

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:

Choices for Independence Waiver Renewal: 2022--->2027

C. Waiver Number:NH.0060

D. Amendment Number:NH.0060.R08.01

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

04/01/23

Approved Effective Date: 04/01/23

Approved Effective Date of Waiver being Amended: 07/01/22

2. Purpose(s) of Amendment

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

The purpose of this waiver amendment is to add Removable Prosthodontic Services and associated provider qualifications.

Removable Prosthodontic Services under this waiver are limited to the provision of dentures, routine post-delivery care and other associated procedures connected to the prosthodontic service that are not included in the New Hampshire Medicaid State Plan, "Adult Dental Services", to individuals who are participants of Choices for Independence Waiver services and as outlined in the Removable Prosthodontic Services definition in Appendix C.

This action also proposes to enact an initial/concurrent 1915(b)(4) waiver for the delivery of Removable Prosthodontic Services via the managed-care authority and the implementation of an additional dispute process for persons utilizing the Prepaid Ambulatory Health Plan (PAHP) for delivery of Removable Prosthodontic Services.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	Concurrent operation with Other Programs
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	Waiver Services
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	F-2-b
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	I-2-a, I-2-b, I-3-g-iii
Appendix J Cost-Neutrality Demonstration	J-2-c-i, J-2-c-ii, J-2-c-iii, J-2-c-iv, J-2-d-i

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

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

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

1. Request Information (1 of 3)

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

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

Choices for Independence Waiver Renewal: 2022--->2027

C. Type of Request: amendment

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

3 years 5 years

Waiver Number: NH.0060.R08.01

Draft ID: NH.001.08.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/22

Approved Effective Date of Waiver being Amended: 07/01/22

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

care:

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

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

The initial 1915(b) application, for the delivery of Removable Prosthodontic Services via managed-care authority in this waiver only, was submitted on 12/19/2022, in alignment with the submission of this amendment.

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

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

§1915(b)(2) (central broker)

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

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

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose/Goal: The purpose of the Choices for Independence (CFI) Waiver, administered by the NH Department of Health and Human Services (NH DHHS), is to support older people and adults with disabilities to live independently in the community.

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

The state has defined, within this waiver, a range of community-based services which support individuals. The covered services include: Adult Day Services, Home Health Aide Services, Homemaker, Personal Care, Respite, Supported Employment, Financial Management Services, Participant Directed and Managed Services, Adult Family Care, Community Transition Services, Environmental and Vehicle Modification Services, Home Delivered Meals, In-Home Services, Non-Medical Transportation, Personal Emergency Response Services, Residential Care Facility Services, Skilled Nursing, Specialized Equipment Services, and Supported Housing.

Individuals living in the Community who wish to apply for CFI Waiver services can access support for the application process through the State's No Wrong Door System of Access for Long Term Supports and Services (NHCarePath). ServiceLink, New Hampshire's Aging and Disability Resource Center, is designated as NHCarePath's full Services Access Partner offering guidance, support, and person centered Options Counseling to CFI Applicants. More information about NHCarePath and ServiceLink can be found by visiting: <http://www.servicelink.nh.gov/index.htm>. NHCarePath and ServiceLink are administered by NH DHHS.

Individuals must qualify for long term care under State Statute RSA 151:E, available for review at: <http://www.gencourt.state.nh.us/rsa/html/XI/151-E/151-E-mrg.htm> and He-E 801, the State Administrative Rule which establishes standards and procedures for the determination of eligibility, the development of a plan of care, and the provision and monitoring of services, for people who are found to be Medicaid Eligible and meet the NF level of care.

The State has defined within this waiver a range of home and community-based services which support waiver participants. Individuals and/or their legal representative work with case managers and the State to identify, through a person-centered planning process, those specific services and supports offered under this waiver that are needed to avoid placement and allow choice of setting.

Adults participating in the CFI Program must be age 18 or older and meet certain financial and clinical eligibility requirements. To be determined financially eligible to participate in the CFI program a person will need to complete the Medicaid application. Once the Medicaid application is completed, applicants have supplied the necessary verification information, and have been interviewed by DHHS financial eligibility will be determined. To be determined clinically eligible to participate in the CFI program, applicants will need to undergo a medical assessment. The Bureau of Elderly and Adult Services will determine if applicants meet the clinical requirements for nursing facility level of care. The assessment focuses on the applicant's ability to perform activities of daily living such as eating, bathing, dressing and the criteria found in RSA 151 E:3 related to medical monitoring; restorative nursing need or medication administration. Once an applicant is found eligible for CFI services and have chosen to participate in the program, participants will be assigned a CFI Case Manager, either based on preference or the availability of a CFI Case Management Agency in the participant's geographic area. Once a CFI Case Manager has been assigned participants will receive a letter from DHHS and a representative of the CFI Case Management Agency will reach out to the participant to begin the development of person centered plan. The CFI Case Manager will also assist with arranging supports and services with enrolled CFI providers, based on the participant's goals, preferences and support needs.

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

When a nursing facility resident indicates an interest in community based services and supports, the nursing facility completes and submits a Section Q referral to the local ServiceLink office. ServiceLink staff provide the resident with information regarding home and community based supports and offer guidance and Person Centered Options Counseling as well as support with the CFI Waiver Application Process.

Some of the supports that the CFI Program could provide to an individual include (but are not limited to):

- In-home services to assist with eating, bathing, dressing and other personal care tasks, as well as general assistance with household tasks and preparation of nutritious meals.
- Medical equipment and home modifications to support independence

- Non-medical transportation
 - Participant-directed and managed services
 - Respite care
 - Supported employment
- (Continued in B. Optional field)

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

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

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita

expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee

schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

The State provided public notice in accordance with 42 CFR §447.205. Access to the full waiver was made available both electronically (via BEAS Website) and hard copy. Newspaper advertisement in two statewide newspapers [NH Union Leader on 10/31/2021 and Nashua Telegraph 10/31/2021 and via postings to the BEAS website (10/29/2021) of the formal public input process. Notification was provided directly to stakeholders via email (10/31/21).

The Bureau of Elderly and Adult Services (BEAS) provided public notice opportunity for public comment for the Choices for Independence Waiver renewal from 11/1/21-12/2/21. Forums were held via Zoom, due to Covid-19, on 11/16/21, 11/18/21, 11/22/21, and 12/1/21. Feedback was received and captured during the forums as well as via written submission. A complete summary of the comments received can be found at:

<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/cfi-waiver-comment-response.pdf>.

BEAS received comments and feedback regarding the following waiver areas:

Telehealth

Appropriateness for each service; General Support

Participant Directed and Managed Services

Questions on workgroup and partnership with Bureau of Developmental Services; Licensing requirements for certain PDMS services; what services will be included; Provider qualifications.

Use of Service Authorizations

Whether MMIS is still needed for entering Service Authorizations

Quality Assurance Eligibility Processing Timeframes

Question on how BEAS measure performance of eligibility processing

Institution for Mental Disease

Questions on Institution of Mental Disease Exclusion

Medical Eligibility Assessment

Comment on Medical Eligibility Assessment (MEA) capturing all impairments

Adult Day

Comment on licensure; Question on difference between state plan and CFI; concerns about telehealth delivery

Home Health Aide

Question on definition; Question on difference between state plan and CFI

Non-Emergency Medical Transportation

Question on whether waiver can cover Non-emergency medical transportation

Relatives as Providers

Question about relatives serving as providers for homemaker services

Personal Care

Question on when personal care providers may provide skilled services.

Respite

Comment on lack of available providers

Supported Employment

Comment on lack of available providers; question on kinship care

Financial Management Services

Question on prerequisites for enrollment; Question on acute care setting

Adult Family Care

Comment on number of people allowed to be living in the household

Community Transitions

Question on service limit and definition.

Environmental Accessibility Services

Question on vehicle modification; comment on relative ownership of a vehicle

Home Delivered Meals

Comment on service in adult family care

In-Home Services

Question on acute care setting

Non-Medical Transportation

Question on whether waiver can cover non-medical transportation with participant's vehicle

Personal Emergency Response Systems

Comment on wearable devices; question on medication dispensers

Residential Care Facility Services

Comments on cost of room and board; Comments on waiver of case management for retroactive coverage of Residential Care Facility services

Skilled Nursing

Comments on definition; Comments on access to services

Specialized Medical Equipment Services

Question on shelf life; Comment on bidding requirements

Supported Housing Services

Concerns on individual provider;

CFI Service Rates

Comments on service rates

CMA Contingency Planning

Comments on contingency planning requirements

Dementia Specific Case Management

Comment on dementia specific case management

Requests for Additional Services

Request for pet care coverage; Request for caregiver coaching coverage

Removable Prosthodontic Services Public Input:

The State provided public notice in accordance with 42 CFR §447.205. The Bureau of Elderly and Adult Services (BEAS) provided public notice of opportunity for public comment for the Choices for Independence Waiver Removable Prosthodontic Services from 11/9/22 - 12/9/22. Access to the full waiver amendment was made available both electronically (via BEAS Website) and hard copy. Newspaper advertisement in two statewide newspapers [NH Union Leader on 11/6/22 and Nashua Telegraph 11/6/22] and via postings to the BEAS website were made of the formal public input process. In addition, a forum was held in-person and via Zoom on 11/30/2022. BEAS received one request for a hard copy of the waiver amendment. During the forum, BEAS received one question: Does an individual need to have Medicare in order to access Removable Prosthodontic Services.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a

Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name:

Lipman

First Name:

Henry

Title:

State Medicaid Director

Agency:

NH Department of Health and Human Services, DHHS

Address:

129 Pleasant Street

Address 2:

City:

Concord

State:

New Hampshire

Zip:

03301-3857

Phone:

(603) 271-9434 Ext: TTY

Fax:

(603) 271-5166

E-mail:

henry.lipman@dhhs.nh.gov

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

Last Name:

Aultman

First Name:

Wendi

Title:

Agency: Bureau Chief

Address: Bureau of Elderly and Adult Services

Address 2: 105 Pleasant Street

City: Concord

State: New Hampshire

Zip: 03301-3857

Phone: (603) 271-9068 Ext: TTY

Fax: (603) 271-4643

E-mail: wendi.aultman@dhhs.nh.gov

8. Authorizing Signature

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

Signature: Jessica Gorton

State Medicaid Director or Designee

Submission Date: Mar 7, 2023

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

Last Name: Gorton

First Name: Jessica

Title: HCBS Waiver Administrator

Agency: Division of Long Term Supports and Services, Bureau of Developmental Services

Address: 105 Main Street

Address 2:

City:

State:

New Hampshire

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

Attachments**Attachment #1: Transition Plan**

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

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

Reducing the unduplicated count of participants (Factor C).

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

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

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

Specify the transition plan for the waiver:

Capitation amounts for services noted in the approved waiver have been lifted or modified to offer greater flexibility and increased coverage. Several covered service definitions have been refined and expanded as noted in Appendix C. Administrative Rules, policies, procedures, and notices will be updated as necessary upon CMS approval.

To ensure a smooth transition, participants will be notified in public comment sessions, via power point, of the limits lifted and service definition refinements.

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

Given CMS approval, assessment based person centered comprehensive care planning sessions will include the appropriate covered services which will meet the individual's needs.

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

Fair Hearing: The comprehensive plans of care have attachments for guardian's signature that outline the process for requesting a fair hearing.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state has submitted a statewide HCB Settings Transition Plan to CMS, NH's plan demonstrates that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6) and that this submission is consistent with the portions of the statewide HCB settings transition plan that are applicable to this waiver.

New Hampshire's Statewide Transition Plan has four main components:

1. Identification – review of existing state standards, policies, regulations, and statute to determine state level changes that are needed to align with the federal requirements.
2. Assessment – Development, implementation and validation of assessments completed by providers and participants.
3. Remediation – Development of a comprehensive, statewide transition plan based on assessment results.
4. Outreach and Engagement – Engagement of stakeholders in the transition plan process.

The state has received initial approval of its plan and continues to work with CMS in obtaining final approval. In the meantime, NH continues implementation of the goals identified in the plan to ensure that all settings are in compliance by the deadline. The statewide efforts include a 16 member Advisory Task Force, which includes individuals/guardians and family members to monitor and support the development and progress of the transition plan.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The following is continued from Main 2. Program Description:

Temporary provision of services in acute care hospitals, based on an individual's needs has been added to this Waiver as identified in Appendix C. All Home and Community Based Services in this Waiver are not duplicative of services available in the acute hospitals. Services that may be temporarily provided in acute hospitals include: Personal Care, Respite, Supported Employment, Financial Management Services, Participant Directed and Managed Services, Community transition services, Environmental accessibility services, In-Home Services, Homemaker services, Personal Emergency Response System (PERS), Specialized Medical Equipment Services and Removable Prosthodontic Services. These services are provided to meet needs of the individual that are not met through the provision of acute care hospital services; Are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide; Will be identified in the individual's person-centered comprehensive care plan; and Will be used to ensure smooth transitions between acute care hospitals and community-based settings and to preserve the individual's functional abilities.

Financial Management Services (FMS) is a monthly service to allow participants to manage and direct their own services. FMS is allowed in acute settings in that the participant can still have FMS assist with PDMS while the individual is in a hospital or other acute setting

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

The provision of Home and Community Based Services via telehealth will be reviewed by the CFI Case Manager. Telehealth as a method of service delivery will be allowable for as long as it meets the need of the individual. As indicated in the service definition, telehealth is an available method of service delivery to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered comprehensive care plan.

The Bureau of Elderly and Adult Services will incorporate Telehealth into DHHS Administrative rules upon approval of the CFI Waiver.

The provision of remote services will be outlined in the individualized comprehensive care plan. The comprehensive care plan will identify how the services are delivered in a way that respects the privacy of the individual and will include consideration of the Waiver participant's privacy expectations with respect to the location where they will participate in the service via telehealth. The person-centered planning process will determine where the devices will be stored when not in use. The person-centered planning process will review the protocols necessary to prepare and participate in services via telehealth as well as the steps to end the service, including disconnecting from the telehealth service and storing of devices. Telehealth is not a method of service delivery that is available to services that require hands on assistance.

The following services may be provided through telehealth: Adult Day, Supported Employment, Financial Management Services, Components of Participant Directed and Managed Services, and Skilled Nursing.

BEAS will create and implement a Telehealth Checklist. The Telehealth Checklist will be completed by 10/2/2022. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a telehealth method of service delivery. If the Waiver participant's needs cannot be met via telehealth services because physical, in-person assistance is required to support the Waiver participant, then telehealth services shall not be an option and in-person service delivery will be the method of service delivery. This will ensure that services are delivered in the amount, frequency and duration that is identified in the service agreement. This determination may be made per service. The Telehealth Checklist will include consideration of the percentage of time that telehealth service provision will be utilized. The amount of time chosen shall be determined during the person centered planning process and outlined in the individual comprehensive care plan. The telehealth checklist will include consideration of the Waiver participant's privacy expectations with respect to the location where they will participate in the service via telehealth and where the devices will be stored when not in use. The Checklist will also outline the protocols necessary to prepare and participate in services via telehealth as well as the steps to end the service, including disconnecting from the telehealth service and storing of devices. The Telehealth Checklist will include a contingency plan that identifies the steps if there is a connectivity or device problem during services and who to notify when support is needed. BEAS does not have the ability to remotely activate or view

cameras in the participant’s device.

The Case Manager will complete the Telehealth Checklist during the person centered planning process in order to aid in the development of the annual individual comprehensive care plan, as well as during the monitoring activities required by He-E 805. Telehealth service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires and He-E 805 is updated.

The Telehealth Checklists completed at the initial comprehensive care plan meeting and at the monitoring meetings will be reviewed by the State as a part of the annual service file review. This review will ensure that appropriate considerations of Waiver participants’ health and safety were part of the person-centered planning process and were reviewed. The review will also ensure that Waiver participants’ services were delivered in the same amount, frequency and duration that was identified in the annual comprehensive care plan, regardless of the method of service delivery chosen.

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

The following is continued from B-3-a:

The projected numbers in this section, for WY1, were derived by using actual 372 Unduplicated Count for FY14-19. These actual Unduplicated Counts were used to calculate an average trend, for FY2014 through FY2019, of 4.7%. This trend was used to project FY20-26, as shown below.

CFI Waiver Renewal FY22-26

WY	Fiscal Year	Projected Undup Participants
1	FY22	4,952
2	FY23	5,185
3	FY24	5,429
4	FY25	5,684
5	FY26	5,951

The following is continued from E-1-n:

The projected numbers in this sections, for WY1-WY5,were updated to mirror the current CMS-approved CFI Waiver WY1-5 due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served. See below:

WY	Fiscal Year	"Projected Undup Count of PDMS E-1-n"
1	FY22	80
2	FY23	125
3	FY24	173
4	FY25	270
5	FY26	280

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

*(Do not complete item A-2)***Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

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

*(Complete item A-2-a).***The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

The NH Department of Health and Human Services (DHHS) is the single state Medicaid agency. As required by RSA 151-E, DHHS has adopted administrative rules, He-E 801 (Choices for Independence), and He-E 805 (Targeted Case Management) which direct the Department's administration of the waiver program.

The BEAS Bureau Chief reports to the Director of the Division of Long Term Supports and Services (DLTSS). Frequent and ongoing communications occur between the State Medicaid Director and the Director of DLTSS.
Online References:

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

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

The Bureau of Elderly and Adult Services:

- a) Negotiates and monitors contracts with the Assessing Services Agency and the Case Management Agency where roles and responsibilities are outlined.
- b) Requires the Assessing Service Agency and Case Management Agencies to submit monthly and /or quarterly reports. These reports: 1) aid in monitoring performance deliverables outlined in the contract;

Methods employed in the oversight of performance include:

- a) Develop program and reimbursement policy related to the waiver.
- b) Coordinate activities and policy related to nursing facility services with waiver policy and procedures.
- c) Manage the MMIS system that handles waiver claims.
- d) Review and approve all communications with CMS, including evidence reports, waiver renewals and annual 372 reports.

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

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

Appendix A: Waiver Administration and Operation

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

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

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

- 1.) DHHS contracts with Conduent to screen and enroll Medicaid Providers and to manage the state's MMIS.
- 2.) DHHS contracts with ServiceLink Resource Centers, New Hampshire's Aging and Disabilities Resource Centers, to provide information, referral, application support and options counseling for LTSS, including CFI Waiver Applicants. NHCarePath, of which ServiceLink is a partner, connects people of all ages, income and abilities to a range of information, assistance, and care throughout New Hampshire, from caregiver resources and services for aging, disability and independent living to counseling and financial planning tools. NHCarePath also connects individuals to statewide partners that provide services and supports, including:
 - Area Agencies offering developmental services
 - Community Mental Health Centers
 - Department of Health and Human Services (DHHS)
 - ServiceLink
- 3.)DHHS utilizes, in addition to DHHS state staff, a contracted agency to complete state approved clinical assessment tools and level of care determinations per RSA –E:3 II. Evaluators must meet criteria for skilled professional medical personnel.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

Check each that applies:

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the

state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Bureau of Elderly and Adult Services utilizes the Department's Division of Program Quality and Integrity to assess the performance of NH Medicaid Enrolled Providers and to monitor for fraud, waste and abuse.

Additional ongoing assessments are performed by other entities within the single state Medicaid Agency/Department of Health and Human Services (DHHS) including the Bureau of Licensing and Certification, DHHS Finance Administration, and Utilization Review Services.

Appendix A: Waiver Administration and Operation

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

NH DHHS employs state staff who are specifically designated to oversee the performance of each entity performing waiver operational and administrative functions. Designated state staff work in partnership with the Department's Division of Program Quality and Integrity to assess the qualifications of and performance of non-state entities.

BEAS meets with contractors monthly respectively for the purpose of evaluating contract performance deliverables and measures, determining any needed remediation, and assisting in the development of remediation plans if necessary.

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

Operational performance and time frames are displayed on New Heights Dashboard for BEAS to monitor daily and prioritize tasks and workflow.

Contract metrics are monitored quarterly. Any noncompliance with a contracted metric can lead to corrective action, liquidated damages, and/or termination of the contract.

A representative sample of participant records are reviewed by CFI Case Management Agencies quarterly to evaluate the delivery of services identified in the comprehensive care plan to ensure that participants' needs are being met in the community, including the type, scope, amount, duration, and frequency of services. Upon CMS approval of the CFI Waiver, CFI Case Management Agency Quarterly Quality Management reports will be sent to the Bureau of Elderly and Adult Services each quarter for Monitoring. Administrative Rule He-E 805 will be updated to reflect this.

