as carpeting, roof repair, air conditioning or other improvement that are of general utility and do not have direct or remedial benefit to the individual's home; and~~
- ~~(2) Adaptations which add to the square footage of the home; and~~

~~(d)~~ Services that are covered through the HCBC ECI program shall not include those items or services already covered through the medicaid program or any insurance.

**Readopt with amendment He-E 801.08 and 801.09, effective 2-8-03 (Document # 7823), renumbered as He-E 801.12 through 801.27, to read as follows:**

He-E 801.12 Adult Family Care.

(a) Adult family care shall be covered:

(1) When provided at a private residence in the community that is either:

a. Licensed or certified in accordance with RSA 151 and He-P 813; or

b. A private residence that is not required to be licensed or certified pursuant to RSA 151 or He-P 813; and

(2) When the services are organized/managed by an adult family care oversight agency as authorized by BEAS.

(b) Adult family care shall include the services required by He-P 813.

He-E 801.13 Adult In Home Care Services.

(a) Adult in home care services shall be covered when provided by an agency licensed in accordance with RSA 151:2 and either He-P 809 or He-P 822.

(b) Covered services shall include:

- (1) Laundering the participant's personal clothing items, towels, and bedding;
- (2) Light cleaning limited to the individual's bedroom, bathroom, and mobility devices;
- (3) Preparing non-communal meals and snacks, unless for multiple CFI participants, including cleaning the food preparation area after the food is served; and
- (4) Hands-on assistance with activities of daily living or cuing a participant to perform a task.

(c) Adult in home care shall not be covered:

- (1) For the purposes of food preparation for meals that include the participant and non-participants;
- (2) When provided on the same day that the participant receives personal care or homemaker services;
- (3) When provided by a legally responsible relative; or
- (4) When provided to a participant receiving residential care services.

He-P 801.14 Adult Medical Day Services.

(a) Adult medical day services shall be covered when provided by an adult day program licensed in accordance with RSA 151:2 and He-P 818.

(b) Covered adult medical day services shall be those services that are provided in accordance with He-E 803, except that the requirement contained in He-E 803.03(a)(6), which requires attendance for a minimum of 4 hours in a day, shall not apply.

(c) Adult medical day services shall not be a covered service when:

- (1) Provided for non-medical reasons; or
- (2) Provided to a participant receiving residential care services.

(d) Adult medical day service providers shall comply with the provider and documentation requirements specified in He-E 803 and He-P 818, in addition to the requirements in He-E 801.28.

He-E 801.15 Environmental Accessibility Adaptations.

(a) Environmental accessibility adaptations (EAA) shall be a covered service when:

- (1) A NH Medicaid-enrolled physical or occupational therapist has determined the need for one or more of the services in (b) below;
- (2) The participant's case manager has requested prior authorization for the service in accordance with (d) below;

(3) BEAS has provided the prior authorization for the service; and

(4) The service is completed by a provider/contractor enrolled with the department in accordance with (e) below.

(b) The following environmental accessibility adaptations shall be covered:

(1) Installation of ramps;

(2) Installation of grab bars;

(3) Widening of doorways; and

(4) Other adaptations authorized by BEAS that are necessary for the health and safety of a participant that are not otherwise covered under the Medicaid State Plan.

(c) The following environmental accessibility adaptations shall not be covered:

(1) Improvements such as carpeting, roof repair, air conditioning or other improvements that are of general utility and do not have direct or remedial benefit to the participant;

(2) Adaptations which add to the square footage of the home;

(3) Purchase of or modifications to a motor vehicle;

(4) Electrical or plumbing work that is beyond what is required to support the authorized adaptation;

(5) Electrical or plumbing work for which the proposed contractor is unable to state, in writing, that the proposed adaptation can be done within the current electrical/plumbing capacity of the home; and

(6) Adaptations to a residential care facility or other licensed facility, except for adaptations in an adult family care home when approved for a specific participant.

(d) The participant's case manager shall submit the following when requesting prior authorization for an EAA:

(1) A completed form 3715, "Choices for Independence Prior Authorization Request Form" (edition date);

(2) A copy of the therapist evaluation in (a)(1) above that describes:

a. The medical or functional need for the adaptation;

b. The description and measurements required for the adaptation; and

c. The proposed training plan for the client/caregiver to ensure safe use of the adaptation;

(3) Proposals from at least 2 registered providers/contractors, except that one proposal may be submitted with a written explanation of why only one proposal is available or appropriate, including the following, as applicable to the project:

a. A supply/materials list;

b. Blueprints or scaled drawings;

c. The name(s) of any subcontractors that will be involved;

d. Written confirmation of whether or not a building permit is required;

e. If electrical or plumbing work is required to support the adaptation, then:

1. A statement signed by the provider/contractor stating that the requested adaptation can be done within the current electrical or plumbing capacity of the residence; and

2. A copy of the electrician or plumber's license;

f. A statement signed by the provider/contractor affirming knowledge of all applicable building codes and permitting requirements and affirming that any subcontractors involved in the work are appropriately licensed; and

g. An agreement signed by the provider/contractor stating that reimbursement for the authorized service through CFI will be payment in full;

(4) If a participant prefers one bid over the other(s), then an explanation of the preference shall be submitted; and

(5) A notarized written statement from the property owner granting permission to complete the project if the participant is not the owner of the residence.

(e) Providers/contractors shall meet the following requirements in order to be enrolled to perform EAAs:

(1) Licensed if the work to be completed requires licensure, such as plumbing or electrical work;

(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.

(f) Payment for EAAs shall not be made until the department receives the following:

(1) A copy of any required building permit and written confirmation from the building inspector that the work was completed as allowed by the permit;

(2) A signed statement from the participant stating that the work has been completed according to the approved bid/plans and to the satisfaction of the participant; and

(3) A signed confirmation from the case manager stating that the work was completed.

(g) Payment for environmental accessibility adaptations shall not exceed the participant lifetime limit specified in the HCBC-CFI waiver approved by the Centers for Medicare and Medicaid Services.

He-E 801.16 Home-Delivered Meals Services.

(a) Covered home-delivered meals services include:

(1) The delivery of nutritionally balanced meals to the participant's home; and

(2) The monitoring of the participant and the reporting of emergencies, crises, or potentially harmful situations to emergency personnel or the participant's case manager, as appropriate.

(b) All home-delivered meals shall be nutritionally balanced and contain at least 1/3 of the current Recommended Dietary Allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.

