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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The following is a description of the changes and enhancements to the approved waiver that are being made in this renewal application:

1.) The waiver participant cap has been raised from $30,000 to $35,000.

2.) To comport with technical guidance from the 1915(c) waiver, the state is providing for In Home Residential Habilitation which includes personal care.

3.) Additional covered services include: In Home Residential Habilitation, Goods and Services, Personal Emergency Response Services (PERS), Non-Medical Transportation, Assistive Technology, Wellness Coaching, and Community Integration Services.

In Home Residential Habilitation has replaced Enhanced Personal Care which is an enhancement as it is a broader definition that includes personal care, protective oversight, supervision, and all activities related to personal growth and development to include acquisition, retention or improvement in skills related to living in the community. Enhanced Personal Care has been replaced however the services that were included in Enhanced Personal Care are included in the definition of the In Home Residential Habilitation service.

4.) Service Coordination has replaced Family Support/Service Coordination in order for New Hampshire's Bureau of Developmental Service's (NHBDS) three 1915(c) waivers to align. Family Support/Service Coordination has been replaced, however all elements of this service are included in the definition of the Service Coordination Service.

5.) Participant Directed and Managed Services (PDMS) has been modified to include the participant's ability to delegate some or all of their services to a third entity.

6.) The waiver includes the compliance and implementation of the Center for Medicare and Medicaid Services (CMS) approved NH Corrective Action Plan regarding conflict of interest requirements, direct bill, and provider selection.

7.) All waiver participants will have a completed Health Risk Screening Tool (HRST) which will result in a health care level (HCL) that identifies service and training considerations which will populate into the written service agreement based on significance of risk.

8.) The Bureau of Developmental Services (BDS) will be coordinating a long term supports and services (LTSS) participant directed and managed services (PDMS) committee with broad stake holder participation. The committee will develop a PDMS manual which will clearly define the rights and responsibilities of individuals and families relative to managing Medicaid funds and detail budget authority and employment authority.

9.) The waiver details compliance with the Home and Community Based Service's (HCBS) Final Rule and Regulations per 42 CFR 441.301(c)(4).

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

11.) Service delivery has been modified to allow for remote service provision.

12.) Temporary provision of services in hospital settings, based on an individual's needs including in home residential habilitation, service coordination, personal emergency response services, environmental and vehicle modifications, assistive technology, consultations, and respite care services.

13.) The Supports Intensity Scale (SIS) and Health Risk Screening Tool (HRST) will not require prior authorization to bill.

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

1. Request Information (1 of 3)

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

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

NH In Home Supports Waiver for Children with Developmental Disabilities: 2021 - 2025

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NH.0397
Waiver Number:NH.0397.R04.00
Draft ID: NH.006.04.00

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

Regular Waiver

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

01/01/21

Approved Effective Date: 01/01/21

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 in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

☐ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose/Goal: The purpose of the Home and Community Based Services (HCBS) In Home Support (IHS) waiver is to provide In Home Residential Habilitation, inclusive of personal care, and other related supports and services to promote greater independence and skill development for a child or youth who has a developmental disability and has significant medical or behavioral challenges, as determined pursuant to He-M 524, that allow them to remain living at home with their family and actively engaged with their community.

The waiver incorporates the core beliefs that children and youth with developmental disabilities live, work, and pursue their life aspirations within their communities. It is the state's intention to support the positive life trajectories, particularly through identified transitions that are known to be challenging, in a manner that ensures the children, youth and their families receive the necessary supports to access the broader community, build upon relationships, aspire to meet personal goals, and have access to technology, goods & services as well as access to qualified providers in order to lead a good life.

The waiver continues to be entirely participant directed and managed. Based on a comprehensive stakeholder feedback process, the waiver has been adjusted to allow for the agencies to provide greater assistance, as needed by individuals and their families, to receive support with monthly reporting, recruiting and supervision of staff and other areas of service provision which will increase the likelihood of the services meeting the waiver participant's needs. This will allow for a greater number of individuals and families to delegate aspects of services, as needed, and to benefit from the waiver. In Home Support Waiver participants will continue to have both Budget Authority and Employer Authority and there are provisions for additional delegation, as needed.