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment			

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of CFI Waiver Provider organizations with a standardized, state approved Medicaid Provider Agreement in place. N: Number of CFI Waiver Provider organizations with a standardized state approved Medicaid Provider Agreement in place D: Number of CFI Waiver Provider organizations"

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually	Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

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

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

The number and percent of members determined eligible for the waiver who are not put on a waitlist for a Waiver opening. **N:** Number members determined eligible for the waiver who are not put on a waitlist for a Waiver opening. **D:** Number of members determined eligible for the Waiver.

Data Source (Select one):

Other

If 'Other' is selected, specify:

New Heights

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of entities that provide Case Management to CFI Waiver participants who have a signed agreement with the state. **N:** Number of CFI Waiver case Management Agencies with a signed agreement. **D:** Number of CFI Waiver Case Management Agencies reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

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

NH DHHS employs state staff who are specifically designated to oversee the performance of each entity performing waiver operational and administrative functions. Designated state staff work in partnership with the Department's Division of Program Quality and Integrity (DPQI) to assess the qualifications of and performance of non-state entities.

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

Operational performance and time frames are displayed on New Heights Dashboard for BEAS to monitor daily and prioritize tasks and workflow.

Contract metrics for all contracted agencies are monitored quarterly. Any noncompliance with a contracted metric can lead to corrective action, liquidated damages, and termination of the contract.

BEAS provides contract oversight and deliverable monitoring. When problematic trends are suspected or confirmed, BEAS will escalate to the NH DHHS Division of Program Quality and Integrity and engaged to conduct a quality assurance review; the results of the quality assurance review are documented and suggested remediation strategies are shared within the Department and with involved providers/provider groups. Annual follow up is conducted to evaluate the effectiveness of the strategies implemented.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	65		
		Disabled (Physical)	18	64	
		Disabled (Other)	18	64	
Aged or Disabled, or Both - Specific Recognized Subgroups					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

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

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

Not applicable. There is no maximum age limit

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (select one)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4952
Year 2	5185
Year 3	5429
Year 4	5684

Waiver Year	Unduplicated Number of Participants
Year 5	5951

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

Selection of entrants to the waiver is in accordance with for the following:

- 1.)state administrative rule He-E 801, which is entitled Choices for Independence Program.
- 2.)NH RSA 151-E:3, 4, which is titled Long-Term Care

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

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

No

Yes

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

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

Low income families with children as provided in §1931 of the Act

SSI recipients

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

Optional state supplement recipients

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

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in

§1902(a)(10)(A)(ii)(XIII) of the Act)

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

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

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

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

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

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

Specify:

Other: Individuals eligible under section 1902(a)(10)(A)(i)(VIII) (42 CFR 435.119) in New Hampshire called Granite Advantage.

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

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

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

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

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

(select one):

The following standard under 42 CFR §435.121

Specify:

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

All of the participant's gross income

Other

Specify:

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

Not Applicable (see instructions)

The following standard under 42 CFR §435.121

Specify:

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

(select one):

The following standard under 42 CFR §435.121

Specify:

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

All of the participant's gross income.

Other

Specify:

[Empty text box]

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

Not Applicable (see instructions)

The following standard under 42 CFR §435.121

Specify:

[Empty text box]

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

[Empty text box]

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

[Empty text box]

Other

Specify:

[Empty text box]

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

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's

Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

- i. Minimum number of services.**

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

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

The provision of waiver services at least monthly

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

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

DHHS utilizes, in addition to DHHS state staff, a contracted operating agency to complete state approved clinical assessment tools and level of care determinations per RSA 151-E:3 II. the current contractor is Kepro. Skilled professional medical personnel employed by or designated to act on behalf of the department shall determine clinical eligibility for home and community based services.

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

Skilled professional medical personnel as defined in RSA 151-E:3, employed by or designated to act on behalf of the department shall determine clinical eligibility for home and community based services.

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

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

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

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

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

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

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

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

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

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

For Initial Level of Care Evaluations:

Skilled professional medical personnel employed by or designated to act on behalf of the department evaluates the applicant in person and completes the Medical Eligibility Evaluation [MEA] instrument or reviews the information in the current MDS or OASIS.

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

For Re-evaluation of Level of Care:

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

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

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

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

NH DHHS contracts with an outside entity to assist with reevaluations. LOC redeterminations are conducted no less than seven 7 days prior to the anniversary date of the most recent NF LOC determination.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

The Number and Percent of applicants for whom there is a reasonable indication that there may be services needed in the future who received a LOC. N = # of applicants for whom there is reasonable indication that there may be services needed in the future who received a LOC. D = # of applicants for whom there is reasonable indication that services may be needed in the future that were reviewed.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data	Frequency of data collection/generation	Sampling Approach <i>(check each that applies):</i>
----------------------------	---	--

collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of initial level of care determinations made using the processes and instruments described in the approved waiver. N = Number of initial LOC determinations made using the processes and instruments described in the approved waiver D = Total Number of initial LOC determinations made that were reviewed

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach
------------------------------	--------------------------	--------------------------

data collection/generation <i>(check each that applies):</i>	collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

The availability of the assessment information in the New Heights Systems continues to increase accountability for all parties and allows the State the benefit of analyzing data that supports policy direction and change.

Services cannot be approved nor will an authorization be issued if all required documents and eligibility criteria are not provided.

b. Methods for Remediation/Fixing Individual Problems

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

NH DHHS employs state staff who are specifically designated to oversee the performance of each entity performing waiver operational and administrative functions. Designated state staff work in partnership with the Department's Division of Program Quality and Integrity to assess the qualifications of and performance of non-state entities.

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

The Bureau of Elderly and Adult Services has daily access to the assessments in New Heights. BEAS reviews assessment data and reports to assure timely and accurate level of care determinations. Remediation may include a reassessment and change in plan of care, additional evaluator training, and/or payment may be withheld.

ii. **Remediation Data Aggregation**

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

ServiceLink Resource Center Counselors conduct standardized education of each applicant concerning:

1. CFI Waiver services as an alternative to institutional care.
2. The range of long term supports and services.
3. The appeal process if the application is denied.

In addition, prior to the provision of services the following actions occur:

1. Staff performing the functional assessment obtains the applicant's consent and authorization for Medicaid LTC and if eligible, CFI. This is obtained upon initially applying for LTC Medicaid and at each redetermination for LTC services.
2. Applicants are able to choose their CFI Case Management agency or have one assigned to them.

CFI Case Managers are responsible for explaining the participant's options and reviewing the options of agency or participant directed and managed services as well as their choice of enrolled and available providers for CFI.

CFI case managers explain service options available through this waiver as well as the New Hampshire Medicaid State Plan, including institutional setting, community resources, and other alternatives that may be pertinent to the specific situation of the individual is made clear to participants and/or their legal representative. Documentation is maintained in each participant's record of his/her choice of community based services instead of institutional services. This documentation is updated annually in the comprehensive care plan.

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

An individuals comprehensive care plan documents freedom of choice. The comprehensive care plan is stored in the individuals record which is retained by the CFI case management agency.

Appendix B: Participant Access and Eligibility

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

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

State regulation He-E 801 requires informed consent relative to services and service provision. This includes a person centered process for planning and supporting the participant receiving services that builds upon the participant’s capacity to engage in activities that promote community life and honors the participant’s preferences, choices, and abilities, such as language access. Samples of informational brochures in various languages are available.

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

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

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

- a. Pocket-talker: These small, battery-operated devices are used by people who are hard of hearing and make it possible for them to hear the person with whom they are speaking.
- b. CCTV device: This enables magnification of documents for reading by people with low vision.
- c. Videophones: The State Office and the SLRCs have videophones that provide access to video relay services for sign language.
- d. Language Line: The Language Line is available at all DOs and SLRCs and provides translation of all languages for people whose primary language is not English.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Services		
Statutory Service	Home Health Aide		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Respite		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Participant Directed and Managed Services		
Other Service	Adult Family Care		
Other Service	Community Transition Services		
Other Service	Environmental Accessibility Services		
Other Service	Home-Delivered Meals		
Other Service	In-Home Services		
Other Service	Non Medical Transportation		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Removable Prosthodontic Services		
Other Service	Residential Care Facility Services		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Equipment Services (SME)		

Service Type	Service		
Other Service	Supported Employment		
Other Service	Supportive Housing Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services furnished as specified in the plan of care at an Adult Day, in a non-institutional, community-based setting, encompassing both health/medical and social services needed to ensure the optimal functioning of the participant. All Adult Day facilities shall be compliant with the HCBS Settings Rule and will incorporate appropriate non residential qualities of a home and community-based setting as described in 42 CFR §441.301(c)(4)(5).

Adult Day programs provide a protective environment individuals with cognitive impairments or who are at risk for isolation or institutionalization. Services include an array of social and health care services and provides day-time respite for primary caregivers. Services are furnished on a regularly scheduled basis, for one or more days per week. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals a day).

This service may be provided remotely through telehealth as determined necessary by the state to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered comprehensive care plan. BEAS will create and implement a Telehealth Checklist. The Telehealth Checklist will be completed by 10/1/2022. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a telehealth method of service delivery. If the individual requires hands-on assistance, telehealth service delivery shall not be an option. The Telehealth Checklist will include consideration of the percentage of time that telehealth service provision will be utilized. The amount of time chosen shall be determined during the person centered planning process and outlined in the individual service agreement. The CFI Case Manager will complete the checklist during the person centered planning process in order to aid in the development of the annual individual comprehensive care plan, as well as during the monitoring activities required by He-E 805. Telehealth service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

Service limitations are set by the participant's comprehensive plan of care.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Individual

Provider Type:

Adult Medical Day Provider

Provider Qualifications

License (specify):

Adult Medical Day, RSA 151:II2 I.(f) He-P 818

Certificate (specify):

Other Standard (specify):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Adult Medical Day Provider

Provider Qualifications

License (specify):

Adult Medical Day, RSA 151:II2 I.(f) He-P 818

Certificate (specify):

Other Standard (specify):

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

NH Bureau of Licensing and Certification

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Home Health Aide

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Home Health Aide Services are home health aide services for non-acute needs listed in the plan of care which are performed by Licensed Nursing Assistants acting within the scope of the State's Nurse Practice Act.

The differences from the State plan are as follows: Home Health Services in the waiver may be provided by a state licensed Home Health Agency that is not Medicare certified. State plan is to address medically oriented needs and different duration. CFI address long term care needs.

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

Service limitations are set by the participant's comprehensive plan of care.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency licensed by the State under RSA 151:2, for home care services, including out-of-state providers
Individual	Agency licensed by the State under RSA 151:2, for home care services

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Agency licensed by the State under RSA 151:2, for home care services, including out-of-state providers

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

NH Bureau of Licensing and Certification

Frequency of Verification:

Annual, and every 5 years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Home Health Aide

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License (specify):

Agency licensed by the State under RSA 151:2, for home care services, including out-of-state providers
Registered Nurse or Licensed Practical nurse under the supervision of a registered nurse, licensed to practice in the State of NH.

Certificate (specify):

Other Standard (specify):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Services that consist of non-hands-on assistance with general household tasks (e.g. meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

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

Service limitations are set by the participant's comprehensive plan of care.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency licensed by the State under RSA 151:2, for home care services, including out-of-state providers
Individual	Homemaker, including out-of-state providers

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Agency licensed by the State under RSA 151:2, for home care services, including out-of-state providers

Provider Qualifications

License (*specify*):

Home Health, RSA 151:2-b, He-P 809, or He-P 822

Certificate (*specify*):

Other Standard (*specify*):

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

NH Bureau of Licensing and Certification

Frequency of Verification:

Annual, and every five years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Homemaker, including out-of-state providers

Provider Qualifications

License (*specify*):

Home Health, RSA 151:2

Certificate (*specify*):

Other Standard (*specify*):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery and every 5 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided with proper nurse delegation may include skilled or nursing care and medication administration to the extent permitted by state law.

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

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

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

Service limitations are set by the participant's comprehensive plan of care.

The provision of Personal Care in acute care hospitals will be reviewed and requested by the case manager and approved BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies licensed by the State under RSA 151:2 for home care, including out-of-state providers
Individual	Personal Care Provider, including out-of-state providers
Agency	Other Qualified Agencies (OQA), including out-of-state providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Agencies licensed by the State under RSA 151:2 for home care, including out-of-state providers

Provider Qualifications

License (specify):

RSA 151:He-P 809 or He-P 822 or an agency certified under He-P 601

Certificate (specify):

Other Standard (specify):

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

NH Bureau of Licensing and Certification

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Personal Care Provider, including out-of-state providers

Provider Qualifications

License (specify):

[Empty text box for license specification]

Certificate (specify):

[Empty text box for certificate specification]

Other Standard (specify):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When Participant Directed: the individual or his/her representative

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Other Qualified Agencies (OQA), including out-of-state providers

Provider Qualifications

License (specify):

[Empty text box]

Certificate (*specify*):

RSA 161-I, OQA certification, He-P 601

Other Standard (*specify*):

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS certifies OQAs

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

[Empty text box]

HCBS Taxonomy:

Category 1:

[Empty text box]

Sub-Category 1:

[Empty text box]

Category 2:

[Empty text box]

Sub-Category 2:

[Empty text box]

Category 3:

[Empty text box]

Sub-Category 3:

[Empty text box]

Service Definition (*Scope*):

Category 4:

[Empty text box]

Sub-Category 4:

[Empty text box]

In accordance with He-E 801, Respite Services consist of the provision of short-term care for participants unable to care for themselves because of the absence or need for relief of those persons who live with and normally provide care for the participant. Respite services can be provided in or out of the participant's home.

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

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

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

Service limitations are set by the participant's comprehensive plan of care.

When respite is provided as a service in a Participant Directed and Managed Service (PDMS) program, the total respite shall not exceed 20% of the overall PDMS budget.

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

The provision of Respite in acute care hospitals will be reviewed and requested by the CFI case manager and approved by BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies certified by the State as Other Qualified Agencies, including out-of-state providers
Agency	Agencies licensed by the State under RSA 151:2 for home care, including out-of-state providers
Agency	Facilities licensed by the State to provide Residential Care Services
Individual	Respite Provider
Agency	Facilities licensed by the State as Nursing Facilities

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Agencies certified by the State as Other Qualified Agencies, including out-of-state providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Provider Type:

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Facilities licensed by the State to provide Residential Care Services

Provider Qualifications

License (specify):

Residential care, RSA 151:2

Certificate (specify):

Other Standard (specify):

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Respite Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When Participant Directed: the individual or his/her representative

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Facilities licensed by the State as Nursing Facilities

Provider Qualifications

License (*specify*):

Nursing Facilities, RSA 151:2

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Health Facilities Licensing

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

Financial management services include employer functions such as assisting the participant to verify worker citizenship status, ensure criminal record and/or state or federal registry status is checked and confirmed, and process payroll. Budget management services include maintaining a separate account for each participant's budget; track and report participant funds, disbursements and the balance of participant funds; process and pay invoices for goods and services approved in the service plan.

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

This service may be provided remotely through telehealth as determined necessary by the state to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BEAS will create and implement a Telehealth Checklist. The Telehealth Checklist will be completed by 10/1/2022. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a telehealth method of service delivery. If the individual requires hands-on assistance, telehealth service delivery shall not be an option. The Telehealth Checklist will include consideration of the percentage of time that telehealth service provision will be utilized. The amount of time chosen shall be determined during the person centered planning process and outlined in the comprehensive care plan. The CFI case manager will complete the checklist during the person centered planning process in order to aid in the development of the annual comprehensive plan of care. Telehealth service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

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

Service limitations are set by the participant's comprehensive plan of care.

The provision of Supported Employment in acute care hospitals will be reviewed and requested by the case manager and approved BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services Provider, including out-of-state providers
Individual	Financial Management Services Provider, including out-of-state providers

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Financial Management Services Provider, including out-of-state providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrollment as a NH Medicaid FMS Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment with NH Medicaid and every 5 years after.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Individual

Provider Type:

Financial Management Services Provider, including out-of-state providers

Provider Qualifications

License (specify):

[Empty text box]

Certificate (specify):

[Empty text box]

Other Standard (specify):

Enrollment as a NH Medicaid FMS Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When participant directed and managed: the individual or his/her representative

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Participant Directed and Managed Services

HCBS Taxonomy:

Category 1:

[Empty text box]

Sub-Category 1:

[Empty text box]

Category 2:

[Empty text box]

Sub-Category 2:

[Empty text box]

Category 3:

[Empty text box]

Sub-Category 3:

[Empty text box]

Category 4:

Sub-Category 4:

Service Definition (Continued)

Participant Directed and Managed Services (PDMS) allow CFI waiver participants to direct and manage a menu of any CFI waiver service, except for residential care facility services in accordance with He-E 801. PDMS allows the participant to design the services that will be provided, select service providers, decide how authorized funding is to be spent base on the needs identified in the participant's comprehensive care plan, and perform ongoing oversight of the services provided.

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

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

The participant may engage a legal representative to assist with participant direction and management.

This service may be provided remotely through telehealth as determined necessary by the state to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BEAS will create and implement a Telehealth Checklist. The Telehealth Checklist will be completed by 10/1/2022. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a telehealth method of service delivery. If the individual requires hands-on assistance, telehealth service delivery shall not be an option. The Telehealth Checklist will include consideration of the percentage of time that telehealth service provision will be utilized. The amount of time chosen shall be determined during the person centered planning process and outlined in the comprehensive care plan. The CFI case manager will complete the checklist during the person centered planning process in order to aid in the development of the annual comprehensive plan of care. Telehealth service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

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

Service limitations are set by the participant's comprehensive plan of care.

The provision of Participant Directed and Managed Services in acute care hospitals will be reviewed and requested by the case manager and approved BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant Directed and Managed Services
Agency	Participant Directed and Managed Services

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Participant Directed and Managed Services

Provider Category:

Individual

Provider Type:

Participant Directed and Managed Services

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When participant directed and managed: the individual or his/her representative

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Participant Directed and Managed Services

Provider Category:

Agency

Provider Type:

Participant Directed and Managed Services

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When participant directed and managed: the individual or his/her representative

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Family Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Participant service option for eligible participants under the CFI waiver program, which includes a combination of personal care, homemaking, and other services that are provided in a certified (as required by law) private home by a principal care provider who lives in the home or the CFI waiver participant’s relative who lives in the home in accordance with a person-centered plan.

There shall be no more than 2 unrelated individuals receiving Adult Family Care services living in the home. Separate payment shall not be made for homemaker services to participants receiving Adult Family Care (AFC), as those services are integral to and inherent in the provision of AFC.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Adult Family Care Provider
Agency	AFC Providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Family Care

Provider Category:

Provider Type:

Provider Qualifications

License (specify):

[Empty text box]

Certificate (specify):

[Empty text box]

Other Standard (specify):

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

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When participant directed: the individual of his/her representative

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Family Care

Provider Category:

Agency

Provider Type:

AFC Providers

Provider Qualifications

License (specify):

RSA 151:2

Certificate (specify):

RSA 151:9 He-P 813

Other Standard (specify):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annual, and every 5 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Non-recurring expenses to enable a person to establish a basic household that does not constitute room and board and may include:

Security deposits that are required to obtain a lease on an apartment or house;

Set-up fees or deposits for utility or service access, including telephone, electricity, heat, and water;

Items required to occupy and use a community domicile, such as essential household furnishings, window coverings, household appliances needed for basic food preparation, and bed and bath linens; and

Services necessary for the participant’s health and safety, such as pest eradication, and one-time cleaning done prior to occupancy.

Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community transition services shall not include monthly rent or mortgage payments, food, monthly utility expenses, or costs for household appliances or items that are intended for entertainment, recreational or diversional purposes or use.

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

(A) Identified through the service plan development process;

(B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;

(C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

(D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual’s functional abilities.

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

Services must be prior authorized by DHHS and are limited to \$3,000/person per transition. This limit is independent of other service limits. The payment of security deposit is not considered rent.

Community Transition Services are one time services and represent one time costs and is this limited to individuals moving from institutional / provider operating locations to private homes. An individual may be able to exceed this cap on a case by case basis with the prior approval of BEAS. A prior authorization for the amount requested above the service limit cap must include supporting documentation, identify need, and correlate to the person centered comprehensive care plan.

The provision of Supported Employment in acute care hospitals will be reviewed and requested by the case manager and approved BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Transition Services

Provider Category	Provider Type Title
Agency	CFI Waiver Medicaid Enrolled Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

Community Transition Services

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When Participant Directed: the individual or his/her representative

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

CFI Waiver Medicaid Enrolled Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Continued)

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

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies, and services necessary for the participant's health and safety, such as pest eradication, and related cleaning.

Excluded are those adaptations or improvements to the home, which are of general utility that are not of direct medical or remedial benefit to the individual.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.(e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

All modifications will be provided in accordance with applicable State or local building codes.