(c) Providers of home-delivered meals services shall:

(1) Have a contract with DHHS to provide home-delivered nutrition services to adults;

(2) Have a director and staff to ensure that meals are prepared and delivered in compliance with the comprehensive care plan and with any applicable state/local requirements;

(3) Provide meals that accommodate diabetic and/or salt restricted diets if such are requested by the case manager;

(4) Provide visual verification that the participant is home and that there are no unusual circumstances that may cause someone to suspect harm or potential harm to the participant; and

(5) Report any observations of unusual circumstances to the designated agency supervisor or, in the case of an emergency, call emergency personnel.

(d) Home-delivered meals services shall not be a covered service when the meal is provided at an adult medical day program or at a residential care facility.

He-E 801.17 Home Health Aide Services.

(a) Home health aide services shall be covered when provided by a licensed nursing assistant (LNA) licensed in accordance with RSA 326-B and Nur 700 and employed by a home health care provider licensed in accordance with RSA 151:2 and He-P 809.

(b) The following home health aide services shall be covered:

(1) Those services allowed within the LNA scope of practice, pursuant to Nur 700; and

(2) Personal care services, as described in He-E 801.20, when the participant's care plan contains documentation that his/her medical condition necessitates the performance of such tasks by an LNA and not an unlicensed provider.

(c) Home health aide services shall not be covered separately when provided at a residential care facility.

He-E 801.18 Homemaker Services.

(a) Homemaker services shall be covered when provided by employees of:

(1) Home health care providers licensed in accordance with RSA 151:2 and He-P 809; or

(2) Home care service providers licensed in accordance with RSA 151:2 and He-P 822.

(b) Homemaker services shall be limited to the following non-hands-on general household services:

(1) Laundering the participant's personal clothing items, towels, and bedding;

(2) Light cleaning limited to the individual's bedroom, bathroom, and mobility devices;

(3) When the participant lives alone, light cleaning of the kitchen and entry way areas, in order to maintain a safe environment;

(4) Errands for necessary tasks identified in the comprehensive care plan; and

(5) Preparation of non-communal meals and snacks, unless for multiple CFI participants including cleaning the food preparation area after the food is served.

(c) Homemaker services shall not be covered:

(1) For the purposes of food preparation for meals that include the participant and non-participants;

(2) When provided on the same day that the participant attends an adult medical day program or receives adult in home care or personal care services;

(3) When provided by a legally responsible relative, as defined in RSA 161-I:2, VIII; or

(4) Separately when provided at a residential care facility.

He-E 801.19 Non-Medical Transportation Services.

(a) Non-medical transportation services shall be covered when provided by employees of:

(1) Home health care providers licensed in accordance with RSA 151:2 and He-P 809;

(2) Home care service providers licensed in accordance with RSA 151:2 and He-P 822;

(3) Other qualified agencies certified in accordance with RSA 161-I and He-P 601; or

- (4) Agencies under contract with BEAS to provide services funded by the Older Americans' Act or the Social Services Block Grant.
- (b) Vehicles used for providing non-medical transportation services shall have a current inspection sticker.
- (c) Drivers providing non-medical transportation services shall:

  - (1) Have a current and valid driver's license;
  - (2) Provide documentation of having car insurance that

    - a. Includes uninsured motorist coverage; and
    - b. Is for a minimum of \$100,000 per passenger per occurrence and \$300,000 per occurrence;
  - (3) Be 18 years of age or older.
- (d) When requesting authorization for non-medical transportation services, the participant's case manager shall submit written documentation that identifies other transportation resources that were investigated by the case manager, and why they do not meet the participant's needs.
- (e) Non-medical transportation shall be limited to 3 trips per week per participant to access community services identified in the comprehensive care plan.
- (f) A case manager may request additional trips by providing written explanation of the individual participant's circumstances that necessitate additional trips.
- (g) Non-medical transportation services shall include:

  - (1) Transportation to and from the authorized destination; and
  - (2) Waiting time when the provider determines that waiting is more efficient than making a separate trip.
- (h) The following services shall not be covered as non-medical transportation:

  - (1) Assistance with tasks at a destination;
  - (2) Transportation to or from medical appointments or services;
  - (3) Transportation provided to a participant receiving residential care or adult family care services;
  - (4) Transportation for the purpose of attending education or employment; and
  - (5) Transportation to activities that are recreational or diversional in nature.

(a) Personal care services shall be covered when provided by employees of:

- (1) Home health care providers licensed in accordance with RSA 151:2 and He-P 809;
- (2) Home care service providers licensed in accordance with RSA 151:2 and He-P 822; or
- (3) Other qualified agencies certified in accordance with RSA 161-I and He-P 601.

(b) Covered personal care services shall include the following services:

- (1) Hands-on assistance with the activities of daily living or cuing a participant to perform a task;
- (2) Meal or snack preparation and assisting the participant with eating, as specified in the care plan;
- (3) Under the direction of the participant, assistance with self-administration of oral or topical medication as prescribed, to include:
  - a. Reminding the participant regarding the timing and dosage of the medication, and to take his or her medication as written on the medication container;
  - b. Placing the medication container within reach of the participant;
  - c. Assisting the participant with opening the medication container;
  - d. Assisting the participant by steadying shaking hands; and
  - e. Observing the participant take the medication and recording the same in the participant's record;
- (4) Accompanying the participant when the assistance of the personal care worker is required for the participant to access necessary services that are documented in the comprehensive care plan, and the need for re-direction and/or direct assistance is documented in the clinical assessment, due to one or more of the following conditions:
  - a. A cognitive impairment;
  - b. A mobility impairment;
  - c. A problem behavior; or
  - d. The need for oxygen or other equipment during the course of the trip that the participant cannot manage independently;
- (5) When non-medical transportation service is authorized, hands-on assistance at the authorized destination for a maximum period of 3 hours per week when the comprehensive care plan documents that this assistance is required at the destination; and
- (6) General household tasks.

(c) Personal care services shall not be covered:

- (1) For the purpose of transportation;
- (2) For the purpose of preparing communal meals that include non-participants;
- (3) On the same day that adult in home care or homemaker services are provided;
- (4) When provided in any of the following settings:
  - a. A residential care facility;
  - b. A hospital;
  - c. A nursing facility;
  - d. A rehabilitation facility;
  - e. An adult family care home; and
  - f. An adult medical day program; and
- (5) When provided by any of the following individuals:
  - a. The participant's legally responsible relative;
  - b. The participant's personal care services representative, designated in accordance with (d) and (e) below;
  - c. The participant's designated power of attorney, regardless of whether the power of attorney has been activated; or
  - d. The participant's legal guardian.