Program Description: Individuals must qualify for the NH developmental services system under RSA 171:A:2, He-M 503, and He-M 524, be Medicaid eligible, meet the ICF/IDD level of care, and are limited to those individuals who require long term support services at the same level as services provided in an institution. The waiver is considered compliant with settings as indicated by Centers for Medicare and Medicaid Services' (CMS) feedback as children residing in their family home are living in a community environment and are not isolated from the broader community.

The state has identified the functions of the Financial Management Services (FMS) entity, which manages and is the employer of record for support staff. FMS will be billed as a Medicaid Administrative function and will be processed though the Department's Center for Medicare and Medicaid Services (CMS) approved Public Assistance Cost Allocation Plan (PACAP). This brings the state into compliance for the In Home Support Waiver under NH's Corrective Action Plan with CMS. In order to further ensure the overall compliance with CMS' expectations, waiver participants and their families/authorized representatives will have a choice of their service coordinator as well as the ability to choose provider agencies. Provider agencies will have the ability to bill Medicaid directly, if they so choose.

The state's activities have been focused on ensuring there is not a conflict of interest regarding the provision of case management, FMS administrative billing, direct billing options for vendors, and compliance with CMS settings criteria. This has resulted in a review of each aspect of the proposed waiver and has resulted in modifications to the statewide service agreement template and amendment process.

The state has defined within this waiver a range of community-based services which support families and individuals. The covered services include: In Home Residential Habilitation, Goods and Services, Assistive Technology, Non-Medical Transportation, Personal Emergency Response Services (PERS), Community Integration Services, and Wellness Coaching. Items and services covered by the waiver must not otherwise be covered by the NH State Plan including but not limited to Early Periodic Screening, Diagnosis and Treatment (EPSDT), the Local Education Authority (LEA) nor the Division of Youth and Families (DCYF). The waiver is the payer of last resort.

Per NH's corrective action plan for conflict of interest compliance, provider selection will enable families to choose from a variety of resources by having access to a statewide electronic listing (provider directory) of all willing and qualified providers. Within an approved budget, the individual and/or guardian selects from all willing and qualified providers.

Program Description continued on Main: 8,B Optional.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

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

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

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on

the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and

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

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

Initially, public comment sessions were scheduled in four geographical regions of the state and included a phone/video option. These locations included Gateways Community Services, 144 Canal St, Nashua, NH; Community Partners, 113 Crosby Road Suite 1 in Dover; Speare Memorial at Boulder Point, 103 Boulder Point Road, Plymouth, NH and UNH Institute on Disability, 57 Regional Drive, Unit 8, Concord, NH. As a result of COVID-19, and per guidance received from CMS on 3/13/2020, all public comment sessions were held using phone and video access to ensure public safety. Public comment period was from 3/16/2020 to 4/15/2020.

State rules and federal requirements, including those relative to all aspects of NH's Developmental Services System, are afforded a public hearing prior to adoption.

As part of the public input process, BDS has included pre-notification and notification of the public input process for the In-Home Support waiver renewal. This includes on-going communication with our stakeholders including:

-Medical Care Advisory Committee;
-State Family Support Councils;
-Families who receive IHS Services;
-Quality Council for Developmental Services;
-Service Coordinator Supervisors;
-NH Council for Developmental Disabilities;
-Institute on Disability, University of New Hampshire; and
-NH Disabilities Rights Center.

The Public at large was notified through newspaper and postings to the DHHS website of the formal public input process.

The draft application for 1915(c) HCBS Waiver: In-Home Supports can be accessed from the BDS Home page through this link:
https://www.dhhs.nh.gov/dcbcs/bds/ihs-renewal.htm

Public Comment Sessions:

The State hosted four public hearings during the public comment period. Participants and families were able to attend via phone or zoom.