Relative to vehicle modification, the following are excluded: Those adaptations or improvements to a vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; purchase or lease of a vehicle; and regularly scheduled upkeep and maintenance of a vehicle with the exception of upkeep and maintenance of the modifications.

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

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

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

Services must be prior authorized by DHHS.

For individuals with unsafe wandering and running behaviors, outdoor fencing may be provided under this waiver. Waiver funds allocated toward the cost of such a fence shall not exceed \$2,500 which can provide approximately 3,500 square feet of a safe area. An individual may be able to exceed this cap on a case by case basis with the prior approval of BEAS. A prior authorization for the amount requested above the service limit cap must include supporting documentation, identify need, and correlate to the person centered comprehensive care plan.

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services unless the provider is a relative of the participant.

The provision of Environmental and Vehicle Modifications in acute care hospitals will be reviewed and approved by BEAS and the CFI Case Manager. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Provider, including out-of-state providers
Individual	Environmental Accessibility provider, including out-of-state providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Services

Provider Category:

Agency

Provider Type:

Environmental Accessibility Provider, including out-of-state providers

Provider Qualifications

License (specify):

As required by state law or local ordinance

Certificate (specify):

As required by state law or local ordinance

Other Standard (specify):

NH Medicaid enrolled provider
Permits relative to state and/or local building codes

Verification of Provider Qualifications

Entity Responsible for Verification:

NH Enrolled Medicaid Provider

Frequency of Verification:

Upon enrollment and When environmental modifications are requested, the qualifications of the provider will be verified.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Services

Provider Category:

Individual

Provider Type:

Environmental Accessibility provider, including out-of-state providers

Provider Qualifications

License (*specify*):

As required by state law or local ordinance

Certificate (*specify*):

As required by state law or local ordinance

Other Standard (*specify*):

Permits relative to state and/or local building codes

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

When environmental modifications are requested, the qualifications of the provider will be verified.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home-Delivered Meals

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Continue)

The delivery of nutritionally balanced meals to the participant’s home; and

Concurrent with meal delivery, monitoring of the participant’s well-being, and the reporting of emergencies, crises, or potentially harmful situations shall be made to emergency personnel or the participant’s case manager, as appropriate.

All home-delivered meals shall:
 Include at least one-third of the dietary reference intakes, established by the U. S. Department of Agriculture for dietary reference intakes as specified in the United States Department of Agriculture’s most recent “Dietary Guidelines for Americans”.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	All qualified nutrition providers, including out-of-state providers

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

NH Medicaid Enrolled;
 Contracted to provide home delivered meals as part of the Older Americans Act; and
 Ability to provide meals to meet dietary needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Improvement and Quality
 DHHS Bureau of Elderly and Adult Services

Frequency of Verification:

Upon enrollment as a NH Medicaid Provider and every 5 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

In-Home Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Non-medical care, supervision and socialization provided to isolated individuals to prevent institutionalization. When specified in the comprehensive care plan, service includes: Meal preparation, light housekeeping, laundry and shopping which are essential to the health and welfare of the participant.

In-home services do not include hands-on care. Home health agencies that provide this service are not required to be certified to provide Medicare services.

In-home care shall not be covered when provided to a participant receiving residential care facility services.

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

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

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

Service limitations are set by the participant's comprehensive plan of care.

The provision of In-Home Services in acute care hospitals will be reviewed and requested by the case manager and approved BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: In-Home Services

Provider Category:

Individual

Provider Type:

Adult in Home Care Provider, including out-of-state providers

Provider Qualifications

License (specify):

[Empty text box]

Certificate *(specify):*

[Empty text box]

Other Standard *(specify):*

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: In-Home Services

Provider Category:

Agency

Provider Type:

Agency licensed by the State under RSA 151:2, for home care services, including out-of-state providers

Provider Qualifications

License *(specify):*

[Empty text box]

Certificate *(specify):*

Home Health or Homemaker RSA 151:2-b and either He-P 809 or He-P 822, or RSA 161-I and He-P 601.

Other Standard *(specify):*

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Health Facilities Licensing

Frequency of Verification:

Upon enrollment as a NH Medicaid provider and every 5 years after.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non Medical Transportation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Transportation services are designed specifically to improve the CFI participants ability to access community activities within their own community in response to needs/choices identified through the individual's person centered comprehensive care plan. Transportation services can include, but are not limited to:

1. Payment for transportation under the waiver needed to access a waiver service included in the participant's service plan or access to other activities and resources identified in the service plan.
2. Transportation provided to enable participants to access the community when personal care services are required to do so as articulated in the comprehensive care plan.
3. Transport for safe movement from one place to another;
4. Travel training such as supporting the individual in learning how to access and use informal and public transport for independence and community integration;
5. Transportation service provided by different modalities, including; public and community transportation, taxi services, transportation specific to prepaid transportation cards, mileage reimbursement, volunteer transportation, and non-traditional transportation providers, and
6. Prepaid transportation vouchers and cards.
7. Parking and toll fees

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

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

Non-Medical Transportation is capped at \$1,000 annually.

The Bureau of Elderly and Adult Services Administrator reserves the right to approve requests that exceed the cap on a case by case basis. Proof of this need to exceed the cap will be required upon request to the Bureau of Elderly and Adult Services.

The following services shall not be covered as non-medical transportation:

Transportation to or from medical appointments; and

Transportation provided to a participant receiving residential care facility services.

The prohibition on use of a participant's vehicle shall not preclude a licensed provider from using a participant's vehicle in offering another authorized service, such as personal care services.

Providers will provide proof of insurance in accordance with state laws and regulations, complete all required registry checks, and have a completed driving record check. Youth under the age of 16 shall not be reimbursed for public transportation expenses.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Non Medical Transportation Provider, including out-of-state providers

Provider Category	Provider Type Title
Agency	Non Medical Transportation Provider, including out-of-state providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non Medical Transportation

Provider Category:

Individual

Provider Type:

Non Medical Transportation Provider, including out-of-state providers

Provider Qualifications

License (specify):

Valid Drivers License

Certificate (specify):

Other Standard (specify):

Valid Vehicle Inspection Sticker

Providers will provide proof of insurance in accordance with state laws and regulations, complete all required registry checks, and have a completed driving record check. Youth under the age of 16 shall not be reimbursed for public transportation expenses.

Verification of Provider Qualifications

Entity Responsible for Verification:

When participant directed, the individual or his/her designee.

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non Medical Transportation

Provider Category:

Agency

Provider Type:

Non Medical Transportation Provider, including out-of-state providers

Provider Qualifications

License (specify):

RSA 151:2 and He-P 809, He-P 822
 RSA 161-I and He-P 601

Certificate (*specify*):

Other Standard (*specify*):

In addition to required licensed providers, Agencies under contract to provide services, which include the provision of transportation, funded by the Older Americans' Act or the Social Services Block Grant.

Verification of Provider Qualifications

Entity Responsible for Verification:

NH Bureau of Licensing and Certification for He-P 809 and 822
 NH Bureau of Elderly and Adult Services for He-P 601 and contracted providers

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Covered):

Smart technology including electronic devices that enable participants at risk of institutionalization to summon help in an emergency. Covered devices include wearable or portable devices that allow for safe mobility, response systems that are connected to the participant’s telephone and programmed to signal a response center when activated, staffed and monitored response systems that operate 24 hours/day, seven days/week and any device that informs of elopement such as wandering awareness alerts. Other covered items include seat belt release covers, ID bracelets, GPS devices, monthly expenses that are affiliated with maintenance contracts and/or agreements to maintain the operations of the device/item.

This service is assists CFI participants who live alone, live only with someone in poor or failing health, or who are alone at home for 8 hours or more per day and who are:

Ambulatory and at risk of falls as assessed by a physician, registered nurse or occupational or physical therapist; or

Identified as at risk of having a medical emergency as identified in the comprehensive care plan; and

Would require ongoing supervision if the PERS were not provided.

Devices can be an option to consider as a part of a multifaceted safety plan, specific to a participant's unique needs.

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

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

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

The provision of Personal Emergency Response Services in acute care hospitals will be reviewed and approved by BEAS and the CFI Case Manager. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency response system providers, including out-of-state providers
Individual	Emergency response system providers, including out-of-state providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Emergency response system providers, including out-of-state providers

Provider Qualifications

License (specify):

As required by state law or local ordinance.

Certificate (specify):

As required by state law or local ordinance.

Other Standard (specify):

NH Medicaid Enrolled Provider of Emergency Response Services

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery and every 5 years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System (PERS)

Provider Category:

Individual

Provider Type:

Emergency response system providers, including out-of-state providers

Provider Qualifications

License (specify):

As required by state law or local ordinance.

Certificate (specify):

As required by state law or local ordinance.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery and periodically thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Removable Prosthodontic Services

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11070 dental services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Removable Prosthodontic Services under this waiver are limited to the provision of dentures, routine post-delivery care and other associated procedures connected to the prosthodontic service that are not included in the New Hampshire Medicaid State Plan, "Adult Dental Services".

Removable Prosthodontic Services are intended to assist individuals as a means to prevent functional limitations in order to support community integration and avoid isolation or institutionalization and when, if not otherwise provided:

- The individual's health would be compromised through reduced food options and result in restrictive nutritional intake, impacting overall health; and/or
- When considerations interfere with supported employment or social development. For example, an individual who has a severe dental deformity may receive treatment if during person-centered-planning, it is determined that provision of dentures would enhance the individual's opportunities for community integration.

Covered services include:

- Complete Dentures, including immediate prosthetic appliances and routine post-delivery care
- Partial Dentures, including immediate prosthetic appliances and routine post-delivery care
- Adjustments to dentures
- Repairs to complete and partial dentures
- Denture rebase procedures
- Denture relining procedures

Removable Prosthodontic Services must be rendered by a qualified provider through the approved Prepaid Ambulatory Health Plan (PAHP), as outlined in the associated Provider Qualifications section for this service.

Services provided through this waiver are intended to support those services that exceed the New Hampshire Medicaid State Plan coverage for fitting, maintenance and other services associated with the removable prosthodontic item.

If this service was selected to support community integration and prevent isolation, the decision to select this service shall be made by the individual and guardian, as applicable, during the person-centered planning process. All treatment notes, radiographic images, laboratory prescriptions and laboratory invoices should be made part of the individual's treatment record with the PAHP and be made available upon request to support any treatment provided.

Removable Prosthodontic Services may be provided in an acute care hospital if the service is alternatively not available and with prior approval from the PAHP if the service is:

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

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

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

Removable Prosthodontic Services are limited to additional services for individuals over the age of 21 that are not otherwise covered under the New Hampshire Medicaid State Plan. All medically necessary Removable Prosthodontic Services and Dental Services for individuals under the age of 21 are covered under New Hampshire State Plan Dental Services as a Children’s Medicaid benefit. This waiver service is only provided to individuals age 21 and over.

There is a \$1500 annual service limit for Removable Prosthodontic Services. An individual may be able to exceed this cap due to medical necessity, on a case-by-case basis, with prior approval from New Hampshire DHHS. A prior authorization for the amount requested above the service limit cap must include supporting documentation, identify need, and correlate to the person centered plan. Removable Prosthodontic Services are overseen by the approved Prepaid Ambulatory Health Plan (PAHP) and payment for this service is included in the PAHP agreement. Medicaid payment is considered payment in-full. Except for members with a "spend down," members cannot be charged beyond the Medicaid fee. Deposits, down-payments or advance payments are prohibited.

Dentures may be provided no more than once in a five-year period. This service limit may be exceeded with prior approval from DHHS.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dentist
Individual	Dentist

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Removable Prosthodontic Services

Provider Category:

Agency

Provider Type:

Dentist

Provider Qualifications

License (specify):

A rendering service provider shall be a licensed dentist in the state where they practice and have the necessary professional licenses and credentials required by federal, state and local statutes and regulations, as applicable.

Unlicensed dental interns and dental students of university-based dental programs may provide services under the general supervision of a licensed, New Hampshire Medicaid enrolled and participating dentist but cannot act as a treating provider or bill Medicaid for covered services.

Certificate (specify):

Other Standard (specify):

Removable Prosthodontic Services must be rendered by a qualified provider and coordinated through the NH Medicaid approved Prepaid Ambulatory Health Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Prepaid Ambulatory Health Plan (PAHP) shall ensure that participating providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with the provider disclosure, screening and enrollment requirements. The PAHP shall demonstrate that its participating providers are credentialed. The State Medicaid Agency will screen and enroll all PAHP-participating providers.

Frequency of Verification:

The State Medicaid Agency will revalidate all Prepaid Health Plan-participating providers every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Removable Prosthodontic Services

Provider Category:

Individual

Provider Type:

Dentist

Provider Qualifications

License (specify):

A rendering service provider shall be a licensed dentist in the state where they practice and have the necessary professional licenses and credentials required by federal, state and local statutes and regulations, as applicable.

Unlicensed dental interns and dental students of university-based dental programs may provide services under the general supervision of a licensed, New Hampshire Medicaid enrolled and participating dentist but cannot act as a treating provider or bill Medicaid for covered services.

Certificate (specify):

Other Standard (specify):

Removable Prosthodontic Services must be rendered by a qualified provider and coordinated through the NH Medicaid approved Prepaid Ambulatory Health Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Prepaid Ambulatory Health Plan (PAHP) shall ensure that participating providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with the provider disclosure, screening and enrollment requirements. The PAHP shall demonstrate that its participating providers are credentialed. The State Medicaid Agency will screen and enroll all PAHP-participating providers.

Frequency of Verification:

The State Medicaid Agency will revalidate all Prepaid Health Plan-participating providers every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Residential Care Facility Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Supportive services provided in a licensed facility, including those services described in He-P 804 and He-P 805 such as: Assistance with activities of daily living and incidental activities of daily living; Personal care; 24 hour supervision; Incontinence management; Dietary planning; Non-medical transportation to community based services and supports necessary to access the home and community based supports outlined in the person centered plan; and any other activities that promote and support health and wellness, dignity and autonomy within a community setting. Shared bedrooms do not accommodate more than two people. Personal care services listed above as part of this service are included in the rate paid to the provider and are not separately billed.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Care Facility

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Residential Care Facility Services

Provider Category:

Agency

Provider Type:

Residential Care Facility

Provider Qualifications

License *(specify):*

Residential Care, RSA 151:2, Licensed under He-P 804 or He-P 805

Certificate *(specify):*

Other Standard *(specify):*

Enrolled NH Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

NH Bureau of Licensing and Certification

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services listed in the comprehensive plan of care that are within the scope of the state’s Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State.

The differences from the State plan are as follows: Home Health Services in the waiver may be provided by a state licensed Home Health Agency that is not Medicare certified. Skilled Nursing Services provided under the waiver are for non-acute needs.

This service may be provided remotely through telehealth as determined necessary by the state to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BEAS will create and implement a Telehealth Checklist. The Telehealth Checklist will be completed by 10/1/2022. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a telehealth method of service delivery. If the individual requires hands-on assistance, telehealth service delivery shall not be an option. The Telehealth Checklist will include consideration of the percentage of time that telehealth service provision will be utilized. The amount of time chosen shall be determined during the person centered planning process and outlined in the comprehensive care plan. The CFI case manager will complete the checklist during the person centered planning process in order to aid in the development of the annual comprehensive plan of care. Telehealth service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the Appendix K expires.

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

Service limitations are set by the participant's comprehensive plan of care.

The provision of Skilled Nursing in acute care hospitals will be reviewed and requested by the case manager and approved BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Service Provider, including out-of-state providers
Individual	Skilled Nursing, including out-of-state providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Home Care Service Provider, including out-of-state providers

Provider Qualifications

License (specify):

Agency licensed by the State under RSA 151:2, and He-P 809 for home health care providers

Registered Nurse or Licensed Practical nurse under the supervision of a registered nurse, licensed to practice in the State of NH.

Certificate (specify):

Other Standard (specify):

Enrolled NH Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

NH Bureau of Licensing and Certification

Frequency of Verification:

Annual, and every 5 years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Skilled Nursing, including out-of-state providers

Provider Qualifications

License (specify):

Agency licensed by the State under RSA 151:2, and He-P 809 for home health care providers.

Registered Nurse or Licensed Practical nurse under the supervision of a registered nurse, licensed to practice in the State of NH.

Certificate (specify):

Other Standard (specify):

Be an Enrolled NH Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

When participant directed: the individual or his/her representative

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment Services (SME)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Specialized Medical Equipment are:

- (1) Devices, controls, or appliances that are specified in the comprehensive care plan which enable a participant to increase his or her ability to perform ADLs or IADLs;
- (2) Devices, controls, or appliances that are specified in the comprehensive care plan to perceive, control, or communicate with the environment in which the participant lives;
- (3) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
- (4) Other durable and non-durable medical equipment not available under the New Hampshire Medicaid state plan that are necessary to address participant functional limitations; and
- (5) Necessary medical supplies not available under the New Hampshire Medicaid state plan.

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

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

The provision of SME in acute care hospitals will be reviewed and requested by the case manager and approved BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

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

Purchases must be prior authorized by the DHHS. The specialized equipment must be identified as necessary in the person centered comprehensive care plan.

Specialized Medical Equipment should have an anticipated shelf life. The frequency of purchase would be contingent upon the continued need of the item and the item's ability to continue to meet that need.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Durable medical equipment and supply providers enrolled as NH Medicaid Providers, including out-of-state providers
Agency	Durable medical equipment and supply providers enrolled as NH Medicaid Providers, including out-of-state providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment Services (SME)

Provider Category:

Individual

Provider Type:

Durable medical equipment and supply providers enrolled as NH Medicaid Providers, including out-of-state providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS Bureau of Quality and Improvement
 When Participant Directed and Managed: the individual or his/her representative.

Frequency of Verification:

Upon enrollment prior to providing services and every 5 years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment Services (SME)

Provider Category:

Agency

Provider Type:

Durable medical equipment and supply providers enrolled as NH Medicaid Providers, including out-of-state providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Employment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Individual Employment Support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities.

Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment.

Supported employment Services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

This service may be provided remotely through telehealth as determined necessary by the state to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered comprehensive care plan. BEAS will create and implement a Telehealth Checklist. The Telehealth Checklist will be completed by 10/1/2022. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a telehealth method of service delivery. If the individual requires hands-on assistance, telehealth service delivery shall not be an option. The Telehealth Checklist will include consideration of the percentage of time that telehealth service provision will be utilized. The amount of time chosen shall be determined during the person centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person centered planning process in order to aid in the development of the annual individual service agreement, as well as during the monitoring activities required by He-E 805. Telehealth service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

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

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

Service limitations are set by the participant's comprehensive plan of care.

The provision of Supported Employment in acute care hospitals will be reviewed and requested by the case manager and approved BEAS. Please refer to additional assurance language found in Main-Brief Waiver Description under section "Main; B; Optional".

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Employment Services Provider, including out-of-state providers
Agency	Employment Services Provider, including out-of-state providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Employment Services Provider, including out-of-state providers

Provider Qualifications

License (specify):

none

Certificate (specify):

none

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

When Participant Directed: the individual or his/her representative

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Employment Services Provider, including out-of-state providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Employment Services Providers must ensure that Employment Counselors meet one of the following criteria:

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

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

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

Employment;

Customized employment;

Task analysis/systematic instruction;

Marketing and job development;

Discovery;

Person-centered employment planning;

Work incentives for individuals and employers;

Job accommodations;

Assistive technology;

Vocational evaluation;

Personal career profile development;

Situational assessments;

Writing meaningful vocational objectives;

Writing effective resumes and cover letters;

Understanding workplace culture;

Job carving;

Understanding laws, rules, and regulations;

Developing effective on the job training and supports;

Developing a fading plan and natural supports;

Self-employment; and

School to work transition.

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

individual in employment:

Understanding and respecting the business culture and business needs;

Task analysis;

Systematic instruction;

How to build natural supports;

Implementation of the fading plan;

Effective communication with all involved; and

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

Must be a NH Enrolled Medicaid Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Verification of provider qualifications is done at time of enrollment as a Medicaid provider.

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

Frequency of Verification:

Verification of provider qualification happens prior to enrollment.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supportive Housing Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supportive Housing Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

RSA 151:2-b

Certificate (specify):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

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

Appendix C: Participant Services

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

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

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

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

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

Criminal records checks at the State level are required as part of the licensing and certification process for personal care service workers, adult family care providers, residential care providers, adult day providers, home health providers, homemaker providers, and supportive housing providers, and is ensured by the Bureau of Health and Facilities Licensing, unless a worker is licensed under the Nurse Practice Act RSA 326-B. For workers that are licensed under the Nurse Practice Act RSA 326-B a criminal background check is required, and the Nursing Board within the Office of Professional Licensure and Certification ensures compliance. Home delivered meals providers are required by contract with the Department to screen workers, and compliance is checked through contract compliance reviews conducted by the Department.