(d) The participant, his/her legal guardian, or a person granted power of attorney by the participant may designate a personal care services (PCS) representative to act on the participant's behalf:

- (1) To direct the personal care services being provided; and
- (2) Under the following conditions:
  - a. The following persons shall not serve as a PCS representative for purposes of directing personal care services:
    1. The personal care worker providing services;
    2. The participant's case manager; and
    3. Anyone having a financial relationship with any agency providing personal care services or intermediary services, as defined in RSA 161-I: VII, to the participant;

b. The PCS representative shall be designated through a written document, stating that:

1. The PCS representative's role only applies to decisions made regarding the personal care services described in this section;

2. The appointment of a PCS representative may be revoked by the participant at any time; and

3. The responsibilities of the PCS representative shall be to:

(i) At a minimum, have weekly face-to-face contact with the participant and the personal care worker;

(ii) At a minimum, have monthly contact with the participant's case manager concerning personal care services;

(iii) Ensure that the personal care worker is taking the participant's care preferences into consideration; and

(iv) Communicate concerns or satisfaction to the provider agency that employs that personal care worker; and

c. The written document, designating the PCS representative, shall be signed by the participant or his/her legal guardian or by the person granted power of attorney and a witness.

(e) When a PCS representative is designated, the participant, his/her guardian, or the person granted power of attorney shall:

(1) Notify the provider agency in writing of the PCS representative's name and scope of authority; and

(2) Notify the provider agency in writing of any changes in representation within 30 days of the date that the change occurs.

He-E 801.21 Personal Emergency Response Systems Services.

(a) Personal emergency response systems are a communication service providing geographically and/or socially isolated participants with 24-hour direct access to a medical control center through an electronic device which allows the participant to alert the control center in the case of an emergency.

(b) Personal emergency response systems shall be a covered service for participants who:

(1) Live alone, live only with someone in poor or failing health, or who are alone at home for greater than 4 hours each day;

(2) Are one of the following:

a. Are ambulatory and have been identified as being at risk of falls after an assessment of fall risk by a registered nurse or occupational or physical therapist; or

b. Have been identified as being at risk of having a medical emergency in the clinical eligibility determination or by a primary care practitioner, registered nurse, or occupational therapist; and

(3) Would require ongoing supervision if the personal emergency response system were not provided.

(c) Personal emergency response systems shall not be covered separately when provided to a participant receiving residential care services.

He-E 801.22 Residential Care Services.

(a) Residential care services shall be covered when provided by facilities licensed in accordance with RSA 151:2 and either He-P 804 or He-P 805.

(b) The following residential care services shall be covered:

(1) Those services described in He-P 804 or He-P 805;

(2) Twenty-four hour per day supervision; and

(3) Transportation to medical services except when a course of prescribed treatment requires any of the following:

a. Emergency transportation;

b. Transportation more than once per week; or

c. Transportation to a treatment location that is a greater distance from the facility than the participant's primary care physician.

(c) The services described in (b) above shall be included in a per diem rate, established by the department in accordance with RSA 161:4, VI(a), and shall not be reimbursed as a separately covered service when provided in a residential care setting.

He-E 801.23 Respite Care Services.

(a) Respite care services shall be a covered service when provided by or in one of the following settings:

(1) A Medicaid-enrolled nursing facility, licensed in accordance with RSA 151:2 and He-P 803;

(2) A Medicaid-enrolled residential care facility licensed in accordance with RSA 151:2 and He-P 804 or He-P 805; or

(3) In the participant's own residence, by:

a. Home health care providers licensed in accordance with RSA 151:2 and He-P 809;

b. Home care service providers licensed in accordance with RSA 151:2 and He-P 822; or

c. Other qualified agencies certified in accordance with RSA 161-I and He-P 601.

(b) Respite care services shall be:

(1) Provided to the participant on a short-term basis, as described in (2) below, because of the absence or need for relief of those persons normally providing that participant's care; and

(2) Limited to a maximum number of units not to exceed 20 24-hour days per state fiscal year.

He-E 801.24 Skilled Nursing Services.

(a) Skilled nursing services shall be a covered service when provided by a registered nurse (RN) or by a licensed practical nurse (LPN) who:

(1) Is employed by a home health care provider licensed in accordance with RSA 151:2 and He-P 809; or

(2) Is licensed in the state in which s/he practices, and as allowed by the NH board of nursing.

(b) Skilled nursing services shall be covered for the provision of chronic long-term care and not short-time or intermittent care.

(c) Skilled nursing services shall not be covered when provided:

(1) On the same day as the participant attends an adult medical day program if the identified need is within the scope of what would normally be provided by the program;

(2) For the purpose of medication management for participants who attend an adult medical day program when that service might be provided by the facility;

(3) For the purpose of nursing oversight of authorized LNA services; or

(4) At a residential care facility.

He-E 801.25 Specialized Medical Equipment Services.

(a) Specialized medical equipment services shall be covered for those durable and non-durable medical equipment items determined necessary for life safety by a registered occupational or physical therapist or ordered by a physician, physician's assistant, or nurse practitioner, and individually prior authorized by a BEAS nurse.

(b) Covered specialized medical equipment services shall include the following durable medical equipment items:

(1) Raised toilet seats;

(2) Shower/bath seats;

(3) Transfer benches;

(4) Dressing aids;

(5) Non-slip grippers to pick up and reach items;

(6) Lift chairs as follows:

a. Coverage shall be limited to the seat lift mechanism and its installation, and not the chair itself; and

b. All of the following criteria shall be met:

1. The participant has severe arthritis of the hip or knee, or a severe neuromuscular disease;

2. The seat lift mechanism is a part of the physician's course of treatment to effect improvement or arrest or retard deterioration in the participant's condition, and shall be prescribed by the attending physician or a consulting physician for the disease or condition resulting in the need for a seat lift;

3. The participant is completely incapable of standing up from a regular armchair or any chair in their home; and

4. Once standing, the participant is able to walk; and

(7) Medication dispensing devices, including training on their use, when the following conditions are met:

a. The participant or caregiver is able to use the device, except that BEAS shall authorize devices when their filling will be done by a registered nurse when such authorization is the most cost-effective means of medication management and the service is medically necessary for the participant as determined by BEAS;

b. The participant does not live in a licensed facility;

c. When the use of this service is documented to either:

1. Replace another service of equal or greater cost; or

2. Avoid the addition of another service; and

d. The type of device is determined by the BEAS nurse to be the least costly device that is appropriate for the participant.

(c) Specialized medical equipment services shall not be covered separately for participants receiving residential care services

He-E 801.26 Supportive Housing Services.

(a) Supportive housing services shall be covered when provided by a home health care providers licensed in accordance with RSA 151:2 and He-P 809 and when provided to participants who live in federally subsidized individual apartments.