The dates, times and locations of these public hearings are listed below:

Date: Thursday, April 2, 2020 – Nashua
5:00 - 7:00 pm
Location: Cancelled
Videoconference (Zoom) or Call-in option:
To participate by videoconference (Zoom), click on the following link on your laptop, tablet, or phone:
https://unh.zoom.us/j/861078127
To participate by phone, call in at 5:00 pm to: phone # +1 646 876 9923.
(Meeting ID: 861 078 127)

Date: Monday, April 6, 2020 - Dover
Time: 5:00 - 7:00 pm
Location: Cancelled
Videoconference (Zoom) or Call-in option:
To participate by videoconference (Zoom), click on the following link on your laptop, tablet, or phone:
https://unh.zoom.us/j/514480306
To participate by phone, call in at 5:00 pm to: phone # +1 646 876 9923
(Meeting ID: 514 480 306)

Date: Tuesday, April 7, 2020 – Plymouth
5:00 - 7:00 pm
Location: Cancelled
Videoconference (Zoom) or Call-in option:

To participate by videoconference (Zoom), click on the following link on your laptop, tablet, or phone:
https://unh.zoom.us/j/184517608
To participate by phone, call in at 5:00 pm to: phone # +1 646 876 9923
(Meeting ID: 184 517 608)

Date: Monday, April 13, 2020 – Concord
10:00 am - 12:00 pm
Location: Cancelled
Videoconference (Zoom) or Call-in option:
To participate by videoconference (Zoom), click on the following link on your laptop, tablet, or phone:
https://unh.zoom.us/j/320712106
To participate by phone, call in at 10:00am to: phone # +1 646 876 9923
(Meeting ID: 320 712 106)

For more information about the public hearings, please email: linda.bimbo@unh.edu

The summary of comments with BDS responses can also be accessed from the BDS Home page through this link:
https://www.dhhs.nh.gov/dcbcs/bds/ihs-renewal.htm

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

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

7. Contact Person(s)

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

Last Name: Scheetz

First Name: Deborah

Title: Division Director of Long Term Supports and Services, DLTSS

Agency: NH Department of Health and Human Services, DLTSS

Address: 105 Pleasant Street

Address 2: Main Building

City: Concord

State: **New Hampshire**

Zip:

03301

Phone:

(603) 271-9459 **Ext:** ☐ **TTY**

Fax:

(603) 271-5166

E-mail:

Deborah.Scheetz@dhhs.nh.gov

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

Last Name:

Hunt

First Name:

Sandy

Title:

Bureau Chief of the Bureau of Developmental Services

Agency:

NH Department of Health and Human Services, DLTSS

Address:

105 Pleasant Street

Address 2:

City:

Concord

State: **New Hampshire**

Zip:

03301

Phone:

(603) 271-5026 **Ext:** ☐ **TTY**

Fax:

(603) 271-5166

E-mail:

Sandy.Hunt@dhhs.nh.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified

in Section 6 of the request.

Signature: Sandy Hunt

State Medicaid Director or Designee

Submission Date: Dec 29, 2020

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

Last Name: Lipman

First Name: Henry

Title: State Medicaid Director

Agency: 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

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:

In the waiver application, In Home Residential Habilitation has replaced the previous covered service titled Enhanced Personal Care. This change does not eliminate or limit or change previously covered services and offers an enhancement to include a focus on the growth and development of the individual relative to skill acquisition, retention and improvement related to living in the community as well as personal care and supervision. The TA guide offers a definition for In Home Residential Habilitation that the state determined was most appropriate for the services described as needed in the listening sessions by families. The services closely align with the previously covered service and offer a broader scope. Additionally, Service Coordination has replaced the previous covered service titled, Family Support/Service Coordination. This change aligns New Hampshire's three 1915(c) waivers. It does not eliminate or limit or change previously covered services.