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

No. The state does not conduct abuse registry screening.

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

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

DHHS is responsible for maintaining the state-wide abuse registry. The first tier of enforcement is the law, RSA 161-F:49, which states that "All employers of programs which are licensed, certified, or funded by the department to provide services to individuals shall be required before hiring a prospective employee, consultant, contractor, or volunteer who may have contact with individuals to submit his or her name, for review against the registry to determine whether the person is on the registry." For providers that are licensed or certified by the Department, the Bureau of Health and Facilities Licensing ensures that registry checks are conducted. For providers that receive funding through contracts, contract compliance reviews conducted by the Department ensure compliance with the state registry requirement. For all providers the Bureau of Elderly and Adult Services State Registry Unit conducts the state registry check and informs providers whether there was a match for the prospective employee or not.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

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

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

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

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

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

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

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

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

Services to be provided must be delineated in the Person Centered Plan. Routine case management contacts ensure that services are being delivered in accordance with the person centered plan.

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

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is

qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

When relatives/legal guardians are paid for the provision of direct support, they are contracted or employed as CFI service providers of the provider agency. On an annual basis a sampling of waiver participants records will be reviewed by BEAS to ensure verification that payments are only made for services rendered.

Other policy.

Specify:

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

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

Under Participant Directed and Managed Services (PDMS), each participant is afforded choice of service provider(s). An individual and/or guardian may choose any willing and qualified provider. New providers may be added at the request of an individual and/or guardian so long as that provider is qualified.

All providers shall comply with the CFI Waiver, Statute and rules pertaining to the service(s) offered and meet the provisions specified within the participants comprehensive care plan.

Under PDMS, Waiver participants/guardians may select any willing and qualified provider without regard to whether or not that provider is currently a provider in the NH Medicaid Provider Enrollment System. Any qualified prospective provider not already providing waiver services can be selected and thus become a provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

and % of new providers demonstrating they initially met required cert. and/or licensing and adhered to other standards prior to providing waiver services. N=# of new providers demonstrating they initially met required cert. and/or licensing and adhered to other standards prior to providing waiver services. D=# of new providers requiring cert. and/or licensing that were reviewed.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of existing providers demonstrating that they continually met required certification and/or licensing standards and adhered to other standards. N= # of existing providers demonstrating that they continually met required certification and/or licensing standards and adhered to other standards. D= # of existing providers requiring certification and/or licensing that were reviewed.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

		<p>Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level with a +/- 5% margin of error</p> </div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (<i>check each that applies</i>):</p>	<p>Frequency of data aggregation and analysis(<i>check each that applies</i>):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

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

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

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

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

Performance Measure:

Number and percent of new non-licensed/non-certified providers that adhere to waiver requirements prior to providing services . N: Number of new non-licensed/non-certified providers that adhere to waiver requirements prior to providing services. D: Number of new non-licensed/non-certified providers reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of existing non-licensed/non-certified providers that adhere to waiver requirements. Numerator:Number of existing non-licensed/non-certified providers that adhere to waiver requirements. **Denominator:** Number of existing non-licensed/non-certified providers reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	Annually	Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

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

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:

Number and percent of providers who meet training requirements in accordance with state requirements and the approved waiver. Numerator: Number of providers who meet training requirements in accordance with state requirements and the approved waiver. D= Number of providers reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

record reviews on and off site

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

		Interval = 95% confidence level with a +/- 5% margin of error
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

When individual problems are discovered, they are remediated through discussions with the enrolled Medicaid Provider by the NH DHHS Provider Relations staff, Bureau of Program Integrity or the CFI Waiver Administrator. Documentation is via email communications.

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

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Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

Furnish the information specified above.

Respite: When respite is provided as a service in a Participant Directed and Managed Service (PDMS), the total respite shall not exceed 20% of the overall PDMS budget. In a PDMS budget, the cost of training family managed employees will be outside of the total funds available for respite. The cost of training will not count toward the 20% respite service limitation. The BEAS Bureau Chief has the ability to determine limits on a case by case basis due to capacity issues.

Community Transition Services: Services must be prior authorized by DHHS and are limited to \$3,000/person per transition. This limit is independent of other service limits. The payment of security deposit is not considered rent. Community Transition Services are one time services and represent one time costs and is this limited to individuals moving from institutional / provider operating locations to private homes. An individual may be able to exceed this cap on a case by case basis with the prior approval of BEAS. A prior authorization for the amount requested above the service limit cap must include supporting documentation, identify need, and correlate to the person centered comprehensive care plan.

Environmental and Vehicle Modifications: For individuals with unsafe wandering and running behaviors, outdoor fencing may be provided under this waiver. Waiver funds allocated toward the cost of such a fence shall not exceed \$2,500 which can provide approximately 3,500 square feet of a safe area. Exceptions to this service limitation may be made on a case by case basis.

Non-Medical Transportation: Non-Medical Transportation is capped at \$1,000 annually.

The Bureau of Elderly and Adult Services Administrator reserves the right to approve requests that exceed the cap on a case by case basis. Proof of this need to exceed the cap will be required upon request to the Bureau of Elderly and Adult Services.

Removable Prosthodontic Services: There is a \$1500 annual service limit for the New Hampshire Medicaid State Plan Adult Dental Benefit, including Removable Prosthodontic Services. Dentures may be provided no more than once in a five-year period. This service limit may be exceeded with prior approval from DHHS.

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

Furnish the information specified above.

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

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

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

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

The first is the Waiver Transition Team which includes the Bureau Chiefs for the Bureau of Developmental Services and the Bureau of Elderly and Adult Services for the Department of Health and Human Services, subject matter experts from the Department of Health and Human Services and Long Term Supports and Services, a Project Director, and an HCBS Project Coordinator, both from the University of New Hampshire Institute on Disability - University Center for Excellence in Disability (UCED).

The second group is the Advisory Task Force which is made up of 16 members and was established in March 2015 to provide participant and stakeholder feedback on the development and implementation activities for the Statewide Transition Plan. The group is advisory in nature and includes representatives from a broad array of stakeholders, including those potentially most impacted by the new rules. There is representation from the following groups:

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

The Advisory Task Force meets quarterly to oversee the implementation process of the Statewide Transition Plan (STP). Updates are provided and input obtained to support the state's efforts in completing the goals outlined in the STP.

NH DHHS completed a thorough review of all standards, rules, and regulations to determine their current level of compliance with the settings requirements. NH received initial approval on their STP on July 3, 2017. NH continues its effort to obtain final approval.

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

NH has identified and begun implementation of goals related to each of the settings' requirements. Training on the final rule and its expectations occurs on an annual basis for both participants and providers.

Ongoing monitoring of settings is completed by NH DHHS Health Facilities Administration, Office of Legal and Regulatory Services (OLRS). For any setting identified as out of compliance, a plan of corrective action is written, and once approved by OLRS, is implemented to meet the expectations. Data regarding the HCBS expectations is shared with the Advisory Task Force every six months. Additionally, Service Coordinators monitor choice and satisfaction of participants on a quarterly basis. Individual issues are addressed as needed.

NH continues its Heightened Scrutiny review process. The onset of the COVID 19 pandemic has required a shift in the process from in-person to virtual.

More detailed information about NH's Statewide Transition Plan can be found at:
<https://www.dhhs.nh.gov/dcbcs/bds/transition.htm>

NH-DHHS allows the option of service provision outside of the state for the following waiver services: Home Health Aide, Homemaker, Personal Care, Respite, Financial Management Services, Environmental Accessibility Services, Home-Delivered Meals, In-Home Services, Non-Medical Transportation, PERS, Skilled Nursing, SME and Supported Employment. The corresponding provider qualifications are listed under each waiver service.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Comprehensive Care Plan

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

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Case managers are employed by Medicaid enrolled CFI Case Management Agencies with signed agreements with DHHS and licensed under He-P 819 unless federal or state law or state administrative rule states otherwise.

Targeted Case Management services are provided under the NH Medicaid State Plan and the requirements for case management services are specified within the CMS Approved CFI Waiver, NH State Administrative Rules He-E 805 and He-P 819 unless federal or state law or administrative rule states otherwise.

CFI Case Managers are responsible for the ongoing assessment, person-centered planning, coordination of continued CFI Waiver enrollment, and monitoring of the provision of services included in the comprehensive care plan, and assisting their CFI participants with required tasks to continue CFI enrollment.

The qualifications for Targeted Case Management Services are as follows:

He-E 805.02 Definition “Case manager” means an individual employed by, or contracted with, a case management agency who:

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

He-E 805.06 Qualification Requirements for Case Managers.

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

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

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

- (1) Have a bachelor’s level degree; or
- (2) Be a registered nurse with 2 years of related experience.

(c) Case management agencies shall not employ individuals who:

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

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

CFI Case Managers maximize the extent to which and individual participates in his or her person-centered planning process by:

- Explaining to the participant his or her rights;
- Explaining to the participant the service planning process;
- Eliciting information from the participant regarding his or her personal preferences, goals, and service needs that shall be a focus of service planning meetings

- Reviewing with the individual issues to be discussed during assessment and comprehensive care plan meetings; and
- Explaining to the individual the limits of the decision making authority of the guardian, if applicable, and the individual's right to make all other decisions related to services.

The planning process includes a discussion on strategies for solving conflict or disagreements within the process, including clear conflict of interest guidelines for all planning participants.

Appendix D: Participant-Centered Planning and Service Delivery

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Once the individual has selected or has been assigned a CFI Case Management Agency, the Agency assigns an CFI Case Manager. The CFI Case Manager conducts a comprehensive assessment pursuant He-E 805.

The comprehensive assessment informs the Comprehensive Care Plan and includes objectives and goals with timelines, services funded by CFI Waiver, Medicaid State Plan, or other funding sources, non-paid services, unfilled needs and gaps, existing risks and mitigation plan for those risks, and contingency planning.

Participants are supported by their CFI Waiver case manager to access information about the supports and services available to them including Medicaid and non-Medicaid funded services and to monitor services provided to ensure the type, scope, amount, duration and frequency is provided as authorized.

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

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

The person centered plan is updated at least annually but reviewed during monthly contact with the participant for as long as the participant is receiving CFI waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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

NH DHHS provides guidance regarding Risk Identification, Mitigation and Planning, through the use of a structured assessment process referred to as the "RIMP". CFI Case Managers use this process to assess risk and development of a mitigation plan.

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

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

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

Additionally, CFI Case Managers are required to operate and maintain a 24-hour on call back up system.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

CFI Case managers are responsible to document in the comprehensive care plan and in the CFI Eligibility system when a provider is not available for services in their comprehensive care plan.

CFI Case managers are also responsible to inform participants of their right to self direct their services and select providers who are not yet enrolled through coordination with the CFI Waiver financial management service. Upon CMS approval of the CFI Waiver Administrative rules will be updated to incorporate changes, clarifications, and additions to options pertaining to selecting from and among qualified providers and services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

NH DHHS has the final authority for approval of the CFI Waiver services within the comprehensive care plan.

A representative sample of comprehensive care plans are reviewed retrospectively to ensure that plans have been developed in accordance with applicable federal Waiver requirements and NH Administrative Rules.

NH DHHS utilizes a record review process for reviewing comprehensive care plans using the requirements to identify whether plans meet or do not meet requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

The responsible CFI Case Management Agency maintains Comprehensive Care Plan and its history pursuant He-E 805.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Case managers monitor the implementation of the person centered comprehensive care plan and participant health and welfare.

as required by NH state administrative rule He-E 805.

Case Management activities completed as required in He-E 805 may be provided remotely through telehealth as determined necessary to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. Face to face visits required by NH state administrative rule He-E 805 may not be completed via telehealth service provision.

b. Monitoring Safeguards. *Select one:*

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

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

Number and percent of participants' person centered plans that address participants' individualized goals. Numerator: Number of participants' person centered plans that address participants' individualized goals. Denominator: Number of Participants' person centered plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-top: 5px;">95% confidence level with a +/- 5% margin of error</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

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

Performance Measure:

Number and percent of person centered plans that address participants' assessed needs, including health and safety risks
Numerator: Number of person centered plans that address participants' assessed needs, including health and safety risks.

Denominator: Number of person centered plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of person centered plans that include a contingency plan for alternative staffing. Numerator: Number of person centered plan that include a contingency plan for alternative staffing. Denominator: Number of person centered plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	Annually	Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input data-bbox="406 340 798 421" type="text"/>	
	Continuously and Ongoing
	Other Specify: <input data-bbox="869 627 1260 707" type="text"/>

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

Performance Measures

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

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

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

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

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

Performance Measure:

Number and percent of person centered plans updated annually Numerator: Number of person centered plans updated annually. Denominator: Number of person centered plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	Annually	Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

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

Performance Measure:

Number and percent of person centered plans that were updated and revised when warranted by changes in the waiver participants' needs. Numerator: Number of person centered plans that were updated and revised when warranted by changes in the waiver participants' needs. **Denominator:** Total number of participant records that reflect a change in the participants' needs reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% confidence level with a +/- 5% margin of error"/>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

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

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

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

Performance Measure:

Number and percent of CFI waiver participants who received waiver services as authorized in their person-centered plans including the type, scope, amount, duration, and frequency. N: Number of CFI Waiver participants who received waiver services as authorized in their person centered plan including the type, scope, amount, duration, and frequency. D: Number of CFI Waiver participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

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

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

Performance Measures

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

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

Performance Measure:

The number and percent of participants whose person centered plan document that they have been provided choice among waiver services and providers. N: The number of participants whose person centered plan document that they have been provided choice among waiver services and providers. D: Total number of person centered plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually	Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Bureau of Elderly and Adult Services (BEAS) monitors Quarterly Quality Management reports provided to the Operating Agency pursuant He-E 805.

In addition to Quarterly Quality Management monitoring, the Bureau of Program Quality (BPQ) and BEAS complete case management agency record reviews. Findings are noted in reports sent to the agencies and provided to BEAS. BEAS works with the case management agency to develop quality improvement plans to address any findings. BEAS monitors each agencies achievement of action steps on a quarterly basis. BEAS also looks at scores and findings across agencies to identify statewide trends from year to year in areas of strengths and areas in need of improvement. BEAS then targets technical assistance efforts, utilizing both individual agency meetings and quarterly CFI Case Management Directors meetings to address trends and recommendations for implementing improvements.

ii. Remediation Data Aggregation

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

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participant Directed and Managed Services (PDMS) allows the participant to design the services that will be provided, select service providers, decide how authorized funding is to be spent base on the needs identified in the participant's comprehensive care plan, and perform ongoing oversight of the services provided.

In NH, there are two methods of service delivery within the PDMS model for CFI Waiver services. They include the following:

1.) Fiscal/Employer Agent (F/EA). Under this PDMS model, the participant (or a representative of their choosing) is the employer of the support workers they hire. The F/EA or Financial Management Services (FMS) entity is the agent to the employer (not the employer of support workers) and operates under Section 3504 of the IRS code and Revenue Procedure 2013-39. The participant can select a F/EA FMS entity to receive and disburse their individual budget funds, manage their support worker's payroll and related taxes, and perform some employer-related tasks (i.e., processing employment-related paperwork, conducting background and registry checks, processing and paying invoices for approved goods and services related to the participant's care needs and facilitating the receipt and payment of worker's compensation insurance). The F/EA FMS entity ensures the participant is compliant with any applicable Internal Revenue Services (IRS) and Department of Labor rules. Under this PDMS model, the participant may hire and manage support workers and purchase approved goods and services related to the participant's care needs.

2.) Agency of Choice Model (AoC). Under this PDMS model, the employment relationship is shared with the AoC FMS entity (Agency) and the participant or representative of their choosing as joint employers of participant's support workers. The Agency performs the employer tasks described in the F/EA model and issues an IRS Form W-2 to support workers as their employer. However, unlike the F/EA model, the Agency also performs tasks directly related to the support worker (i.e., hiring, training and formally dismissing, providing regular and backup support workers as needed). The participant, or the representative of their choosing, is the "managing employer" of their support workers, responsible for recruiting and referring support worker candidates to the Agency for hire, establishing work schedules, managing the day-to-day performance and determining the rate of pay for their workers, providing evaluation feedback to the Agency on their support workers, dismiss their support workers from their homes and inform the Agency and manages the backup plan for their support workers.

PDMS is available statewide through their Financial Management Services provider and provides for the selection of two basic participant direction opportunities and these opportunities may be used in combination, which is common.

These opportunities include:

- Participant Employer Authority. The participant is supported to recruit, hire, supervise, and direct the workers who furnish supports. In some cases, the participant is the co-employer of record of these workers who are referred to as Family Managed Employees (FME). The participant is responsible to document the training of the employee on the unique aspects of the person to whom they are assisting. Additional training responsibilities are outlined within the waiver and further identified in He-E 801.
- Participant Budget Authority. The participant has the authority and accepts the responsibility to manage their support plan and budget. The participant has the authority to make decisions about the acquisition of waiver goods and services that are authorized and documented in the individual's service plan and to make decisions based on a budget. Participants are expected to approve expenses within the budget and be provided assistance to prioritize the use of their funds, if needed.

When used in combination the above authorities promote a comprehensive, participant directed plan.

Financial Management Services are furnished for two purposes: (a) to address federal, state, and local employment tax, labor and worker's compensation insurance rules and various requirements that apply when the participant functions as the employer and (b) to address changes in the recipient's wishes to demonstrate how the budget will be spent and to document expenditures and keep receipts from expenses in order to support the individual's service plan. Monthly documentation of both services chosen, and corresponding expenses are expected to be documented and available for audits by BEAS.

The services available through the CFI Waiver are allowed to be delivered through the participant directed and managed service delivery model, except residential care facility services. Participants are defined as: (a) the individual acting independently on their own behalf; (b) the legal guardian(s) of the individual accessing the waiver and acting on behalf of the individual; and, (c) a non-legal, chosen representative to act on behalf of the waiver recipient.

Services provided through the waiver are specifically tailored to the competencies, interests, preferences, and needs of the

participant and/or his/her guardian and are respectful of the personal values and lifestyle of the participant.

In extending the participant choice and control over their comprehensive care plan, the CFI Case Manager provides information and assistance to facilitate and optimize participation, direction, and management of services. Responsiveness to participant preferences and requests occur within the context of state and federal laws and regulations, policies and procedures.

Beginning with the initial discussion and education about CFI Waiver services, CFI Case Managers share information with the participant regarding such expectations, requirements, and limitations.

The Division of Long Term Supports and Services (DLTSS), PDMS committee, will be making recommendations relative to the following:

- Adoption of a PDMS self-assessment screening tool;
- Development of a PDMS handbook;
- Development and implementation of Orientation, Remediation and Transition policies;
- Expectations relative to delegating direct services to another entity; and
- Clarification regarding opportunities to purchase additional assistance relative to documentation, recruitment, or supervision, if applicable.

Comprehensive care plans document choice and control as well as responsibilities of the different parties involved in the comprehensive care plan and compliance with laws and regulations.

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

The participant, guardian, CFI Case Manager, FMS Provider, private provider agencies and the Bureau of Elderly and Adult Services (BEAS) collaborate to identify the necessary level of service provision and funding while ensuring supervision, safety, satisfaction, and effective utilization of authorized funds.

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

CFI Case Managers work with individuals and their team to develop an individualized person centered comprehensive care plan identifying all supports, services and total cost. The service plan must identify services that are available through the waiver, any needs that are met outside of the waiver, as well as any unmet needs.

The FMS in partnership with BEAS and the CFI Case Manager will educate individuals that utilize PMDS on fraud, waste, and abuse. BEAS will hold individuals that utilize PMDS accountable on fraud, waste, and abuse. In cases where criterion for PDMS is not met, a transition policy will be implemented to assist individuals in accessing services outlined in the comprehensive care plan.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

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

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

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Participant directed and managed services are available to all individuals with the exception of those living in a residential care setting.

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Information about the option to self direct is provided to individuals as they explore the option of applying for the CFI Waiver. ServiceLink and other NHCarePath Partners include information, guidance and support as people begin the process for applying.

Information about the option to self direct is provided at the time of the initial intake assessment by the CFI Case Manager and development of the person centered comprehensive care plan, during annual person centered planning and during any review as requested by the participant. Discussions regarding the option to self direct are documented in the person centered comprehensive plan.