(b) The following supportive housing services shall be covered:

(1) Personal care services;

(2) Assistance with activities of daily living;

(3) Assistance with the following activities:

a. Making telephone calls; and

b. Obtaining and keeping appointments;

(4) Home health aide services;

(5) Homemaker services;

(6) Personal emergency response services; and

(7) Medication reminders and other supportive activities as specified in the comprehensive care plan developed in accordance with He-E 805.05 or which promote and support health and wellness, dignity and autonomy within a community setting.

(c) The services described in (b) above shall be included in a per diem rate, established by the department in accordance with RSA 161:4, VI(a), and shall not be reimbursed as a separately covered service when provided in a supportive housing setting.

He-E 801.27 Provider Participation.

(a) Each participating provider shall:

(1) Be enrolled in NH Medicaid as a CFI provider; and

(2) Meet the applicable licensing, certification or other requirements of the specific service they provide, such as a contract with the bureau.

(b) Each participating provider shall:

(1) Create and maintain an individual care plan for each participant served in accordance with He-E 801.28(a);

(2) Create and maintain other documentation in accordance with He-E 801.28;

(3) Submit claims for payment in accordance with He-E 801.29;

(4) Provide services in accordance with He-E 801.10 through He-E 801.26; and

(5) Be subject to BEAS and SURS review.

(c) Each participating provider shall comply with the provisions of RSA 161-F:49 with regard to checking the names of prospective or current employees, volunteers or subcontractors against the BEAS state registry.

(d) Each participating provider shall report to the appropriate DHHS authority any individual who is suspected of being abused, neglected, exploited or self-neglecting, in accordance with the adult protection law, RSA 161-F:46.

~~He E 801.08 Individual Service Descriptions.~~

~~(a) Adult in home care services shall include a combination of direct and indirect services, as defined in He E 801.02.~~

~~(b) Adult medical day care services shall be provided by agencies licensed in accordance with RSA 151:2, and in accordance with He W 550, except that the requirement contained in He W 550.05(b), which requires a minimum of 2 days attendance per week, shall not apply. Adult medical day care services shall include services furnished 5 or more hours per day on a regularly scheduled basis, for one or more days per week.~~

~~(c) Assisted living services shall include the following, to be provided as described in the individual's support plan and in conjunction with the HCBC-ECI recipients' residence in the assisted living facility:~~

~~(1) Personal care services;~~

~~(2) Homemaker services;~~

~~(3) Chore services meant to maintain the home in a clean, sanitary and safe environment such as:~~

~~a. Washing floors, windows and walls;~~

~~b. Tacking down loose rugs and tiles; and~~

~~c. Moving heavy items of furniture in order to provide safe access and egress;~~

~~(4) Attendant care services as defined as hands-on care, of both a supportive and a health-related nature, specific to the needs of a medically stable, physically disabled individual;~~

~~(5) Companion services as defined as non-medical care, supervision and socialization, provided to an individual;~~

~~(6) Medication management to the extent permitted under State law;~~

~~(7) Therapeutic social and recreational programming provided in a licensed, where applicable, community care facility;~~

~~(8) Meal preparation and serving;~~

~~——(d) Assisted living services may also include:~~

- ~~a. Nursing services, personal emergency response systems, intermittent skilled nursing services, and in-home day care; and~~
- ~~b. 24-hour availability of on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence and to provide supervision, safety, and security for the residents.~~

~~——(e) Assistive technology support services shall include:~~

- ~~(1) An evaluation of the needs of the individual, including a functional evaluation of the individual in his/her customary environment;~~
- ~~(2) Coordination of the acquisition of assistive technology;~~
- ~~(3) Selecting, designing, fitting, customizing, adapting, applying, repairing or maintaining assistive technology devices;~~
- ~~(4) Coordinating and using other therapies, supports or services with assistive technology devices, such as those associated with the existing support plan; and~~
- ~~(5) Provision of technical assistance for the individual or, if appropriate, for his/her caregiver or personal care attendant.~~

~~——(f) Congregate care services shall be provided in conjunction with the individual's residence in a congregate care unit, and include, at a minimum:~~

- ~~(1) Case management;~~
- ~~(2) Homemaker;~~
- ~~(3) Meals;~~
- ~~(4) Personal assistance;~~
- ~~(5) Transportation; and~~

~~——(g) Congregate living services may include one or more of the following, as determined by the HCBC ECI case manager in conjunction with the CHSP service coordinator and the individual:~~

- ~~(1) Adult group day care;~~
- ~~(2) Health maintenance; and~~
- ~~(3) Personal emergency response system.~~

~~——(h) Environmental accessibility adaptations shall include:~~

- ~~(1) Installation of ramps;~~

~~(2) Installation of grab bars;~~

~~(3) Widening of doorways; or~~

~~(4) Other adaptations as determined by DEAS that are necessary for health and safety of an individual, subject to the limitations described in He E 801.15(c).~~

~~——(i) Home delivered meals services shall:~~

~~(1) Combine the delivery of nutritionally balanced meals to the individual's home with the monitoring of the individual and the reporting of emergencies, crises or potentially harmful situations to the appropriate case manager;~~

~~(2) Provide meals that contain at least 1/3 of the current Recommended Dietary Allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council;~~

~~(3) Deliver meals as specified in the support plan;~~

~~(4) Accommodate diabetic and salt-restricted diets; and~~

~~(5) For each meal delivered, include visual verification that the individual is home and that there are no unusual circumstances that would cause a normally prudent person to suspect harm or potential harm to the individual.~~

~~——(j) Home health aide services shall:~~

~~(1) Be provided by an aide who is licensed in accordance with RSA 326-B:28 and Nur 700, and employed by a home health agency that is licensed by DHHS in accordance with RSA 151:2; and~~

~~(2) Include, but not be limited to, the following activities:~~

~~a. Identifying hazardous conditions in the environment;~~

~~b. Providing personal care;~~

~~c. Determining temperature, pulse, respiration or blood pressure;~~

~~d. Ambulating, positioning, supporting or transferring the individual;~~

~~e. Providing nutrition or hydration; and~~

~~f. Other activities described in Nur 703.02 of the rules adopted by the board of nursing.~~

~~——(k) Homemaker services shall be those general household activities provided by a homemaker who is employed by, or under contract with, a homemaker or home health agency licensed in accordance with RSA 151:2, including but not limited to:~~

~~(1) Meal preparation;~~

~~(2) Keeping a safe environment in areas of the home used by the individual needing the service;~~

~~(3) Changing bed linens;~~

~~(4) Light housecleaning;~~

~~(5) Rearranging furniture to assure that the individual can safely reach necessary supplies or medication;~~