The CFI Case Manager provides detailed information to participants who indicate a desire to self direct and ensure an informed decision is being made by providing information about the benefits, responsibilities and potential liabilities of self direction, including:

Benefits such as a greater degree of choice and control over selecting and hiring staff and flexibility to direct authorized funds to the services best able to meet the participant's needs; responsibilities including ongoing oversight of all aspects of service delivery such as staffing, budget and state/federal regulatory compliance (as appropriate); and potential liabilities such as the high level of responsibility required of self direction, particularly for those participants who have accessed agency driven service models where CFI Case Managers and others, not the participant, are responsible for securing staff, ensuring payroll functions are appropriately completed and providing oversight to ensure services are delivered according to the person centered plan.

BEAS coordinates with the PDMS long term supports and services committee.

The goal(s) of the committee include the:

- 1.) Identification of a self-assessment tool to assist individuals/guardians to determine if PDMS is an option for them.
- 2.) Development a PDMS Participant Handbook

The handbook will include all relevant information for an individual/guardian to understand the use of Medicaid funds. The handbook will include the rights and responsibilities associated with the management of Medicaid funds, on-boarding staff including the recruitment, training, supervision and necessary background checks, as well as covered services in the approved waiver.

State Administrative Rule He-E 801, eligibility for CFI Services, requires that services will facilitate as much as possible the individual's ability to determine and direct the services he or she will receive. This rule also articulates individuals' right to choose his/her CFI Case Manager.

At the time of the initial and annual comprehensive care plan, CFI Case Managers are required to provide the following information to individuals/guardians:

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

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

Explaining to the individual his or her rights and responsibilities;

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

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

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

Explaining to the individual the limits of the decision-making authority of the guardian, if applicable, and the individual's

right to make all other decisions related to services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Emergency Response System (PERS)		
Home Health Aide		
Environmental Accessibility Services		
Skilled Nursing		
In-Home Services		
Community Transition Services		
Participant Directed and Managed Services		
Respite		
Personal Care		
Non Medical Transportation		
Specialized Medical Equipment Services (SME)		
Financial Management Services		
Adult Family Care		
Homemaker		

Waiver Service	Employer Authority	Budget Authority
Supportive Housing Services		
Adult Day Services		
Supported Employment		
Home-Delivered Meals		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

Governmental entities

Private entities

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

Financial Management Services

FMS are provided as an administrative activity.

Provide the following information

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

A wide range of entities may furnish FMS. Any willing and qualified provider meeting the definition of Financial Management Services Provider in Appendix C, and that have the capabilities to perform the required tasks in accordance with 26 USC 3504 of the IRS code and Revenue Procedure 70-6 may do so when enrolled as a NH Medicaid Provider.

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

FMS Services are provided as a waiver service.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

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

Services/functions that assists the family or participant to:

- (1) Manage and direct the disbursement of funds in accordance with the PDMS budget and plan;
- (2) Facilitate the employment of staff by the family or CFI participant including assisting with processing criminal background checks on prospective workers;
- (3) Provide orientation and skills training to the participant or the participant's legal representative who is to act as co-employer of direct support staff about responsibilities as co-employers for the direct support workers employed;
- (4) Provide fiscal accounting to include: a. Disbursements for goods and services approved in the comprehensive care plan and the balance of the participant's available funds; and b. Ensuring separation of each participant's budget and expenses;
- (5) Provide employer functions, including but not limited to:
 - a. Hiring workers chosen by the participant;
 - b. Verifying worker citizenship status;
 - c. Ensuring completion of required background checks and obtain a waiver if necessary pursuant to He-E 801.37;
 - d. Processing payroll and issuing payment to employees;
 - e. Withholding all federal, state, and local taxes and making tax payments to the applicable tax authorities; and
 - f. Documenting required training.

The participant's budget shall include the following, based on the needs identified by the case manager in the comprehensive care plan:

- (1) The specific PDMS components;
- (2) The frequency and duration of the required services; and
- (3) An itemized cost of the PDMS.

The FMS provider shall prepare a budget worksheet that details how the participant intends to spend the funds allocated in the participant's budget and the worksheet shall be reviewed monthly by the participant. Expenses that exceed the limits allowed under a participant's PDMS budget or that exceed service limits allowed for SME or EAS, or that are not allowed under this program as authorized by CMS, shall not be paid.

All FMS providers shall:

- (1) Provide services as described in this part;
- (2) Maintain an account for the participant for the purposes of tracking expenditures from the participant's budget;
- (3) Inform participants of procedures for payment requests for goods and services;
- (4) Review and submit for payment to the department the items or services that the participant purchases based on his or her budget; and
- (5) Provide the participant with a monthly statement to track expenditures and to ensure that the FMS provider is handling the participant's budget appropriately and accurately.

Supports furnished when the participant exercises budget authority:

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

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

NH DHHS monitors and assesses the performance of FMS entities, including the integrity of the financial transactions they perform through the following activities, performed on an annual basis:
 Record review and audit of participant directed services, including post-payment review, to ensure documentation is in place to demonstrate that the FMS:

- Assists participants in verifying support worker citizenship status;
- Collects and processes timesheets of support workers appropriately; Processes payroll, withholding, filing and payment of applicable Federal, state and local employment related taxes and insurance appropriately;
- Maintains a separate account for each participant's budget;
- Tracks and reports disbursements and balances of participant funds;
- Processes and pays invoices only for goods and services approved in the comprehensive care plan; and
- Provides participants with reports, on a schedule agreed upon by the participant, of expenditures and the status of the participant directed budget.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

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

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

Case Management activities are separate and distinct from FMS activities in that the case management activities provided for self direction are specific to ensuring that the individual is aware of the opportunity to self direct, for providing information about the opportunities and challenges associated with self directing and by ensuring that the following requirements of He-E 805 are met:

- (1) Conduct the case management contacts required for each participant;
- (2) Ensures the referral process for participant to enroll in FMS services to access PDMS is followed;
- (3) Ensure that services for FMS and PDMS are authorize, are adequate and appropriate for the participant’s needs, and are being provided, as described in the comprehensive care plan;
- (4) Ensure that the participant is actively engaging in the services described in the comprehensive care plan;
- (5) Ensure that the participant is satisfied with the comprehensive care plan; and
- (6) Identify any changes in the participant’s condition, discuss these changes with the participant in order to determine whether changes to the comprehensive care plan are needed, and make changes to the comprehensive care plan as needed.

Waiver Service Coverage.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response System (PERS)	
Home Health Aide	
Environmental Accessibility Services	
Skilled Nursing	
In-Home Services	
Community Transition Services	
Participant Directed and Managed Services	
Respite	
Personal Care	
Non Medical Transportation	
Specialized Medical Equipment Services (SME)	
Financial Management Services	
Removable Prosthodontic Services	
Adult Family Care	
Homemaker	
Supportive Housing Services	
Adult Day Services	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supported Employment	
Home-Delivered Meals	
Residential Care Facility Services	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

I. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

In accordance with He-M 801, an individual or guardian may withdraw voluntarily from any service(s) at any time or from participant direction of any service. Likewise, an individual or guardian may withdraw voluntarily from the CFI waiver.

The CFI waiver is designed to support individuals to be involved with Participant Directed and Managed Services to the extent they wish, and this may be altered at any time.

This waiver allows individuals to direct and manage their services along a continuum; if they no longer have any interest in directing and managing their services, they would be supported by their CFI Case Manager to transition to agency directed services available through the CFI Waiver. Transitional activities are discussed by the case manager, individual and his/her team and documented in the person centered comprehensive care plan. Provisions are specifically outlined in the plan to ensure all necessary services continue and to monitor participant health and safety.

Specific attention to the individual's health and welfare is provided through on-going contacts with the individual by the CFI Case Manager.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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

- (1) Incident(s) of behaviors that pose a risk to community safety with or without police or court involvement;
- (2) Determined to be unable to carry out their responsibilities under participant direction, to assure the participant's health and welfare or when there is evidence of misuse of public funds.

In the event that participant direction is involuntarily terminated, the case manager will assist the individual to transition to agency directed managed service delivery. Transitional activities are discussed with the case manager, individual and his/her team and documented in the person centered plan. Provisions are specifically outlined in the plan to ensure all necessary services continue and to monitor participant health and safety.

Individuals and their guardians have the right to appeal a decision to disallow or terminate participant direction and management.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="80"/>
Year 2	<input type="text"/>	<input type="text" value="125"/>

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 3		173
Year 4		270
Year 5		280

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Both strategies are supported.

The participant retains ultimate authority over delivery of services when participating in a co-employer or a participant common law arrangement in that payment for services to the employee, provider, or the employing agency is contingent upon signature verification of the individual or family that the services have been provided as agreed by all parties.

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Provided via the Financial Management Service

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Does not vary from Appendix C-2-a

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

As part of the person centered planning process, the individual/guardian is provided the opportunity to fully participate and have the "lead voice" in the decision-making process.

The method that BEAS uses to consistently apply budget development to each participant is based on the average cost for services within this waiver. Budgets are adjusted either up or down to match the individual's needs. Participants whose assessed needs exceed the level of services provided, on average, may request additional funds. Requests for additional service funding are reviewed by DHHS and are approved based on demonstrated clinical need as documented in an approved assessment and on the requirements contained in NH State Statute RSA 151-E:11.

Individuals have the flexibility to reallocate among the approved services within the comprehensive care plan, including increasing or decreasing the hourly wage of providers and services to meet specific needs of the individual. A strength of this approach is that individuals/guardians can negotiate different payment levels for staff and providers, based on provider skill set and the individual's needs.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Service authorizations and the corresponding budgetary allocation are coordinated by between DHHS, the FMS Provider and the CFI Case Manager. The CFI Case Manager works with the participant to build the person centered comprehensive care plan.

Participants whose assessed needs indicate a need for a higher level of services/budgetary allocation can request additional services [and a corresponding budget increase]. This request is made by the CFI case manager.

Requests for additional service funding are reviewed by DHHS and are approved based on demonstrated need.

Individuals/guardians have the right to appeal BEAS' decisions.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Participants have the authority to modify the waiver services included in the participant directed plan without prior approval as long as these changes are budget neutral, meet the requirements for the CFI Waiver, and do not exceed service limits, there may be no need for BEAS to review/approve such changes. All budgets and comprehensive care plans are reviewed by the CFI Case Manager on at least an annual basis.

Changes in services must be preceded by an update/amendment to the comprehensive care plan and communicated to the FMS by the participant.

As with all waiver services, the impact of any changes in the comprehensive care plan as a result of modifications in the self directed budget are monitored on a regular basis during monthly case management contacts and at the time of the service plan renewal in coordination with the participant and the FMS Provider.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS is required to provide budget management services that include maintaining a separate account for each participant's budget; tracking and reporting the use of participant funds, disbursements and the balance of participant funds; and processing and paying invoices for goods and services approved in the service plan.

The frequency of reports as outlined above is clearly articulated in the comprehensive care plan and monitored by the participant and the CFI case manager to prevent premature depletion of the participant directed budget and to address potential service delivery problems that may be associated with budget under utilization.

The CFI Case Manager in coordination with the participant and the FMS Provider monitor the funds budgeted for an individual as it relates to appropriateness and utilization of services in accordance with the comprehensive plan of care.

The Participant Directed and Managed Services workgroup will provide input to the development of policies and procedures that articulate how the funding allocated to each individual will be monitored to ensure that funds are appropriately and fully utilized in order to avoid waste in HCBS-CFI services. These policies and procedures must articulate how to make budgetary adjustments if a participant has not fully utilized the allocated funding.

Discrepancies relative to planned service utilization and spending vs. actual utilization and spending are monitored through the FMS provider in coordination with DHHS, the CFI Case Manager and the participant.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

NH DHHS provides notice for and opportunities to request a Fair Hearing of Department decisions as follows:

He-E 801.04 Eligibility Determination.

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

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

a. Conduct an on-site, face-to-face visit with the applicant;

b. Perform a clinical assessment of the applicant; and

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

(2) The applicant shall sign the following:

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

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

c. An authorization for release of information; and

d. An authorization for release of protected health information;

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

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

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

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

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

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

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

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

(2) The eligibility start date.

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

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

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

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

He-E 801.07 Redetermination of Eligibility and Service Authorization.

(a) The eligibility of each participant, as determined in accordance with He-E 801.04, shall be subject to redetermination at least annually.

- (b) The redetermination shall be conducted in accordance with He-E 801.04, except that (e)(2)c.2. below shall apply.
- (c) The annual redetermination required in (a) above shall not preclude earlier redetermination or reevaluation and subsequent changes to the identified needs list or service authorizations.
- (d) Upon a redetermination of eligibility, the identified needs list and service authorizations shall be updated as necessary by the department.
- (e) If a participant is determined ineligible, or if services are identified as no longer being clinically necessary, the department shall either terminate CFI eligibility or reduce or terminate the services authorized, respectively, as follows:
- (1) Payment for services shall be terminated 30 calendar days from the date of the notice described in (2) below, unless an appeal has been filed within 15 calendar days of the date of the notice; and
 - (2) A written notice of eligibility termination or the reduction or termination of the services authorized, as applicable, shall be sent to the participant, or his or her legal representative, and the participant's case manager, including:
 - a. The reason and legal basis for the termination or reduction;
 - b. The date that service coverage shall be terminated or reduced, absent the filing of an appeal; and
 - c. Information concerning the participant's right to appeal pursuant to He-C 200, as follows:
 1. The participant shall have 30 calendar days to file an appeal, otherwise the department's decision shall be final; and
 2. If the participant files an appeal within 15 calendar days of the date of the notice of service coverage termination or reduction, continued payments for CFI services shall be authorized until 30 calendar days after a hearing decision has been made.

Within fifteen days of receiving the notice that services will be discontinued, the participant can appeal a decision through NH's Administrative Appeals Unit (AAU) in accordance with He-C 200, the rule established to govern the process regarding Administrative Appeals in accordance with the following State Laws: RSA 541-A:16 I and RSA 126-A:5, VII. The notice states that services will not be discontinued if the appeal is filed within fifteen days.

When a participant elects to make use of the dispute mechanism process, they are informed of all their right to have a fair hearing and that they are not required to use the dispute mechanism process prior to or in lieu of filing an appeal with the AAU.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Pursuant He-E 801.06 DHHS has a process through which participants who disagree with a service authorization request can request reconsideration. Participants must request reconsideration within 30 days of a service authorization. Participants may provide additional or revised information to support a request for reconsideration. A request for reconsideration is not an appeal. Participants who receive a denial or partial denial can request reconsideration, file for an appeal, do both, or do neither.

The Prepaid Ambulatory Health Plan (PAHP) operates a member grievance and appeal process, which are specific to Removable Prosthodontic Services only, as this is the only service in this waiver that is delivered by the PAHP. The PAHP grievance and appeal processes do not supplant the waiver participant's ability to request State a fair hearing.

PAHP Grievance Process

The PAHP shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the PAHP either orally or in writing at any time. [42 CFR 438.402(c)(1)(i-ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

- The quality of care or services provided;
- Aspects of interpersonal relationships such as rudeness of a Provider or employee;
- Failure to respect the Member's rights;
- Dispute of an extension of time proposed by the PAHP to make an authorization decision;

The PAHP shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the PAHP receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the PAHP does not have all the information necessary to make the decision. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

The PAHP may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

- If the Member requests the extension; or
- If the PAHP shows that there is need for additional information and that the delay is in the Member's interest (upon State request). [42 CFR 438.408(c)(1)(i-ii); 438.408(b)(1)]

If the PAHP extends the timeline for a grievance not at the request of the Member, the PAHP shall:

- Make reasonable efforts to give the Member prompt oral notice of the delay; and
- Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.408(c)(2)(i-ii); 42 CFR 438.408(b)(1)]

The PAHP shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

PAHP Appeal Process

The PAHP shall permit a Member, or the Member's authorized representative, or a Provider acting on behalf of the Member and with the Member's written consent, to request an appeal orally or in writing of any PAHP action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

The PAHP shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's State. [42 CFR 438.406(b)(6)]

The PAHP shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the PAHP's notice of action. [42 CFR 438.402(c)(2)(ii)]

The PAHP shall ensure that oral inquiries seeking to appeal an action are treated as appeals. [42 CFR 438.406(b)(3)]

If the Department receives a request to appeal an action of the PAHP, the Department shall forward relevant information to the PAHP and the PAHP shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

The PAHP shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

The PAHP shall permit the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing [42 CFR 438.406(b)(4)]. The PAHP shall inform the Member of the limited time available for this in the case of expedited resolution.

The PAHP shall provide the Member and the Member's representative an opportunity to receive the Member's case file, including medical records, and any other documents and records considered during the Appeal Process free of charge prior to the resolution. [42 CFR 438.406(b)(5); 438.408(b-c)]

The PAHP may offer peer-to-peer review support, with a like clinician, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should occur in a timely manner.

The PAHP shall resolve standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the PAHP. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

The date of filing shall be considered either the date of receipt of an oral request for appeal or a written request for appeal from either the Member or Provider, whichever date is the earliest.

If the PAHP fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the PAHP's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

The PAHP shall permit the appeal of any action taken by the PAHP. Actions shall include, but are not limited to the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service. [42 CFR 438.400(b)(3)];
- Failure to provide services in a timely manner, as defined by this Agreement;
- Untimely service authorizations;
- Failure of the PAHP to act within the timeframes outlined in the PAHP Agreement; and
- At such times, if any, that the Department has an Agreement with fewer than two (2) PAHPs, for a rural area resident with only one (1) PAHP, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

Expedited Appeal

For appeals when the PAHP determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

The PAHP shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals. [42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)]

The PAHP shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the PAHP receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

The PAHP may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the PAHP justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] The PAHP shall also make reasonable efforts to provide oral notice.

The date of filing of an expedited appeal shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest.

If the PAHP extends the timeframes not at the request of the Member, it shall:

- Make reasonable efforts to give the Member prompt oral notice of the delay by providing a minimum of three (3) oral attempts to contact the Member at various times of the day, on different days within two (2) calendar days of the PAHP's decision to extend the timeframe as detailed in He-W 506.08(j);
- Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision;
- Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i-iii); 42 CFR 438.408(b)(2)-(3)]

The PAHP shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

If the PAHP denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

The Member has a right to file a grievance regarding the PAHPs denial of a request for expedited resolution. The PAHP shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

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

Pursuant to State Administrative Rule He-801, all providers 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 state registry maintained by the department's Bureau of Elderly and Adult Services.

The Department of Health and Human Services (DHHS) has a policy regarding critical events, referred to as the Bureau of Quality Assurance and Improvement (BQAI) PO.1003 Sentinel Event Reporting and Review Policy, as part of a comprehensive quality assurance program with BQAI that establishes the reporting and review requirements of sentinel events involving individuals served by the Department. Both community providers and DHHS divisions or bureaus that provide direct care services shall report sentinel events as directed by this policy. Statutory authority for reviews of sentinel events is set forth in NH RSA 126-A:4, IV.

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. The Bureau of Quality Assurance and Improvement (BQAI) has adopted the following categories of reportable sentinel events.

Client-centered sentinel events, in which the individual is either a victim and/or perpetrator, include:

1. Any sudden, unanticipated, or accidental death, not including homicide or suicide, and not related to the natural course of an individual's illness or underlying condition.
2. Permanent loss of function, not related to the natural course of an individual's illness or underlying condition, resulting from such causes including but not limited to:
 - A medication error, and/or
 - An unauthorized departure or abduction from a facility providing care, and/or
 - A delay or failure to provide requested and/or medically necessary services due to waitlists, availability, insurance coverage, or resource limits.
3. Homicide.
4. Suicide.
5. Suicide attempt, such as self-injurious behavior with a non-fatal outcome, with explicit or implicit evidence that the person intended to die, and medical intervention was needed.
6. Rape or any other sexual assault.
7. Serious physical injury to or by a client.
8. Serious psychological injury that jeopardizes the person's health that is associated with the planning and delivery of care.
9. Injuries due to physical or mechanical restraints.
10. High profile event, such as:
 - media coverage;
 - police involvement when the involvement is related to a crime or suspected crime; and/or,
 - an issue that may present significant risk to DHHS staff or operations.

Reportable sentinel events shall be those sentinel events that involve individuals who:

- Are receiving Department funded services,
- Have received Department funded services within the preceding 30 days; or
- Are the subject of a Child or Adult Protective Services report.

All providers of services through DHHS and the Bureau of Elderly and Adult Services (BEAS) are required to report sentinel events that involve an individual who is receiving BDS funded services; has received BEAS funded services within the preceding 30 days; is employed in a BEAS funded program; or is visiting a BEAS funded program when an event occurs.

Notification shall be provided to the BEAS Bureau Administrator or designee in accordance with the timeframes and methods outlined in the Sentinel Event Reporting and Review Policy.

Bureau of Quality Assurance and Improvement (BQAI) PO.1003 Sentinel Event Reporting and Review Policy:
<https://www.dhhs.nh.gov/bqai/documents/sentinel-event.pdf>

Upon the discovery of a sentinel event by a community provider or by a DHHS Division or Bureau (whether by direct

report by a provider, other mandatory reporting mechanisms, or a more general discovery), that person or entity shall provide verbal notification to the appropriate DHHS Bureau Chief or designee within 24 hours. Written notification of the sentinel event shall be provided by the reporting person or designated agency staff to the appropriate DHHS Office within 72 hours of the event.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and information sharing concerning protections from abuse, neglect, and exploitation is conducted by the NH DHHS Adult Protective Services [APS] Unit.

Information is shared online, through community presentation and through distribution of the NH APS brochure found at <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/beas-abuse-hurts.pdf>.

The brochure entitled "Abuse Hurts at Any Age" provides the following information for participants, and/or families or legal representatives, as appropriate, to notify APS when the participant may have experienced abuse, neglect, self-neglect or exploitation:

In New Hampshire, adult abuse is defined by the Adult Protection Law (RSA 161-F:42-57). Adult abuse is any action or omission that results or could result in harm to a person age 18 or older who cannot provide for his or her own care and protection due to the effects of aging or a chronic illness or disability.

The Adult Protection Law identifies six types of abuse: physical, emotional, sexual, neglect, self-neglect, and exploitation. As required by law, the NH Dept. of Health and Human Services, receives and investigates reports of adult abuse and, when necessary, provides protective services.

It's the Law:

If you suspect or believe that you are, or someone else is, being abused, neglected, self-neglecting, or exploited the Adult Protection Law requires that you report this to the Bureau of Elderly and Adult Services, Adult Protective Services. You can do this by:

Calling: 800-949-0470 or 603-271-7014

Faxing: 603-271-4743

Emailing: apsintake@dhhs.state.nh.us

All calls and contacts are completely confidential.

Additionally, the rights of all participants to be free from abuse, neglect, and exploitation are included in the Patients' Bill of Rights NH State RSA 151: 21. In accordance with State statute and administrative rules, provider agencies are required to notify individuals and guardians or representatives of individuals' rights in accordance RSA 151:21 in advance of or during the initial evaluation visit and before initiation of care. If a Participant cannot read the statement of rights it shall be read to the participant in a language such participant understands.

<http://www.gencourt.state.nh.us/rsa/html/xi/151/151-mrg.htm>

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Bureau of Elderly and Adult Services, Adult Protective Services (APS) receives reports of abuse, neglect, and exploitation in accordance with RSA 161-F 42-57.

Adult Protection Program activities include:

- The receipt and investigation of reports of alleged emotional abuse, physical abuse, sexual abuse, neglect, exploitation, and/or self-neglect, and referral to law enforcement agencies as necessary;
- The determination of the validity of the report and the need for protective services; and
- The provision of and/or arrangement for the provision of protective services when necessary, and when accepted by the adult who has been determined to be in need.

The Adult Protection Law requires any person who has a reason to believe that a vulnerable adult has been subjected to abuse, neglect, exploitation or self-neglect to make a report to the appropriate state agency or office.

The responsibility to receive and investigate reports of suspected abuse, neglect, exploitation or self-neglect of vulnerable adults under NH's Adult Protection Law, is determined based on an vulnerable adult's living arrangement or situation, as outlined below:

- An adult is defined as living in an independent living situation if that person lives in their own home or apartment, the home or apartment of friends or relatives, a boarding home, or there is no fixed address. For these situations, the report should be made to the local Bureau of Elderly & Adult Services District Office.
- The Office of the Long-Term Care Ombudsman is responsible to receive initial reports involving vulnerable adults who are residents of nursing facilities or assisted living facilities.
- A central adult protective services (APS) unit in the BEAS Central Office receives and investigates reports involving vulnerable adults who live in or are participating in homes/programs administered by or affiliated with the DHHS Bureaus of Behavioral Health and Developmental Services.
- The central APS unit is also responsible to receive and investigate reports involving vulnerable adults who are suspected to have been abused, neglected or exploited in their own homes by individuals paid to provide care, or while receiving care in a community, general or specialized hospital, rehabilitation center or other treatment center.

The policy for reporting Sentinel Events requires the provider to make verbal notification to the State within 24 hours of the discovery of a sentinel event, and to provide written notification to the State on the required Sentinel Event form within 72 hours of the Sentinel Event. For sentinel events reported to BEAS that do not require a APS report in accordance with He-E801, the BEAS Choices for Independence Administrator will review the sentinel event and assure it is provided to the appropriate BEAS staff for follow up with the provider. APS investigations must be completed within 60 business days of the report.

Each provider is expected to complete its own review of a reportable sentinel event consistent with the applicable DHHS administrative rules and its agency policies regarding incidents and events that are consistent with the definition of a sentinel event. The review of the event shall identify recommendations for follow-up activity to address identified systemic issues, if any and shall be reported to BEAS on a quarterly basis.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Bureau of Elderly and Adult Services oversees the reporting of and responses to critical incidents that affect waiver participants in accordance to state laws and regulations.

BEAS meets monthly with CFI Case Managers to provide technical assistance and review critical incident reports.

BEAS meets quarterly to monitor critical indecent reports and Sentinel Event reporting.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

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

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

CFI Waiver participants are served in several different types of settings: their own homes, adult family care homes, adult day, supported housing, in the homes of their families or caregivers and in licensed residential care facilities.

Pursuant to NH RSA 151:21 IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records. Pursuant to NH RSA 151:21-b, 2 (h) Be free from chemical and physical restraints except as authorized in writing by a physician.

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

The Bureau of Licensing and Certification is responsible for conducting annual, unannounced licensing inspections of all licensed health facilities, including residential care facilities, including investigating any complaints and taking action if the licensee is non-compliant with NH law or rule.

Information concerning investigations, findings or sanctions related to CFI Waiver providers is shared and monitored in partnership with the Bureau of Elderly and Adult Services CFI Waiver Administrator on a monthly basis. During monthly meetings BEAS monitors for any enrolled CFI Provider who may be at risk of licensing or certification revocation, and to ensure that Adult Protective Services is involved as needed pursuant He-E 700.

The state collects data from the investigations and analyzes it to identify trends and patterns. The Bureau of Health Facilities works in collaboration with the Bureau of Elderly and Adult Services to inform on trends, education and training at the provider level.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

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

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

State law, RSA 151.21, "Patient Bill of Rights," specified the safeguards that are in effect concerning the use of restrictive interventions, access to other individuals, locations, or activities, or restrict participant rights. CFI Waiver Provider requiring and license or Certification follow the training requirements pursuant to that license.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

BEAS meets monthly with the Bureau of Licensing and Certification to review complaint reporting, investigations and findings pertaining to enrolled CFI Providers serving CFI Participants.

The state collects data from the investigations and analyzes it to identify trends and patterns. The Bureau of Health Facilities works in collaboration with the Bureau of Elderly and Adult Services to inform on trends, education and training at the provider level

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

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

State law, RSA 151.21 VIII, "Patient Bill of Rights," specifies the right to be free of involuntary seclusion.

BEAS meets monthly with the Bureau of Licensing and Certification to review complaint reporting, investigations and findings pertaining to enrolled CFI Providers serving CFI Participants.

A report of involuntary seclusion also results in an Adult Protective Services report and investigation pursuant He-E 700.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

In the event that an individual has a cognitive impairment or mental disorder, a skilled nursing visit is put into place via the CFI Waiver service authorization process to provide oversight of the individual’s medication regimen including medication compliance, monitoring for side effects and communicating with the prescriber, as needed.

Individuals may also receive additional skilled nursing visits to set up pill boxes or pre-fill the individual’s electronic medication dispensing device.

The Bureau of Licensing and Certification monitors medication management during required annual inspections.

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

Providers that are responsible for medication administration are required to record and report medication errors to the Bureau of Health Facilities and Licensing. The Bureau of Health Facilities and Licensing monitors medication management and compliance with administrative rules He-E 804.17 and He-E 805.17. The Bureau of Health Facilities and Licensing monitors compliance during re-inspections. The Bureau of Health Facilities and Licensing reports findings and any other corrective actions to the Bureau of Elderly and Adult Services. Additionally, case managers review medication management when the case manager contacts the participant and report any irregularities to the Bureau of Elderly and Adult Services and the Bureau of Health Facilities and Licensing.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

Medication administration is provided by licensed personnel in any setting or by licensed nursing assistants or unlicensed assistive personnel in accordance with the Nurse Practice Act (NPA) under RSA 326-B:14, II-a and RSA 326-B:28 when the licensed nurse delegates the task of medication administration.

Additionally, medication administration for CFI Waiver participants living in assisted living/residential care facilities is governed by State Administrative Rules He-P 804 and 805 [http://www.gencourt.state.nh.us/rules/state_agencies/he-p800.html] and allows for self administration, self-directed medication administration, self administration of medications with supervision, administration of medications by a licensed nurse or medication nursing assistant.

Prior to supervising medication administration in an assisted living facility/residential care setting, personnel who are not licensed practitioners or nurses but who assist a resident with self administration with supervision or self-directed administration are required to complete, at a minimum, a 4-hour medication supervision education program covering both prescription and non-prescription medication taught by a licensed nurse, licensed practitioner or pharmacist, or other person who has undergone such training by a licensed nurse, licensed practitioner or pharmacist, and shall be conducted either in person or through other means such as electronic media.

- iii. Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to record and report medication errors to the Bureau of Licensing and Certification [and to the participant's primary care provider].

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

Home Health agencies must report errors as follows, as required by He-P 809:

Develop and implement a system for reporting to the client's prescribing, licensed practitioner any:
Observed adverse reactions to medication; and
Side effects, or medication errors such as incorrect medications.

Assisted Living/Residential Care Facilities are required by He-P 804 to report to the resident's licensed practitioner any adverse reactions and side effects to medications or medication errors, such as incorrect medications, within 24 hours of the adverse reaction or medication error, including documentation in the resident's file.

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

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

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

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

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

Compliance is monitored during regularly, usually annual unless otherwise specified, licensing inspections are conducted by the Bureau of Licensing and Certification .

Findings regarding CFI Waiver participants, and any subsequent actions planned, are reported to BEAS.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participant records demonstrating that the risk for instances of abuse, neglect, and exploitation were assessed and discussed annually. N: Number of waiver participant records demonstrating that the risk for instances of abuse, neglect, and exploitation were assessed and discussed annually. D: Number of waiver participant records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews, off and on-site

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>

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

Data Aggregation and Analysis:

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

Performance Measure:

The number and percent of CFI participant substantiated reports of abuse, neglect, and exploitation that were investigated within the required timelines. N: Number of CFI participant substantiated reports of abuse, neglect, and exploitation that were investigated within the required timelines. D: Number of CFI Participant substantiated reports of abuse, neglect, and exploitation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

BEAS Options IT system Abuse, neglect, and exploitation reports

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of CFI Waiver participant sentinel events regarding abuse, neglect, exploitation, and unexplained death (ANEUD) that were referred to appropriate investigative entities. N: Number of CFI Waiver participant sentinel events regarding ANEUD that were referred to appropriate investigative entities. D: Number of CFI Waiver participant sentinel events regarding ANEUD.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Supplemental information provided with submission of sentinel event forms

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

		<input type="text"/>
	<p>Other Specify:</p> <input type="text"/>	

Data Aggregation and Analysis:

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

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

The number and percent of CFI Waiver participant sentinel events that are analyzed to identify trends. Numerator: The number of CFI Waiver participant sentinel events that are analyzed to identify trends. Denominator: Number of CFI Waiver participant sentinel events.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Bureau of Elderly and Adult Services (BEAS) sentinel event data

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

Data Aggregation and Analysis:

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

Performance Measure:

The number and percent of CFI Waiver participant sentinel event (SE) trends identified from the SE analysis that received recommendations for systemic interventions. N: The number of CFI waiver participant SE trends identified from the SE analysis that received recommendations for systemic interventions. D: Number of CFI waiver participant SE trends identified from SE analysis.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Bureau of Elderly and Adult Services (BEAS) sentinel event data

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

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

Data Aggregation and Analysis:

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

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

The number and percent of residential care (RC) licensing visits with documentation that policies are in place regarding the use of restrictive interventions(RI), including restraints and seclusion. N: The number of RC licensing visits with documentation that policies are in place regarding the use of RI, including restraints and seclusion. D: Total number of RC licensing visits.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

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

Performance Measure:

The number and percent of instances of restrictive interventions (including restraint and seclusion) in which agency policies and procedures were followed. N: The number of instances of restrictive interventions (including restraint and seclusion) in which agency policies and procedures were followed. D: Total number of restrictive interventions (including restraint and seclusion).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews on and off site.

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

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

Number and percent of assisted living facility/residential care licensing visits demonstrating compliance with regulatory requirements for medication management. N: Number of ALF/RC licensing visits demonstrating compliance with regulatory requirements for medication management D: Number of ALF/RC licensing visits

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

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

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of quarterly case management Quality Management Reports that include the requirements found in He-E 805. N: Number of quarterly case management Quality Management Reports that include the requirements found in He-E 805. D: Number of quarterly Case Management Quality Management Reports reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports submitted to DHHS by the Case Management Agency

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>	Annually
	Continuously and Ongoing

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Pursuant to He-E 805 the Case Management Agencies are required to perform quarterly reviews and develop quality management reports which are reviewed quarterly as part of the quality process. The requirement is that on a quarterly basis, case management agencies shall conduct a participant record review to evaluate the delivery of services identified in the comprehensive care plan to ensure participant needs are being met in the community, and shall document and submit to the Department the results of the review quarterly in a quality management report with specific details as required from He-E 805 Administrative Rules.

On a quarterly basis, Case Management Agencies are also expected to conduct a review of all reported complaints, incidents and sentinel events related to the delivery of services identified in the comprehensive care plan, and to document and submit to the Department the results of the review in a quarterly quality management report. Case Management Agencies are guided by the Administrative Rules to plan and take any remedial action necessary to address deficiencies in service delivery identified in the quarterly quality management reports. Case Management Agencies are subject to monitoring by DHHS to ensure that services are provided in accordance with He-E 805.

Case Management Agencies are also required to, on a quarterly basis conduct a review of all reported complaints, incidents and sentinel events related to services provided through the CFI Waiver participant’s person centered plan and to document and submit to the Department the results of the review. Reports include: the number of reported complaints, incidents and sentinel events, summary of the review results, description of deficiencies and remedial action taken or planned including the dates the action was taken or will be taken.

Care Management Agency reports are retained by the Case Management Agency for a minimum of two years and are provided to the Department on a quarterly basis.

The Department’s Bureau of Program Quality (BPQ) plays a pivotal role in collaboration with the CFI Waiver Administrator, in promoting safe and effective CFI Waiver Services.

BPQ works with the CFI Waiver Administrator to ensure the results of data collection related to health and safety are made available on a timely basis; meets with relevant state entities responsible for oversight of Waiver related health and safety activities; assists with record/compliance reviews and the development of and when indicated, Quality Improvement Plans. BPQ is responsible for receipt and the documentation of sentinel event data. BEAS is responsible for reviewing and tracking all reports and internal reviews and reviews with community providers are conducted when there are multiple system touch points and/or to identify recommendations and opportunities to mitigate future negative events.

BEAS facilitates meetings to review and discuss CFI Waiver issues, reaching out to other state agencies that provide critical oversight and monitoring of CFI Waiver services including the Office of the Long Term Care Ombudsman, the Bureau of Family Assistance, Adult Protective Services, and the Bureau of Licensing and Certification to ensure open lines of communication and follow up on issues and concerns related to CFI Waiver participants.

The Bureau of Elderly and Adult Services reviews Sentinel Event data quarterly for trending and informing quality performance measures are being met. The BEAS reviews each Sentinel Event report that comes in for completeness and compliance with regulation and policy and uses Technical Assistance sessions with CFI Case Managers to review problems and provide guidance for corrections.

The Bureau of Licensing and Certification monitor compliance during on site visits and if an ALF/RC is found to be out of compliance a corrective action plan is required of the facility and monitored by the Bureau until compliance is met.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

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

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the

waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The criteria for selecting priority areas of improvement will be based on the following factors: prevalence (i.e. would improvement affect many participants); relevance (i.e. to what extent would improvement affect participant outcomes); probability of success (i.e. have improvement strategies been tested and documented); and available resources (i.e. are there sufficient staff, funds and other resources to sufficiently address the issue). As part of this work, within the first six months of the waiver renewal, the Operating Agency will develop Quality Management (QM) Plan that sets forth the purpose of the QM plan; its governing values and principles; roles and responsibilities for QM activities; core domains and measures for assessing performance; discovery methods, criteria for selecting priority areas for improvement; and a work plan. As part of this, the Operating Agency will review roles and responsibilities for oversight and improvement functions to ensure they are clearly delineated. The Bureau of Elderly and Adult Services will identify at least one area of quality improvement to address each year. The areas to be addressed will be identified by the end of each waiver year and remediation actions will occur during the following year.

The Operating Agency is ultimately responsible for trending, prioritizing and determining system improvements based on data analysis and remediation information. The Bureau of Elderly and Adult Services and the Division of Program Quality and Integrity meet regularly to discuss quality monitoring, quality issues, policies and provider compliance. Issues may arise that need to be addressed with system improvement initiatives. Implementing or modifying system improvement activities impacts the overall quality management strategy, therefore, it is assessed on an ongoing basis.

The Bureau of Elderly and Adult Services is the lead entity responsible for trending, prioritizing and determining system improvements based on the data analysis, remediation information, and from the ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data, which also includes data analysis, trending and the formulation of recommendations for system improvements. These partners include, but are not limited to, the Bureau of Program Integrity, Bureau of Licensing and Certification, Bureau of Program Quality, Bureau of Developmental Services, providers, participants, and family members. A plan to work on significant problem areas may result in the establishment of a specific task group or groups, which may include external stakeholders.

The Bureau of Elderly and Adult Services receives and reviews program data. Data sources include but are not limited to provider enrollment documents, Case Management record reviews, the CFI provider database, the CFI Waiver and LTSS performance Dashboards, critical incident reports, Sentinel Event Trending, Licensing and certification reviews, and provider appeals. Data are disseminated to appropriate staff to be reviewed, prioritized and recorded in the appropriate databases, spreadsheets and logs for analysis. The data analysis identifies trends and anomalies that may need immediate attention. Forums such as team meetings, Waiver Quality meetings are utilized to discuss trending topics and recommendations for remediation. Plans developed as a result of this process will be shared with stakeholders for review and recommendations. Stakeholders are notified of systemic changes through BEAS letters, memos and/or postings on the Medicaid Provider Communications website. Ongoing analysis is an important part of the process to ensure remediation efforts are working and/or to implement or alter efforts based on an analysis of outcome data.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify:	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

As indicated in section a. System Improvements above, a systematic and standardized approach for reviewing Key Indicator data is reviewed by internal DHHS staff, CFI Case Management Agencies and stakeholders at the frequency outlined. The data is reviewed as part of regularly scheduled meetings to engage all levels of the system to better understand performance data and the importance of remediation, as necessary, to ensure a meaningful and timely quality improvement process.

BEAS will remain engaged with all of its stakeholders in its efforts to continuously monitor and improve the quality of and satisfaction with services. The approach will also be subject to continuous evaluation and refinement as we learn lessons from implementation.

Within this waiver period, BEAS will aim to develop a plan and implement a Patient Experience of Care/Quality of Life Survey for CFI. The results will be evaluated to inform system design changes, effectiveness of current waiver, and improvements.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Bureau of Elderly and Adult Services and the Bureau of Developmental Services meet monthly with the the Bureau of Program Quality to review waiver quality and performance monitoring.

BEAS Waiver Manager will review the information needed to assess waiver quality and whether aspects of the quality improvement system require revision. The analysis and any recommendations, if necessary, will be shared with the BEAS Management Team and staff for initial review and then broadly shared with CFI Case Managers and stakeholders.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

--

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All claims for CFI services are paid through the New Hampshire Medicaid Management Information System (MMIS) and edits are applied to ensure that only prior authorized services are covered, provided by properly enrolled providers, and rendered to individuals who were eligible on the dates of service. Prior service authorizations are maintained in the New HEIGHTS Information System with a nightly data interface from New HEIGHTS to the MMIS where providers receive notification of the prior service authorization.

This ensures that only those services authorized by DHHS will be paid and will prevent payment of any service that is not authorized for the participant.

The Bureau of Program Integrity (BPI) within the Department of Health and Human Services monitors financial claims for NH's Medicaid Unit. BPI reviews all provider claims for fraud, waste or abuse. The unit also recovers over payments. The State conducts post-payment reviews yearly.