~~(6) Doing laundry that is essential to the individual's comfort and cleanliness; and~~

~~(7) Seeing that the nutritional needs of the individual can be met, including the purchase of food and assistance in the preparation of meals and special diets.~~

~~——(l) Nursing services shall be provided by a registered nurse (RN) or by a licensed practical nurse (LPN) who is employed or under contract with a home health care provider licensed in accordance with RSA 151:2, and as allowed by the board of nursing under the following conditions or limitations:~~

~~(1) Nursing services shall be provided in accordance with the individual's support plan; and~~

~~(2) Nursing services provided under the support plan shall be chronic long term care in contrast to part-time or intermittent care.~~

~~——(m) The following provisions shall apply to personal care services:~~

~~(1) Based upon the individual's consent or the consent of his/her representative, the individual shall be provided with:~~

~~a. Consumer directed services, through a licensed home health agency or an other qualified agency;~~

~~b. Agency directed services, through a licensed home health agency or an other qualified agency with a limited license as described in RSA 151:2 b, III; or~~

~~c. A combination of consumer directed and agency directed services;~~

~~(2) Personal care services shall be provided as specified in the support plan and in accordance with the provider requirements contained in He E 801.09;~~

~~(3) Personal care services shall be covered services for eligible individuals in the following settings when these services are not already included in the rate being paid to another provider:~~

~~a. At home;~~

~~b. In a day program; or~~

~~c. In another community setting;~~

~~(4) Personal care services shall not be a separately paid service when provided in any of the following settings:~~

- ~~a. A residential care facility;~~
- ~~b. A hospital;~~
- ~~c. A nursing facility; or~~
- ~~d. Other institutional settings;~~

~~(5) The individual shall meet the eligibility requirements described in He-E 801.03 and He-E 801.04, and, based on an individual assessment conducted by a home health agency or an other qualified agency, not be in need of services beyond the scope of those described in He-E 801.08 and He-E 801.09;~~

~~(6) Personal care workers who are employed either by a home health agency or by an other qualified agency shall be selected by the eligible individual or by his/her representative;~~

~~(7) Personal care workers in (6) above shall not include any of the following:~~

- ~~a. The individual's legally responsible relative;~~
- ~~b. The individual's case manager; or~~
- ~~c. The individual's personal care services representative;~~

~~(8) The individual, his/her legal guardian or a person granted power of attorney by the individual may designate a representative to act on the individual's behalf:~~

- ~~a. When directing the personal care services being provided; and~~
- ~~b. Under the following conditions:~~

~~1. The persons named below shall not serve as representatives for purposes of directing personal care services:~~

- ~~(i) The personal care worker providing services;~~
- ~~(ii) The individual's case manager; and~~
- ~~(iii) Anyone having a financial relationship with any agency providing personal care services or intermediary services to the individual;~~

~~2. The personal care representative shall be designated through a written document, stating that:~~

- ~~(i) The personal care representative's role only applies to decisions made regarding the personal care services described in He-E 801.08;~~

~~(ii) The appointment of a personal care representative may be revoked at any time by either party; and~~

~~(iii) The responsibilities of the personal care representative shall be to:~~

~~i. Have weekly face to face contact with the individual and the personal care worker, including the responsibility for signing the weekly time sheet described in He E 801.09(e)(7)c.2;~~

~~ii. Have monthly contact with the HCBC ECI case manager concerning personal care services;~~

~~iii. Ensure that the personal care worker is taking the individual's care preferences into consideration; and~~

~~iv. Communicate concerns or satisfaction to the home health agency or other qualified agency that employs that personal care worker; and~~

~~3. The written document, designating the personal care representative, shall be signed by the individual or his/her legal guardian or by the person granted power of attorney and a witness;~~

~~(9) When a personal care representative is designated, the individual, his/her guardian or the person granted power of attorney shall:~~

~~a. Notify the home health agency or other qualified agency in writing of the personal care representative's name and scope of authority; and~~

~~b. Notify the home health agency or other qualified agency in writing of any changes in representation within 30 days of the date that the change occurs;~~

~~(10) Personal care services shall be provided in accordance with a care plan developed by the individual in conjunction with the home health agency or other qualified agency;~~

~~(11) The care plan described in (9) above shall:~~

~~a. Be consistent with the scope, duration and intent of the DEAS support plan described in He E 801.05;~~

~~b. Contain a statement of the actual needs of, and the goals of care for, the individual;~~

~~c. Contain the home health agency's or other qualified agency's assessment and observations of the individual;~~

~~d. Identify the specific personal care services needed to help the individual meet his or her needs, including the frequency and duration;~~

~~e. Describe how the specific personal care services are to be provided to the individual, based on the scope of services provided in He E 801.05; and~~

~~f. Contain observations stating whether or not the goals of care are met;~~

~~(12) The scope of personal care services shall include, but not be limited to:~~

- ~~a. Basic personal care and grooming;~~
- ~~b. Transfer assistance;~~
- ~~c. Mobility assistance;~~
- ~~d. Assistance with toileting and toileting hygiene measures;~~
- ~~e. Assistance with personal appliances;~~
- ~~f. Assistance with nutrition, hydration and meal preparation;~~
- ~~g. Assistance with self administration of medication as defined in He E 801.02(d); and~~
- ~~h. Essential household services; and~~

~~(13) The personal care worker may, under the direction of the individual or the representative, assist the individual with preparing and taking medication as prescribed.~~

~~——(n) Personal emergency response system shall:~~

~~(1) Be a communication service providing geographically and/or socially isolated individuals with 24 hour direct access to a medical control center through an electronic device which alerts the control center whenever a problem arises;~~

~~(2) Be limited to those individuals who:~~

- ~~a. Live alone or who are alone for more than one half of the day;~~
- ~~b. Have no regular caregiver for extended periods of time; and~~
- ~~c. Would require ongoing supervision if the personal emergency response system were not provided.~~

~~——(o) Residential care services shall include the following services, provided as described in the individual's support plan and by facilities licensed by DHHS in accordance with RSA 151:2:~~

- ~~(1) Nursing services;~~
- ~~(2) Homemaker services;~~
- ~~(3) Home health aide services;~~
- ~~(4) Personal care assistance;~~
- ~~(5) Environmental accessibility modifications;~~
- ~~(6) Twenty four hour per day supervision;~~

~~(7) Periodic evaluations; and~~

~~(8) Transportation to medical and non-medical services.~~

~~——(p) Respite care shall be:~~

~~(1) Provided to the individual on a short-term basis, as described in (2) below, because of the absence or need for relief of those persons normally providing that individual's care;~~