Specific activities within BPI include:

- On-site audits and desk reviews of provider bills and medical records;
- Monitor the Quality Inpatient Organization Contract for in-patient claims;
- Review of pending provider claims;
- Verification of recipient medical services;
- Monitor provider sanctions received by Medical Boards;
- Make recommendations for claims processing system modifications;
- Assess and report on program outcomes and recommend policy and procedure changes as necessary; and
- Review of new provider enrollment applications and provider enrollment re-validations.

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

If a credible allegation of fraud is determined after the completion of the review, a referral is made to the Medicaid Fraud Control Unit at the NH Attorney General's office for further review.

In accordance with NH Rule He-C all DHHS providers that receive \$500,000 or more in Federal Funds are required to submit an annual audit or certified financials.

The BPI monitors all financial claims for fraud, waste, or abuse in a number of ways, including, but not limited to: 1) upon a referral from a participant, DHHS staff, provider staff, etc. when a suspicion of fraud, waste, or abuse occurs; 2) When BPI data analytic system determines an anomaly in the claims data; or 3) Upon request due to a post-payment review. The State conducts post-payment reviews yearly.

The State's recoupment process is as follows: BPI sends a letter to the provider indicating an over payment has occurred and recoupment will occur from future claims. Included in the letter is the process for appealing the finding of overpayment and recoupment.

When there is suspicion of fraud, waste or abuse, the BPI will conduct reviews based on referrals or analysis of claims. On an annual basis BPI Staff will conduct post-payment reviews. BPI performs the provider reviews based on information from data analytics, upon a referral from a participant, DHHS staff, provider staff, etc. when a suspicion of fraud, waste, or abuse occurs. On-site reviews may be conducted based on individual provider investigation and the type of allegation. An on-site review is required during the enrollment process for any new home health agency provider. BPI uses a 95% confidence level with a 5% margin of error for provider reviews. These reviews may be on-site or off-site and the sample is drawn from the information identified from data analytics.

BPI completes an investigation finding letter and sends the results to the Provider. The Provider is given 30 days to respond to the findings and afforded their appeal rights. BPI may provide education to the Provider based on the review but BPI does not complete corrective action plans. BPI will follow up to ensure the Provider is complying with the education provided.

If BPI finds inappropriate claims they are recouped and removed from claims for FFP. The provider has the option to return the recovery by check, or through future claims recoupment. BPI completes a service request to the MMIS of the Provider type, and recoupment amount that is to be completed. If paid by check, the funds are processed to the appropriate fund code to ensure FFP is returned to CMS. Audits are conducted similarly across all CFI providers.

Klynveld Peat Marwick Goerdeler (KPMG) is the entity responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act.

The goals of the New Hampshire's EVV program include:

- Ensuring individuals receive the services that they are authorized to receive in order to stay healthy and safe in the

community; and

- Complying with the requirements within the 21st Century Cures Act and ensuring fraud prevention.

EVV will impact all personal care services and home health care services provided under:

- The Medicaid state plan, which are administered by the three NH Medicaid Managed Care Organizations and fee-for-service standard Medicaid; and
- Four Home and Community-Based Service (HCBS) waivers in the Division of Long Term Services and Supports under fee-for-service standard Medicaid.

CFI specific services BEAS has identified to be subject to EVV include:

- | | | | | | |
|-----------------|-----|---|-------|----|----|
| • Personal Care | CFI | Personal Care Agency Directed | T1019 | HC | U1 |
| • Personal Care | CFI | Personal Care Consumer Directed | T1019 | HC | U2 |
| • Personal Care | CFI | Participant Directed Services Personal Care | T1019 | HC | U3 |
| • Personal Care | CFI | Personal Care Special Rate | T1019 | HC | U4 |
| • Home Health | CFI | Supported Housing Level 2 | H0043 | HC | U6 |
| • Home Health | CFI | Respite Care Services** | T1005 | HC | |
| • Home Health | CFI | Respite Care Special Rates** | T1005 | HC | U1 |
| • Home Health | CFI | Home Health Aide Per Visit | T1021 | HC | |
| • Home Health | CFI | Home Health Aide 8+ Units | G0156 | HC | U1 |
| • Home Health | CFI | Skilled Nurse Per Visit | T1030 | HC | |

The NH Bureau of Program Integrity, Medicaid Program Integrity Unit is charged with oversight and validation that services are billed according to the personalized care plan by ensuring appropriate payment based on service delivery. In preparation of the implementation of EVV the Medicaid Program Integrity Unit completed random sampling of providers to identify the risks and incorporate safeguards in EVV implementation. EVV is identified as a strong mechanism for ensuring financial accountability of the programs, including reduction in unauthorized services, improvement in quality services to individuals and reduce fraud, waste and abuse.

To secure funding through the NH biennial budget process, this project was not identified in time to meet the September 1, 2016 submission deadline for the State Fiscal Year (SFY) 2018-2019 capital budget. The EVV project was submitted as part of the SFY 2020-2021 capital budget request but was ultimately not funded. It was resubmitted in the SFY 2022-2023 capital budget request, which was approved by the State Legislature and Governor in June 2021. Funding availability was the primary reason EVV implementation for New Hampshire is delayed until January 2023.

NH is planning to implement an Open Vendor/Hybrid EVV Design Model. This model gives flexibility to the State to contract with a single EVV vendor, but allows providers and MCOs to use other vendors. The State EVV system could be used by providers that do not have their own EVV solution and will aggregate EVV data from multiple sources for use prior to claims payment.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

The number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. D: Number of coded claims.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of coded claims paid for individuals that are enrolled and eligible for Waiver services. Numerator: Number of coded claims paid for individuals that are enrolled and eligible for Waiver services. Denominator: Number of coded claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System (MMIS)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

The number and percent of participants with a financial record review with sufficient documentation that services paid were actually rendered. Numerator: The number of participants with a financial record review with sufficient documentation that services

paid were actually rendered. Denominator: Number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews onsite and offsite

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <i>95% confidence level with a +/- 5% margin of error</i> </div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<i>Annually</i>	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<i>Continuously and Ongoing</i>	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

Number and percent of Waiver service rates that are consistent with the approved rate methodology. Numerator: The number of waiver service rates that are consistent with the approved rate methodology. Denominator: Number of waiver service rates.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System (MMIS) and post payment review

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

		<p><i>Sample Confidence Interval =</i></p> <input type="text"/>
<p><i>Other Specify:</i></p> <input type="text"/>	<p><i>Annually</i></p>	<p><i>Stratified Describe Group:</i></p> <input type="text"/>
	<p><i>Continuously and Ongoing</i></p>	<p><i>Other Specify:</i></p> <input type="text"/>
	<p><i>Other Specify:</i></p> <input type="text"/>	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

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

If payment errors are noted, the State requires that payments be recouped through the Medicaid Management Information System (MMIS).

Staff in the Bureau of Program Integrity (BPI) monitor financial claims for NH's Medicaid plan. They review all provider claims for fraud, waste or abuse. The unit also recovers overpayments. If there appears to be a case of fraud, it is referred to the Attorney General's office for further review. They also conduct reviews to determine if recipients are inappropriately using certain types of medications.

If it appears that a provider does not understand the program rules and requirements, DHHS provides individual training and considers the likelihood of other providers having similar misunderstandings. Additional provider training and written guidance targeted to specific issues is provided as needed.

The Bureau of Program Integrity provides management of the Quality Improvement Organization (QIO) contract, which is responsible for the review of all hospital admissions for medical necessity and quality of care.

Specific activities include:
On-site audits and desk reviews of provider bills and medical records;
Monitor the Quality Inpatient Organization Contract for in-patient claims;
Review of pended provider claims;
Verification of recipient medical services;
Monitor provider sanctions received by Medical Boards;
Make recommendations for claims processing system modifications;
Assess and report on program outcomes and recommend policy and procedure changes as necessary; and
Review of new provider enrollment applications as necessary

ii. Remediation Data Aggregation

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

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

<i>Responsible Party</i> (check each that applies):	<i>Frequency of data aggregation and analysis</i> (check each that applies):
	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

DHHS through its Division of Medicaid Services, with input from the CFI Waiver program is responsible for baseline rate determination and oversight.

The rate structure for the program consists of 1) fee-for-service billing from an established fee schedule that pays uniform rates across providers; 2) "special rates" established individually with providers based on special participant needs; and 3) "manually priced" rates that are used for specialized medical equipment services or other services such as environmental or vehicle modifications that require manual pricing.

Services reimbursed according to fee schedule rates include: Adult Family Care, Personal Emergency Response System (PERS), Adult Day Services (AMDC), In-Home Services, Financial Management services, Home Delivered Meals, Home Health Aide, Homemaker, Non-Medical Transportation, Residential Care Facility Services, Personal Care, Respite, Skilled Nursing, Supported Employment, and Supportive Housing services.

Adult Family Care, Residential Care Facility Services, Respite, Personal Care and Supported Employment services also qualify for manually-priced special rates. Upon request, manually-priced rates may be authorized for these services if DHHS determines that a participant requires specialized care not adequately reflected in the standard rate. For example, special rates for Respite services may be allowed when a participant requires ventilator care or when care must be delivered at a specialty facility with an enhanced fee. These rates are dependent on the individual needs of the participant, and determination of the rate is made on a participant-by-participant basis.

Services reimbursed exclusively through manual pricing include: Community Transition Services, Environmental Accessibility Services, Participant Directed and Managed Services, and Specialized Medical Equipment Services. The following general approach is taken by the State Medicaid Agency regarding the Rate Setting Methodology for all CFI Waiver services:

(a) The rate setting methodology shall use baseline rates effective on June 30, 2021 as the basis for rate adjustment in the State Fiscal Year 2022 and 2023 Biennium.

(b) All CFI rates shall be adjusted each Biennium to be effective July 1 of the even State Fiscal year (For example, for State Fiscal Year 2022 and 2023 Biennium, rates will be adjusted to be effective on July 1, 2021 which is the start of State Fiscal Year 2022).

(c) Rates shall be calculated by adjusting the rate in effect the prior July 1 of the even State Fiscal Year of the previous biennium by applying the Centers for Medicare and Medicaid Services (CMS) Federal Register, Actual Regulation Market Basket Update for Home Health Agency Prospective Payment System (PPS) Market Basket Update (For example, the federal fiscal year 2021, or calendar year 2021 on the Home Health Agency PPS table, will be used to calculate the July 1, 2021 rates).

(d) The calculated rates in (c) above shall be multiplied by an estimated utilization by service to reach an aggregate estimated expenditure for all CFI services.

(e) Using the aggregate estimated expenditure, calculated in (c) and (d) above, rates for CFI waiver services may be subject to a budget neutrality provision.

(f) When the New Hampshire Legislature approves CFI rate increases in a state budget, the rate increases rather than the rate adjustments established in (c) above, shall be applied as required by the budget legislation. The Department shall apply the procedures in (d) and (e), for rates not established by the New Hampshire Legislature, above to align the aggregate estimated expenditures with the legislative appropriation.

(g) No updated rates shall be in excess of the usual and customary charge for the service as provided to the general public as required by RSA 126-A:3III.(b).

Rates subject to the waiver fee schedule are established according to standard rate setting methodologies, and are determined in one of three ways:

1) For waiver services in which there is a comparable Medicaid state plan rate, the waiver service rate is established at the comparable Medicaid state plan rate. This applies to Personal Care (PCSP) Agency Directed, Home Health Aide, Adult Day Services, and Skilled Nursing.

2) For remote monitoring waiver services subject to commercial pricing, in which there is no comparable state plan rate, rates are established based on typical market prices. In 2020-2021, DHHS performed a market scan on PERS and other remote monitoring devices covered under the waiver to confirm whether the rate update methodology has kept pace with prevailing market prices. This methodology applies to PERS.

3) For waiver services in which there is no comparable state plan rate or market benchmark, rates are established based

on a rate methodology designed to cover reasonable costs incurred by providers, as informed by national and regional wage data as well as other cost benchmarks. DHHS initiated a comprehensive review of the CFI fee schedule in 2020-2021 in order to benchmark rates and improve the consistency, rationale and efficiency of the current program. Rates have been benchmarked against those for comparable services paid by other state Medicaid agencies and evaluated for cost adequacy. Determination of cost adequacy relies on national benchmarks from the federal Bureau of Labor Statistics, the United States Department of Agriculture, and other state and regional cost data and employment benchmarks. The review considered median direct wages, payroll taxes, benefits, and employee-related expenses, as well as provider administrative and program support expenses, along with representative productivity rates for each service. Rate adequacy was evaluated through modeling base rates that reflect wages of the direct care staff providing each service, as well as direct supervisory costs. Employee-related expenses, administrative and overhead expenses, and program support costs were derived as a percentage of direct care wages, based on national and regional industry standards, and then factored into the rate as a multiplier of the base wage rate. The rates also incorporate service-specific productivity factors, as well as facility, equipment, transportation, training and supply costs unique to certain types of services. This methodology applies to the following waiver services: Adult Family Care, Financial Management Services, Home Delivered Meals, Home Health Aide, Homemaker, In-Home Services, Non-Medical Transportation, Residential Care Facility Services, Respite, Skilled Nursing, Supported Employment, and Supportive Housing Services.

The rates for reimbursement are published by the state of New Hampshire and available to the public. The state of New Hampshire follows Administrative Procedures Act and conducts public hearings and solicits comments from Interested Parties, Providers, Participants, advocates and any member of the public who wishes to submit comments for input.

The URL to the Fee schedule is:

<https://www.nhmmis.nh.gov/portals/wps/wcm/connect/4d28f1004350cec3829ba2125a61be2c/2021+Fee+Schedule+-+HCBC+CFI+Covered+Procedures+Codes+as+of+07-01-2021.pdf?MOD=AJPERES>

The State provided public notice in accordance with 42 CFR §447.205. Access to the full waiver was made available both electronically (via BEAS Website) and hard copy. Additional information outlining the public process for public input for waiver amendments can be found in section Main 6-I of this waiver.

The actuarially determined rates for Dentures (Removable Prosthodontic Services), per the Milliman Report, State of New Hampshire, Department of Health and Human Services, April 1, 2023 to June 30, 2024, per the Milliman Report, State of New Hampshire, Department of Health and Human Services, April 1, 2023 to June 30, 2024 Capitation Rate Development for Adult Dental Services for the Medicaid Care Management Program, hereinafter referred to as the "Milliman Report", have an average charge of \$414.74 at a utilization of 8 per 1,000 as outlined in Exhibit C, Class III, Dentures multiplied by 1.20 Pent up Demand Adjustment and 1.013 Milliman Health Cost Guidelines – Dental™ Adjustment for a total of 9.725 per 1,000 projected utilization.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers bill the MMIS directly via submission of an 834 claims transaction or online within the MMIS. All HCBS billing is processed through the MMIS. All billing for HCBS-CFI services requires that a prior service authorization be open and current in the MMIS and that the individual is approved for the HCBS-CFI program. Prior service authorizations include only the services outlined in the approved service plan. If an individual's Medicaid status changes, claims are not paid until or unless the individual has open Medicaid status for the time period included on the claim(s).

For Removable Prosthodontic Services, rendering service billing will be submitted to the NH Medicaid approved Prepaid Ambulatory Health Plan (PAHP) for payment. Payment for this service is included in the PAHP agreement based on a rate of \$1.40 at a utilization of 8 per 1,000, as outlined in Exhibit C, Class III, Dentures, of the Milliman Report.

Providers are not authorized to bill for services without documentation that the services have been provided.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability***I-2: Rates, Billing and Claims (3 of 3)***

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

All provider billings are processed through the MMIS, which has claim edits and audits in place that ensure:

- Procedure codes that can be billed by CFI providers are limited to a specific list of services;*
- A prior service authorization is utilized and restricts claim payment;*
- Payment is made only for Program-covered services rendered by qualified providers; and*
- Participants are Program-eligible on the date(s) of service.*
- Services billed were included in the approved service plan.*

The state ensures that services billed were rendered and documented during record review. This is specified in the QI section of this Appendix (I) in the performance measure which describes the state's review of records to ensure appropriate documentation of services rendered.

The provider has the option to return the recovery by check, or through future claims recoupment. BPI completes a service request to the MMIS of the Provider type, and recoupment amount that is to be completed. If paid by check, the funds are processed to the appropriate fund code to ensure FFP is returned to CMS.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and*

providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)**g. Additional Payment Arrangements**

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

The Choices for Independence Waiver utilizes a Prepaid Ambulatory Health Plan (PAHP) for the delivery of Removable Prosthodontic Services only. No other services in this waiver, as outlined in Appendix C, are delivered by the PAHP. The PAHP operates statewide for Removable Prosthodontic Service delivery and payment for this service is included in the PAHP agreement. The PAHP does not perform any waiver operational functions nor administrative functions on behalf of the State Medicaid Agency for this waiver.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs,

or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

DHHS is the single state Medicaid agency. DHHS receives the funds.

According to state statute RSA 167:18-a: county governments pay the state a fixed amount, set biennially by the NH legislature, to fund a portion of the non-federal share of CFI Waiver costs.

The non-Federal share is comprised of State general funds appropriated from the Legislature directly to DHHS as well as county funds transferred to DHHS. The State has an IGT agreement between the State and each county.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

According to state statute RSA 167:18-a: county governments pay the state a fixed amount, set biennially by the NH legislature, to fund a portion of the non-federal share of CFI Waiver costs. There is an IGT agreement between the State and each County that governs the transfer of funds process.

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Participants who live in residential settings are responsible for paying room and board from the CFI participants income. This is paid directly to the residential care provider. The waiver payment is designated for Waiver services only.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)****a. Co-Payment Requirements.****ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)****a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	14730.61	37389.12	52119.73	53739.00	6684.00	60423.00	8303.27
2	14690.28	39726.12	54416.40	54384.00	7078.00	61462.00	7045.60
3	14708.71	42287.12	56995.83	55037.00	7496.00	62533.00	5537.17
4	14735.11	45093.12	59828.23	55697.00	7938.00	63635.00	3806.77
5	14802.35	48169.12	62971.47	56365.00	8406.00	64771.00	1799.53

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	4952		4952
Year 2	5185		5185
Year 3	5429		5429
Year 4	5684		5684
Year 5	5951		5951

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The State used the actual average length of stay (ALOS) as submitted on 372's for FY2014 through FY2019. These actual ALOS were used to calculate an average trend, for FY2014 through FY2019, of 0.30%. This trend was used to calculate FY2020 through FY2026. However, due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served, the projected numbers used for the average length of stay (ALOS) were updated to mirror the CMS approved current CFI Waiver WY1-5, FY 2017-2022 as follows:

WY	Fiscal Year	Projected ALOS J-2-b
1	FY22	289
2	FY23	289
3	FY24	289
4	FY25	289
5	FY26	289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the

following factors.

***i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D equals totals in J-2-d divided by total projected participants in each year of the waiver.

The 3.1% rate increase was a result of the State's Biennial budget legislation of 2019. This increase was applied to all services under the current, approved DD Waiver, including: Community Participation Services, Residential Habilitation/Personal Care Services, Respite, Service Coordination, Supported Employment, Assistive Technology Support Services, Community Support Services, Crisis Response Services, Environmental and Vehicle Modification Services, Specialty Services and Wellness Coaching.

Five (5) tables were created that were used to populate the WY templates in J-2-d-i. The completion of the J-2-d-i for each WY calculated a projected total expenditure. The total was divided by the projected utilization to calculate Factor D for each WY1 through WY5.

The source of data for the Developmental Disabilities (DD) waiver for State Fiscal Year (SFY) 14-19 was queried in NH's Medicaid Management Information System (MMIS). In addition, NH's Bureau of Elderly and Adult Services (BEAS), Choices for Independence (CFI) waiver for SFY14-19 was queried to assist in projecting new services to the DD waiver: Assistive Technology, for which CFI Special Medical Equipment service was used for, as they are similar services; and, Personal Emergency Response System (PERS). The additional new DD services: Individual Goods and Services (items/services otherwise not covered by NH State Plan); Non-Medical Transportation; Community Integration Services (inclusive of therapeutic, recreation and campership); and Wellness Coaching, were projected based on feedback from Bureau experience and public session input. The data calculated in each table is as follows and each WY table in J-2-d-i was entered into WMS:

Table 1: Number of Users – Projected # of Unduplicated Count by service, based on % of Total Waiver Unduplicated count, per submitted 372 reports, multiplied by updated projected utilization in B-3.