~~(2) Limited to a maximum of 80 6-hour units or 20 24-hour days per state fiscal year; and~~

~~(3) Provided in one of the following settings:~~

~~a. A Medicaid-enrolled NF;~~

~~b. A Medicaid-enrolled residential care facility licensed in accordance with RSA 151:2; or~~

~~c. In the individual's own residence, by a home health or other qualified agency, or by a homemaker agency.~~

~~——(q) Specialized medical equipment services shall include those durable and non-durable medical equipment items necessary for life support, subject to the limitations described in He E 801.15(d), including but not limited to:~~

~~(1) Raised toilets;~~

~~(2) Shower/bath seats;~~

~~(3) Transfer benches;~~

~~(4) Dressing aids; and~~

~~(5) Non-slip grippers to pick up and reach items.~~

~~——He E 801.09 Provider Participation.~~

~~——(a) All providers shall be enrolled with the New Hampshire Medicaid program pursuant to He W 521, and shall also be enrolled as HCBC-ECI providers.~~

~~——(b) Each service provider shall develop and implement a written care plan that is consistent with the scope, duration, and intent of the DEAS support plan.~~

~~——(c) Each service provider shall obtain authorization from DEAS prior to changing the support plan, as described in He E 801.12.~~

~~——(d) Each provider shall report to the appropriate DHHS authority any individual who is suspected of being abused, neglected, exploited or self-neglecting, in accordance with the adult protection law, RSA 161-F:46.~~

~~(e) Specific requirements for each service provider shall be as follows:~~

~~(1) Adult in-home care services shall be:~~

~~a. Authorized only in conjunction with home health aide service and/or homemaker service;~~

~~b. Supervised by a home health agency or homemaker agency;~~

~~c. Documented by the service provider in written progress notes that include, but are not limited to, the following:~~

~~1. The individual's name;~~

~~2. The date(s) of service delivery;~~

~~3. The type(s) of service(s) delivered;~~

~~4. The total amount of time in which service was delivered;~~

~~5. An evaluation, which shall include information on the individual's progress and the outcome of service provision; and~~

~~6. The name of the individual's caregiver.~~

~~(2) Adult medical day care service providers shall:~~

~~a. Meet the provider requirements specified in He-W 550; and~~

~~b. Document the services provided in written progress notes that include, but are not limited to, the following:~~

~~1. The individual's name;~~

~~2. The date(s) of service delivery;~~

~~3. The type of service(s) delivered;~~

~~4. The total amount of time in which service was delivered;~~

~~5. An evaluation, which shall include information on the individual's progress and the outcome of service provision; and~~

~~6. The name of the individual's caregiver;~~

~~(3) Assisted living services providers shall:~~

~~a. Provide individual living units:~~

~~1. Which may include kitchenette and/or living rooms; and~~

- ~~2. Which contain bedrooms and toilet facilities that are separate and distinct from other units; or~~
- ~~b. Provide dually occupied units when both occupants consent to this arrangement;~~
  - ~~1. Which may include kitchenette and/or living rooms; and~~
  - ~~2. Which contain bedrooms and toilet facilities and that are separate and distinct from other units; and~~
- ~~c. Maintain each individual's resident's right to privacy by allowing living units to be locked at the discretion of the individual, unless:~~
  - ~~1. Prohibited by fire code; or~~
  - ~~2. A physician or mental health professional has certified in writing that the individual is cognitively impaired sufficiently enough to be a danger to self or to others if given the opportunity to lock the door.~~
- ~~d. Provide routines of care provision and service delivery which:~~
  - ~~1. Are consumer driven to the maximum extent possible;~~
  - ~~2. Foster the independence of each individual;~~
  - ~~3. Facilitate aging in place;~~
  - ~~4. Promote the dignity and respect of each resident; and~~
  - ~~5. Recognize that the individual retains the right to assume risk tempered only by the individual's ability to assume responsibility for that risk;~~
- ~~e. Be licensed as applicable and as required in accordance with RSA 151;~~
- ~~f. Provide services are provided by trained and licensed individuals, as applicable;~~
- ~~g. Comply with other applicable statutes, regulations, standards, policies, and procedures;~~
- ~~h. Enroll as a HCBC ECI provider in the New Hampshire Medicaid Program pursuant to He W 521;~~
- ~~i. Develop and implement a written care plan consistent with the scope, duration, and intent of the DEAS support plan;~~
- ~~j. Fully inform residents of their rights and responsibilities in working with the assisted living facility, including the formal internal complaint, grievance, and appeals process;~~
- ~~k. Develop and implement formal policies and procedures for supervising and monitoring the provision of services; and~~

~~1. Document the services provided in written progress notes that include, but are not limited to:~~

- ~~1. The individual's name;~~
- ~~2. The date(s) and service delivery;~~
- ~~3. The type(s) of service(s) delivered;~~
- ~~4. The total amount of time in which services was delivered;~~
- ~~5. An evaluation of services provided, including information on the individual's progress and the outcome of service provision; and~~
- ~~6. The name of the individual's caregiver;~~

~~(4) Assistive technology support services providers shall:~~

- ~~a. Provide workmanship that is warranted for at least 90 days;~~
- ~~b. Provide services that are consistent with the individual's support plan; and~~
- ~~c. Develop and implement an individual specific rehabilitation plan that includes an evaluation of the individual's home, individual specific education and training, and a follow up visit within 30 days after home modifications have been completed;~~

~~(5) Congregate living service providers shall:~~

- ~~a. Provide congregate housing settings that meet the criteria described by the Department of Housing and Urban Development in 24 CFR 700.105;~~
- ~~b. Confirm the agreement to provide care in accordance with the HCBC ECI support plan by the congregate housing administrator's signature on the HCBC ECI support plan;~~
- ~~c. Document the services provided in written progress notes that include, but are not limited to:~~
  - ~~1. The individuals' name;~~
  - ~~2. The date(s) and service delivery;~~
  - ~~3. The type(s) of service(s) delivered;~~
  - ~~4. The total amount of time in which services was delivered;~~
  - ~~5. An evaluation of services provided, including information on the individual's progress and the outcome of service provision; and~~
  - ~~6. The name of the individual's caregiver;~~

~~(6) Environmental accessibility/adaptation services providers shall meet the requirements contained in He E 801.09(e)(3)a-c;~~

~~(7) Home-delivered meals service providers shall:~~

~~a. Have a contract with DHHS to provide nutrition services as described under Title III, Part C, of the Older Americans Act, or be otherwise approved as providers by DEAS;~~

~~b. Have a director and staff to ensure that meals are prepared and delivered in compliance with the HCBC ECI support plan and with any applicable state/local requirements;~~

~~c. Report any observations of unusual circumstances to the case manager and the appropriate authority; and~~

~~d. Document service provision by recording the individual's name and the dates that services are provided;~~

~~(8) Home health aide service providers shall:~~

~~a. Be licensed by DHHS in accordance with RSA 151:2; and~~

~~b. Document service provision in written progress notes that include, but are not limited to, the following:~~

~~1. The individual's name;~~

~~2. The date(s) of service delivery;~~

~~3. The type(s) of service(s) delivered;~~

~~4. The total amount of time in which service was delivered;~~

~~5. An evaluation, which shall include information on the individual's progress and the outcome of service provision; and~~

~~6. The name of the individual's caregiver;~~

~~(9) Homemaker agencies shall:~~

~~a. Be licensed as required by RSA 151:2; and~~

~~b. Provide services through homemakers who are trained and supervised by homemaker or home health agencies licensed in accordance with RSA 151:2;~~

~~(10) Nursing services shall be:~~

~~a. Provided by registered nurses or licensed practical nurses licensed to practice by the state in which they practice; and~~

~~b. Delivered by a home health agency which is licensed by DHHS in accordance with RSA 151:2;~~

~~e. Documented by the service provider in written progress notes, that include, but are not limited to, the following:~~

- ~~1. The individual's name;~~
- ~~2. The date(s) of service delivery;~~
- ~~3. The type(s) of service (s) delivered;~~
- ~~4. The total amount of time in which service was delivered;~~
- ~~5. An evaluation, which shall include information on the individual's progress and the outcome of service provision; and~~
- ~~6. The name of the individual's caregiver;~~

~~(11) Personal care services shall be provided by employees of licensed home health agencies pursuant to RSA 151, or other qualified agencies pursuant to RSA 161-I, as follows:~~

~~a. Home health agencies providing personal care services shall be licensed by DHHS in accordance with RSA 151:2;~~

~~b. Other qualified agencies providing personal care services pursuant to RSA 161-I shall:~~

- ~~1. Be registered with the New Hampshire secretary of state to provide personal care services;~~
- ~~2. Have a federal employer identification number;~~
- ~~3. Carry liability insurance for personal care services and provide workers compensation protection; and~~
- ~~4. If providing agency directed services, have a limited license as described in RSA 151:2 b, III.~~

~~e. Home health agencies and other qualified agencies shall:~~

- ~~1. Be able to provide personal care services or intermediary services as described in RSA 161-I or both;~~
- ~~2. Maintain weekly time sheets for all services rendered through personal care workers in their employ, which contain, at a minimum:
  - ~~(i) The name and address of the personal care services worker;~~
  - ~~(ii) The day of the week, date, and amount of time spent providing each occurrence of personal care service;~~~~

~~(iii) The total number of units of service provided during the time period documented;~~

~~(iv) The signature of the individual receiving or directing the service, indicating that the service was provided in accordance with the support plan, and to the individual's satisfaction; and~~

~~(v) The signature of the personal care services employee, indicating that the information provided is accurate and signifying that the employee understands that falsification of the information provided could lead to prosecution; and~~

~~3. Maintain monthly payroll reports for all services rendered through personal care services workers in their employ, which:~~

~~(i) Shall be kept on file; and~~

~~(ii) Shall contain, at a minimum:~~

~~i. The name, address and Medicaid identification number of the individual receiving personal care service;~~

~~ii. The name and address of the personal care service worker;~~

~~iii. The total number of service hours provided during the month; and~~

~~iv. Wages paid and deductions withheld for the month and year to date.~~

~~d. Home health agencies and other qualified agencies providing consumer directed services shall prepare, maintain, and make available policies and procedures regarding the provision of consumer directed personal care services, which includes, at a minimum:~~

~~1. A description of the roles and responsibilities of individuals, representatives and personal care services workers, and the services available to individuals and representatives;~~

~~2. A confidentiality policy;~~

~~3. A drug free workplace statement;~~

~~4. A statement on the prohibition of sexual harassment;~~

~~5. An individual bill of rights statement;~~

~~6. A description of the customer service system and policy;~~

~~7. The agency's grievance and appeal process;~~

~~8. A universal precautions policy;~~

~~9. Proper lifting techniques/body mechanics policy;~~

~~10. An individual site and home safety checklist;~~

~~11. Procedures that allow the individual and his/her representative, when appropriate, to have an active role in determining the individual's needs and in developing the care plan;~~

~~12. A statement to the effect that individuals have the right to train their personal care services providers and to access other training opportunities that the individual or his representative believes are necessary; and~~

~~13. A description of how the agency will develop and maintain a registry of personal care services workers that consumers and representatives can access when recruiting personal care workers, and how the agency will keep the registry updated;~~

~~e. Home health and other qualified agencies providing consumer directed services shall prepare, maintain and make available a manual for individuals using their agency for consumer directed services which includes:~~

~~1. The following information about the home health agency/other qualified agency:~~

~~(i) Business hours;~~

~~(ii) Key staff contacts and telephone numbers;~~

~~(iii) Payroll pay days, or the day that checks are issued;~~

~~(iv) The payroll schedule, or the day of the week that time sheets are due from personal care providers;~~

~~(v) Descriptions of consumer directed personal care services and programs, based on the requirements contained in this rule; and~~

~~(vi) Procedures for accessing counseling and support or technical assistance from staff regarding personal care services;~~

~~2. The following safety information:~~

~~(i) A consumer site and home safety checklist;~~

~~(ii) Procedures regarding personal care provider injuries;~~

~~(iii) Procedures regarding emergencies;~~

~~(iv) Emergency telephone numbers; and~~

~~(v) Instructions on universal precautions and safe lifting techniques; and~~

~~3. The following information about recruiting, interviewing, hiring and firing providers, including samples:~~

~~(i) Writing job descriptions;~~

~~(ii) Posting ads;~~

~~(iii) Using the personal care services worker registry developed by the other qualified agency;~~

~~(iv) Preparing interview questions, scheduling and conducting an interview;~~

~~(v) Orienting and training personal care services workers and documentation of training provided;~~

~~(vi) Supervising the personal care services worker's performance of tasks;~~

~~(vii) Preparing, signing and submitting time sheets;~~

~~(viii) Evaluating the personal care services worker's performance;~~

~~(ix) Procedures for submitting documentation to and communicating with the agency; and~~

~~(x) Discharging the personal care services worker; and~~

~~f. Documentation of personal care services shall include, for each individual who receives these services:~~

~~1. Personal care service related training received by each personal care worker, including the training dates and activities covered, and the name of the person who provided the training; and~~