- a. SFY14-19 unduplicated counts for DD services, mentioned above, were averaged. The average was divided by the average total projected DD unduplicated count for SFY14-19 to determine the % of total unduplicated individuals. These percentages were used to project the unduplicated count per services as a percentage of the DD waiver renewal updated projected utilization in B-3.*
- b. SFY14-19 unduplicated counts for CFI services, mentioned above, were averaged. The average was divided by the average total CFI unduplicated count for SFY14-19 to determine the % of total unduplicated individuals. These percentages were used to project the unduplicated count per services as a percentage of the DD waiver renewal updated projected utilization in B-3.*
- c. For the additional new DD services, the percentage used was based on Bureau expertise and public session input, to project the unduplicated count per services as a percentage of the DD waiver renewal projected utilization in B-3.*

Table 2: Units per User part 1 - Actual Units Billed in MMIS by year.

- a. Actual units billed in MMIS by year, for the current DD services, was used to calculate an average trend by service. In addition, the average units for FY14-19 was calculated by service. The average trend was applied to the average units for FY14-19 as the base to project units used for FY22 through FY26.*
- b. Actual units billed in MMIS by year, for the CFI services (listed above), was used to calculate an average trend by service. In addition, the average units for FY14-19 was calculated by service. The average trend was applied to the average units for FY14-19 as the base to project units used for FY22 through FY26.*

Table 3: Units per User part 2 - Units Billed per service (Table 2) divided by WY projected Utilization by service (Table 1). The numbers are entered into J-2-d-i.

- a. Projected units by service (Table 2), for the current DD services, was divided by WY projected utilization by service (Table 1) to arrive at a units per user number.*
- b. Projected units by service (Table 2), for the CFI services (see above), was divided by WY projected utilization by service (Table 1) to arrive at a units per user number.*
- c. For the additional new DD services, the unit per user used was based on Bureau expertise and public session input, to project the unit per user per service.*

Table 4: Avg. Cost per unit of service - Rates (to include 3.1% rate increase) & CAPS per service, if applicable.

- a. The services for current DD and CFI that have rates are listed. A 3.1% rate increase calculation was done and added to the rate to show the rate that will be in effect 1/1/21.*
- b. The services that have a CAP are listed.*
- c. The services that are independently determined, based on an individual's needs using customary costs within their region, was listed. The rate increase, for independently determined services, is not shown as it is calculated when the prior authorization (PA) is approved in MMIS. For these services, the Avg. Cost per unit of service are calculated.*

Table 5: Projected expenditure per service - Actual 372 Expenditures, for DD & CFI services, as explained above, by year for FY14-19 were used to calculate an average trend percentage. In addition, the average expenditures for FY14-19 was calculated by service. The average trend was applied to the average expenditures for FY14-19 as the base to project expenditures used for FY22 through FY26.

Factor D's are projected to increase due to additional services added to the DD Waiver and to increasing staffing costs due to workforce shortages.

- ii. Factor D' Derivation.** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The projected numbers for Factor D', were updated to mirror the CMS approved current DD Waiver WY1, 3-5 due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served. In addition, WY2 is projected to be the same as WY1 as the current waiver shows a decrease in WY2, which is not allowed as a result of the MOE of the ARP. The updated numbers are as follows:

WY Year Projected Factor D'

WY1 FY22 \$12,183.87

WY2 FY23 \$12,183.87

WY3 FY24 \$12,500.00

WY4 FY25 \$13,000.00

WY5 FY26 \$13,500.00

Factor G' is greater than Factor D' because the acuity of individuals in the ICF-IID institution, Cedarcrest, is much higher than the acuity of individuals on the DD Waiver. In addition, managed care is making a difference in home and community based care, with cost being deferred to the MCO, thus reducing Factor D'.

- iii. Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The projected numbers for Factor G were updated to mirror the current CMS approved current DD Waiver due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served as follows:

WY Year Projected Factor G

WY1 FY22 \$158,067.00

WY2 FY23 \$164,000.00

WY3 FY24 \$168,000.00

WY4 FY25 \$172,000.00

WY5 FY26 \$176,000.00

In addition, the 2020 & 2021 numbers were increased by the rate increases of 3.1% given January 1, 2020 & January 1, 2021.

- iv. Factor G' Derivation.** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The 3.1% increase given to all Medicaid services in January 1, 2020 and 2021 was not a Medical Consumer Price Index increase but rather a State of NH Legislative mandate as part of its SFY20-21 biennial budget. In addition, as part of the State of NH Legislative SFY22-23 biennial budget, an additional 5% rate increase was given for SFY22.

Due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served, Factor G was updated in Appendix J-1 as follows:

WY	Year	Projected Factor G'
WY1	FY22	\$ 33,816.51
WY2	FY23	\$ 33,816.51
WY3	FY24	\$ 33,816.51
WY4	FY25	\$ 33,816.51
WY5	FY26	\$ 33,816.51.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Services	
Home Health Aide	
Homemaker	
Personal Care	
Respite	
Financial Management Services	
Participant Directed and Managed Services	
Adult Family Care	
Community Transition Services	
Environmental Accessibility Services	
Home-Delivered Meals	
In-Home Services	
Non Medical Transportation	
Personal Emergency Response System (PERS)	
Removable Prosthodontic Services	
Residential Care Facility Services	
Skilled Nursing	
Specialized Medical Equipment Services (SME)	
Supported Employment	
Supportive Housing Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							1971000.00
Adult Day Services		day	292	90.00	75.00	1971000.00	
Home Health Aide Total:							3388401.72
Home Health Aide Services		15 min	891	402.00	9.46	3388401.72	
Homemaker Total:							976860.00
Homemaker		15 min	540	335.00	5.40	976860.00	
Personal Care Total:							32579262.30
Personal Care		15 min	3130	2053.00	5.07	32579262.30	
Respite Total:							148277.76
Respite		15 min	64	1347.00	1.72	148277.76	
Financial Management Services Total:							194604.24
Financial Management Services		month	173	12.00	93.74	194604.24	
Participant Directed and Managed Services Total:							2057126.40
Participant Directed and Managed Services		month	80	144.00	178.57	2057126.40	
Adult Family Care Total:							1351026.00
Adult Family Care		day	50	394.00	68.58	1351026.00	
Community Transition Services Total:							53821.60
Community Transition Services		transition	5	2.00	5382.16	53821.60	
Environmental Accessibility Services Total:							2035926.63
GRAND TOTAL:							72945996.84
Total: Services included in capitation:							72945996.84
Total: Services not included in capitation:							4952
Total Estimated Unduplicated Participants:							14730.61
Factor D (Divide total by number of participants):							14730.61
Services included in capitation:							14730.61
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Services		occurrence	153	1.00	13306.71	2035926.63	
Home-Delivered Meals Total:							1630063.29
Home-Delivered Meals		meal	1104	182.06	8.11	1630063.29	
In-Home Services Total:							84088.80
In-Home Services		15 min	10	2061.00	4.08	84088.80	
Non Medical Transportation Total:							500000.00
Non Medical Transportation		trip	500	1.00	1000.00	500000.00	
Personal Emergency Response System (PERS) Total:							1364381.76
Personal Emergency Response System (PERS)		month	2674	12.00	42.52	1364381.76	
Removable Prosthodontic Services Total:							5391.62
Removable Prosthodontic Services		Each	13	1.00	414.74	5391.62	
Residential Care Facility Services Total:							11249033.55
Residential Care Facility Services		day	961	219.00	53.45	11249033.55	
Skilled Nursing Total:							3493119.60
Skilled Nursing		15 min	2204	15.00	105.66	3493119.60	
Specialized Medical Equipment Services (SME) Total:							411920.37
Specialized Medical Equipment Services (SME)		item	867	3.00	158.37	411920.37	
Supported Employment Total:							7722086.40
GRAND TOTAL:							72945996.84
Total: Services included in capitation:							
Total: Services not included in capitation:							72945996.84
Total Estimated Unduplicated Participants:							4952
Factor D (Divide total by number of participants):							14730.61
Services included in capitation:							
Services not included in capitation:							14730.61
Average Length of Stay on the Waiver:							289

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment		15 min	560	2688.00	5.13	7722086.40	
Supportive Housing Services Total:							1729604.80
Supportive Housing Services		day	139	224.00	55.55	1729604.80	
GRAND TOTAL:							72945996.84
Total: Services included in capitation:							72945996.84
Total: Services not included in capitation:							4952
Total Estimated Unduplicated Participants:							14730.61
Factor D (Divide total by number of participants):							14730.61
Services included in capitation:							14730.61
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2130907.50
Adult Day Services		day	306	92.85	75.00	2130907.50	
Home Health Aide Total:							3474641.28
Home Health Aide Services		15 min	933	368.00	10.12	3474641.28	
Homemaker Total:							931012.65
Homemaker		15 min	565	305.15	5.40	931012.65	
Personal Care Total:							33958240.20
Personal Care		15 min	3277	2020.00	5.13	33958240.20	
GRAND TOTAL:							76169085.06
Total: Services included in capitation:							76169085.06
Total: Services not included in capitation:							5185
Total Estimated Unduplicated Participants:							14690.28
Factor D (Divide total by number of participants):							14690.28
Services included in capitation:							14690.28
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							156362.59
Respite		15 min	67	1349.00	1.73	156362.59	
Financial Management Services Total:							203603.28
Financial Management Services		month	181	12.00	93.74	203603.28	
Participant Directed and Managed Services Total:							2129040.00
Participant Directed and Managed Services		month	125	96.00	177.42	2129040.00	
Adult Family Care Total:							1729247.00
Adult Family Care		day	52	475.00	70.01	1729247.00	
Community Transition Services Total:							55705.40
Community Transition Services		transition	5	2.00	5570.54	55705.40	
Environmental Accessibility Services Total:							2235527.28
Environmental Accessibility Services		occurrence	168	1.00	13306.71	2235527.28	
Home-Delivered Meals Total:							1788218.02
Home-Delivered Meals		meal	1156	190.74	8.11	1788218.02	
In-Home Services Total:							87044.76
In-Home Services		15 min	10	2133.45	4.08	87044.76	
Non Medical Transportation Total:							518000.00
Non Medical Transportation		trip	518	1.00	1000.00	518000.00	
Personal Emergency Response System (PERS) Total:							1428672.00
Personal						1428672.00	
GRAND TOTAL:							76169085.06
Total: Services included in capitation:							76169085.06
Total: Services not included in capitation:							5185
Total Estimated Unduplicated Participants:							14690.28
Factor D (Divide total by number of participants):							14690.28
Services included in capitation:							14690.28
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System (PERS)		month	2800	12.00	42.52		
Removable Prosthodontic Services Total:							21151.74
Removable Prosthodontic Services		Each	51	1.00	414.74	21151.74	
Residential Care Facility Services Total:							11652437.64
Residential Care Facility Services		day	1006	213.00	54.38	11652437.64	
Skilled Nursing Total:							3341916.97
Skilled Nursing		15 min	2307	13.71	105.66	3341916.97	
Specialized Medical Equipment Services (SME) Total:							421392.20
Specialized Medical Equipment Services (SME)		item	907	2.00	232.30	421392.20	
Supported Employment Total:							8146868.05
Supported Employment		15 min	586	2710.04	5.13	8146868.05	
Supportive Housing Services Total:							1759096.50
Supportive Housing Services		day	145	218.00	55.65	1759096.50	
GRAND TOTAL:							76169085.06
Total: Services included in capitation:							76169085.06
Total: Services not included in capitation:							5185
Total Estimated Unduplicated Participants:							14690.28
Factor D (Divide total by number of participants):							14690.28
Services included in capitation:							14690.28
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2305680.00
Adult Day Services		day	320	96.07	75.00	2305680.00	
Home Health Aide Total:							3565033.92
Home Health Aide Services		15 min	977	336.00	10.86	3565033.92	
Homemaker Total:							886312.80
Homemaker		15 min	592	277.25	5.40	886312.80	
Personal Care Total:							35450464.40
Personal Care		15 min	3431	1987.00	5.20	35450464.40	
Respite Total:							164802.36
Respite		15 min	71	1334.00	1.74	164802.36	
Financial Management Services Total:							213727.20
Financial Management Services		month	190	12.00	93.74	213727.20	
Participant Directed and Managed Services Total:							2203590.96
Participant Directed and Managed Services		month	173	72.00	176.91	2203590.96	
Adult Family Care Total:							2213424.36
Adult Family Care		day	54	574.00	71.41	2213424.36	
Community Transition Services Total:							57655.05
Community Transition Services		transition	5	1.00	11531.01	57655.05	
Environmental Accessibility Services Total:							2475048.06
Environmental Accessibility Services		occurrence	186	1.00	13306.71	2475048.06	
Home-Delivered Meals Total:							1961688.49
GRAND TOTAL:							79853601.25
Total: Services included in capitation:							79853601.25
Total: Services not included in capitation:							5429
Total Estimated Unduplicated Participants:							14708.71
Factor D (Divide total by number of participants):							14708.71
Services included in capitation:							14708.71
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home-Delivered Meals		meal	1211	199.74	8.11	1961688.49	
In-Home Services Total:							90091.21
In-Home Services		15 min	11	2007.38	4.08	90091.21	
Non Medical Transportation Total:							536000.00
Non Medical Transportation		trip	536	1.00	1000.00	536000.00	
Personal Emergency Response System (PERS) Total:							1496023.68
Personal Emergency Response System (PERS)		month	2932	12.00	42.52	1496023.68	
Removable Prosthodontic Services Total:							21981.22
Removable Prosthodontic Services		Each	53	1.00	414.74	21981.22	
Residential Care Facility Services Total:							12073413.69
Residential Care Facility Services		day	1053	207.00	55.39	12073413.69	
Skilled Nursing Total:							3323674.77
Skilled Nursing		15 min	2416	13.02	105.66	3323674.77	
Specialized Medical Equipment Services (SME) Total:							431072.00
Specialized Medical Equipment Services (SME)		item	950	2.00	226.88	431072.00	
Supported Employment Total:							8594940.92
Supported Employment		15 min	613	2733.16	5.13	8594940.92	
Supportive Housing Services Total:							1788976.16
GRAND TOTAL:							79853601.25
Total: Services included in capitation:							79853601.25
Total: Services not included in capitation:							5429
Total Estimated Unduplicated Participants:							14708.71
Factor D (Divide total by number of participants):							14708.71
Services included in capitation:							14708.71
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Housing Services		day	152	211.00	55.78	1788976.16	
GRAND TOTAL:							79853601.25
Total: Services included in capitation:							
Total: Services not included in capitation:							79853601.25
Total Estimated Unduplicated Participants:							5429
Factor D (Divide total by number of participants):							14708.71
Services included in capitation:							
Services not included in capitation:							14708.71
Average Length of Stay on the Waiver:							289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2494661.25
Adult Day Services		day	335	99.29	75.00	2494661.25	
Home Health Aide Total:							3658125.24
Home Health Aide Services		15 min	1023	308.00	11.61	3658125.24	
Homemaker Total:							843796.44
Homemaker		15 min	620	252.03	5.40	843796.44	
Personal Care Total:							36947060.56
Personal Care		15 min	3592	1955.50	5.26	36947060.56	
Respite Total:							173659.50
Respite		15 min	74	1341.00	1.75	173659.50	
Financial Management							223851.12
GRAND TOTAL:							83754386.02
Total: Services included in capitation:							
Total: Services not included in capitation:							83754386.02
Total Estimated Unduplicated Participants:							5684
Factor D (Divide total by number of participants):							14735.11
Services included in capitation:							
Services not included in capitation:							14735.11
Average Length of Stay on the Waiver:							289

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Financial Management Services		month	199	12.00	93.74	223851.12	
Participant Directed and Managed Services Total:							2280700.80
Participant Directed and Managed Services		month	270	48.00	175.98	2280700.80	
Adult Family Care Total:							
Adult Family Care		day	57	681.00	72.99	2833252.83	2833252.83
Community Transition Services Total:							
Community Transition Services		transition	6	1.00	9945.50	59673.00	59673.00
Environmental Accessibility Services Total:							
Environmental Accessibility Services		occurrence	204	1.00	13306.71	2714568.84	2714568.84
Home-Delivered Meals Total:							
Home-Delivered Meals		meal	1268	209.00	8.11	2149247.32	2149247.32
In-Home Services Total:							
In-Home Services		15 min	11	2077.64	4.08	93244.48	93244.48
Non Medical Transportation Total:							
Non Medical Transportation		trip	554	1.00	1000.00	554000.00	554000.00
Personal Emergency Response System (PERS) Total:							
Personal Emergency Response System (PERS)		month	3069	12.00	42.52	1565926.56	1565926.56
Removable Prosthodontic Services Total:							
							23225.44
GRAND TOTAL:							83754386.02
Total: Services included in capitation:							83754386.02
Total: Services not included in capitation:							5684
Total Estimated Unduplicated Participants:							14735.11
Factor D (Divide total by number of participants):							14735.11
Services included in capitation:							14735.11
Services not included in capitation:							
Average Length of Stay on the Waiver:							289

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Removable Prosthodontic Services		Each	56	1.00	414.74	23225.44	
Residential Care Facility Services Total:							12508483.26
Residential Care Facility Services		day	1103	201.00	56.42	12508483.26	
Skilled Nursing Total:							3302766.77
Skilled Nursing		15 min	2529	12.36	105.66	3302766.77	
Specialized Medical Equipment Services (SME) Total:							441003.90
Specialized Medical Equipment Services (SME)		item	995	2.00	221.61	441003.90	
Supported Employment Total:							9067685.81
Supported Employment		15 min	642	2753.24	5.13	9067685.81	
Supportive Housing Services Total:							1819452.90
Supportive Housing Services		day	159	205.00	55.82	1819452.90	
GRAND TOTAL:							83754386.02
Total: Services included in capitation:							
Total: Services not included in capitation:							83754386.02
Total Estimated Unduplicated Participants:							5684
Factor D (Divide total by number of participants):							14735.11
Services included in capitation:							
Services not included in capitation:							14735.11
Average Length of Stay on the Waiver:							289

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2699365.50
Adult Day Services		day	351	102.54	75.00	2699365.50	
Home Health Aide Total:							3754133.46
Home Health Aide Services		15 min	1071	282.00	12.43	3754133.46	
Homemaker Total:							803289.37
Homemaker		15 min	649	229.21	5.40	803289.37	
Personal Care Total:							3856875.12
Personal Care		15 min	3761	1924.00	5.33	3856875.12	
Respite Total:							184127.79
Respite		15 min	77	1351.00	1.77	184127.79	
Financial Management Services Total:							233975.04
Financial Management Services		month	208	12.00	93.74	233975.04	
Participant Directed and Managed Services Total:							2360526.00
Participant Directed and Managed Services		month	280	49.00	172.05	2360526.00	
Adult Family Care Total:							3626716.80
Adult Family Care		day	60	812.00	74.44	3626716.80	
Community Transition Services Total:							61761.54
Community Transition Services		transition	6	1.00	10293.59	61761.54	
Environmental Accessibility Services Total:							2994009.75
Environmental Accessibility Services		occurrence	225	1.00	13306.71	2994009.75	
Home-Delivered Meals Total:							2360638.12
GRAND TOTAL:							88088809.70
Total: Services included in capitation:							88088809.70
Total: Services not included in capitation:							5951
Total Estimated Unduplicated Participants:							14802.35
Factor D (Divide total by number of participants):							14802.35
Services included in capitation:							14802.35
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home-Delivered Meals		meal	1327	219.35	8.11	2360638.12	
In-Home Services Total:							96507.99
In-Home Services		15 min	12	1971.16	4.08	96507.99	
Non Medical Transportation Total:							574000.00
Non Medical Transportation		trip	574	1.00	1000.00	574000.00	
Personal Emergency Response System (PERS) Total:							1639911.36
Personal Emergency Response System (PERS)		month	3214	12.00	42.52	1639911.36	
Removable Prosthodontic Services Total:							24054.92
Removable Prosthodontic Services		Each	58	1.00	414.74	24054.92	
Residential Care Facility Services Total:							12957227.40
Residential Care Facility Services		day	1154	195.00	57.58	12957227.40	
Skilled Nursing Total:							3281909.49
Skilled Nursing		15 min	2648	11.73	105.66	3281909.49	
Specialized Medical Equipment Services (SME) Total:							451138.17
Specialized Medical Equipment Services (SME)		item	1041	1.00	433.37	451138.17	
Supported Employment Total:							9566389.53
Supported Employment		15 min	672	2774.99	5.13	9566389.53	
Supportive Housing Services Total:							1850373.36
GRAND TOTAL:							8808809.70
Total: Services included in capitation:							8808809.70
Total: Services not included in capitation:							5951
Total Estimated Unduplicated Participants:							14802.35
Factor D (Divide total by number of participants):							14802.35
Services included in capitation:							14802.35
Services not included in capitation:							289
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Housing Services		day	167	198.00	55.96	1850373.36	
GRAND TOTAL:							88088809.70
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							88088809.70
Total Estimated Unduplicated Participants:							5951
Factor D (Divide total by number of participants):							14802.35
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							14802.35
Average Length of Stay on the Waiver:							289