~~2. The supervision provided to the personal care worker by the agency when agency directed services are provided or reports of supervision provided by the individual when consumer directed services are provided.~~

~~(12) Personal emergency response system providers shall be enrolled as Medicaid providers pursuant to He W 521;~~

~~(13) Residential care facility services providers shall:~~

~~a. Be licensed by DHHS in accordance with RSA 151:2;~~

~~b. Confirm the facility's agreement to provide care in accordance with the support plan, which shall be indicated by the facility's administrator's signature on the support plan; and~~

~~e. Document the service provided in written progress notes that include, but are not limited to:~~

- ~~1. The individual's name;~~
- ~~2. The date(s) of service delivery;~~
- ~~3. The type(s) of service (s) delivered;~~
- ~~4. The total amount of time in which service was delivered;~~
- ~~5. An evaluation, including information on the individual's progress and the outcome of service provision; and~~
- ~~6. The name of the individual's caregiver;~~

~~(14) Respite care providers shall:~~

~~a. Meet one of the following 2 requirements:~~

- ~~1. Be participating providers under Title XVIII of the Social Security Act as determined by HCFA; or~~
- ~~2. Be licensed as a nursing facility or residential care facility by DHHS;~~

~~b. Have the following professional qualifications:~~

- ~~1. For registered nurses and licensed practical nurses, be licensed pursuant to applicable state law(s) to provide such services;~~
- ~~2. For home health aides, be licensed pursuant to applicable state law(s) to provide such services; and~~
- ~~3. For homemakers, be employed by a homemaker or home health agency that is licensed in accordance with RSA 151:2; and~~

~~e. Document the service provided in written progress notes that include, but are not limited to, the following:~~

- ~~1. The individual's name;~~
- ~~2. The date(s) of service delivery;~~
- ~~3. The type(s) of service (s) delivered;~~
- ~~4. The total amount of time in which service was delivered;~~
- ~~5. An evaluation, including information on the individual's progress and the outcome of service provision; and~~
- ~~6. The name of the individual's caregiver; and~~

~~(15) Providers of specialized medical equipment services, including durable medical equipment, shall meet the requirements in 801.09(e)(3)a. e.~~

**Repeal He-E 801.11, effective 2-8-03 (Document # 7823), as follows:**

~~He E 801.11 Appeals. All individuals who are denied coverage of services through the HCBC-ECI program shall have the right to appeal a decision made by DEAS and shall be informed of their rights to appeal pursuant to He C 200.~~

**Readopt with amendment He-E 801.14, effective 2-8-03 (Document # 7823), renumbered as He-E 801.28, to read as follows:**

~~He-E 801.1428 Required Documentation. Retention of Records. Providers shall maintain clinical records to support claims submitted for reimbursement for a period of at least 6 years from the date of service or until the resolution of any legal action(s) commenced during the 6 year period, whichever is longer.~~

~~(a) Each participating provider, with exceptions noted in (b) below, shall develop, maintain, and implement a written care plan that is consistent with the scope, duration, and intent of the participant's comprehensive care plan and in accordance with applicable licensure or certification requirements.~~

~~(b) Providers of the following services shall not be required to develop a care plan:~~

- ~~(1) Environmental accessibility adaptations;~~
- ~~(2) Home-delivered meals services;~~
- ~~(3) Personal emergency response system services;~~
- ~~(4) Specialized medical equipment services; and~~
- ~~(5) Non-medical transportation services.~~

~~(c) Each participating provider shall:~~

- ~~(1) Maintain documentation in accordance with applicable licensure, certification or other requirements;~~
- ~~(2) Maintain any other supporting records in accordance with He-W 520; and~~
- ~~(3) Maintain documentation in their records to fully support each claim billed for services including the specific service provided, the number of service units provided, the name of the employee who provided the service, and the date and time of service provision, as applicable.~~

~~(d) In addition to (c) above, documentation of personal care services shall include verification of the personal care services worker's time, including, when paper timesheets are used, the signature of the participant or PCS representative indicating that the service was provided in accordance with the care plan and to the participant's satisfaction.~~

~~(e) The documentation required by this section shall be made available to the department upon request.~~

(f) The documentation required by this section shall be maintained for a period of at least 6 years from the date of service or until the resolution of any legal action(s) commenced during the 6 year period, whichever is longer

**Readopt with amendment He-E 801.12, effective 2-8-03 (Document # 7823), renumbered as He-E 801.29, to read as follows:**

He-E 801.~~1229~~ Payment For Services.

(a) Providers shall submit all initial claims to the Medicaid fiscal agent, so that the fiscal agent receives the claims no later than one year from the earliest date of service on the claim.

(b) If a provider has submitted a claim during the one-year billing period and the claim is subsequently rejected by the fiscal agent, the provider shall resubmit the claim within 15 months from the earliest date of service if the provider still wishes to receive reimbursement.

(c) Providers shall not bill the participant if Medicaid does not pay due to billing practices of the provider which result in non-payment for a Medicaid item, supply, or service.

(d) Payment to providers of CFI services shall be made in accordance with rates established by the department in accordance with RSA 161:4, VI(a).

~~—(e) Providers participating in the Medicaid program shall be responsible for timely and accurate billing, as required above, and the provider shall not bill the individual if Medicaid does not pay due to billing practices of the provider which result in non-payment for a Medicaid item, supply or service.~~

~~—(d) Reimbursement to providers of HCBC ECI services shall be made in accordance with rates established by DEAS.~~

~~—(e) Reimbursement for HCBC ECI services shall be made only for those services which have been authorized by DEAS, and which are included in the support plan described in He E 801.06. Providers shall request DEAS authorization prior to making any changes in the support plan, except when there is an emergency which makes it necessary to make changes before obtaining DEAS authorization, and in this situation, DEAS authorization shall be requested within 3 working days.~~

**Adopt He-E 801.30, to read as follows:**

He-E 801.30 Utilization Review and Control. The department shall monitor utilization of CFI services in accordance with 42 CFR 455, 42 CFR 456, He-W 520, and He-E 801.

**Readopt with amendment He-E 801.13, effective 2-8-03 (Document # 7823), renumbered as He-E 801.31, to read as follows:**

He-E 801.~~1331~~ Third Party Liability. ~~In accordance with He W 521, all third party obligations shall be exhausted before Medicaid may be billed.~~

(a) All third party obligations shall be exhausted before Medicaid may be billed, in accordance with 42 CFR 433.139.

(b) Providers shall determine if third party liability exists and file a claim with the third party before billing Medicaid.

(c) If third party liability exists, and the provider is not enrolled with the third party in a manner that allows the provider to submit a claim for service, the provider shall not bill Medicaid or the participant.