Capitation amounts for services noted in the approved waiver have been increased or remained the same to offer greater flexibility and increased coverage. Several covered services have been added and include limits as noted in Appendix C.

Transition Plan:

To ensure a smooth transition, participants will be notified in public comment sessions, via power point, of the new name & definition of In Home Residential Habilitation that will replace the previous Enhanced Personal Care service definition.

BDS 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 planning sessions will include the appropriate covered services which will meet the individual's needs. Individualized Service Agreements (ISAs) are renewed annually.

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 individual service agreement.

Fair Hearing: Service agreements 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.

The In Home Support waiver is deemed compliant with the HCB Settings requirements because participants live at home with their family.

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 and family members to monitor and support the development and progress of the transition plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Program Description continued from Main: 2

Families and waiver participants will work with the state designated area agencies to identify, through an assessment based, person centered planning process, specific services and supports offered under this waiver that are needed to avoid placement in an institutional setting. The state maintains the ability to control costs and establish expectations regarding available resources. These resources are identified through an established rate methodology open for public inspection.

The state ensures the health and welfare of the individuals in the program through the provision of services and supports identified in the person centered plan and implementation of the complaint investigation process as outlined in He-M 202 Rights Protections Procedures and He-M 310 Rights of Individuals.

The Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST) are used to establish the written service agreement and the overall supervision and individual needs as well as individual and family factors identified in He-M 524. The previous caps, by waiver service category, have been modified which allows the families and individuals to have greater flexibility but still operate within an individual allocation.

The state provides the final approval of services and cost allocation based on the cost effectiveness of proposed services. BDS processes all Level of Care (LOC) determination reviews and applications for prior authorization of services. All waiver services must be authorized by State BDS staff. No Medicaid billing can be done without a current prior authorization service and claims submission in the Medicaid Management Information System (MMIS).

Organizational Structure: NH has identified ten state designated area agencies that are responsible for the delivery of HCBS services. Area agencies are nonprofit 501(C)(3) entities and function within state determined and identified geographic regions. Area agencies are governed by independent Boards of Directors and regional Family Support Councils. NH’s long standing tradition of local control continues to be a prominent element of the service delivery system which is driven by the overarching concepts of choice, control, and self-determination.

Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the state Medicaid agency.**

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

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

The Bureau of Developmental Services

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

RSA 171-A establishes the program requirements and directs the NH Department of Health and Human Services (DHHS), which is the single state Medicaid agency, in its responsibility of ensuring that the waiver program requirements are met. As required by RSA 171-A, DHHS has adopted administrative rules which define how the Bureau of Developmental Services (BDS) must establish, implement, and maintain a comprehensive service delivery system for people with developmental disabilities.

Administrative rule He-M 503 specifies that BDS is the responsible unit within DHHS to operate the service delivery system including the waiver program. The BDS Bureau Administrator directly reports to the Director of the Division of Long Term Supports and Services (DLTSS). Ongoing communication and regular meetings occur between the State Medicaid Director and the Director of DLTSS.

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

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

Appendix A: Waiver Administration and Operation

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

- ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Appendix A: Waiver Administration and Operation

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

- ○ **Not applicable**
- ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:

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

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

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

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

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

CMS has determined that New Hampshire is out of compliance with conflict of interest requirements, specific to the In-Home Supports for Children with Developmental Disabilities Waiver (NH.0397). In order to bring this waiver into compliance with federal regulations, the State has developed a conflict of interest (COI) corrective action plan (CAP). CMS approved the NH CAP, as originally submitted on 4/21/2017 and amended on 4/28/2018. The deadline for the implementation of the COI CAP is 8/31/21. Due to Covid-19 setbacks, CMS has granted NH an extension on the CAP to 7/1/2023.

The following is the approved approach by CMS:

1) Develop a timeline and implementation plan to provide services that comply with Conflict of Interest (COI) Regulations for those receiving Waiver Services under the following NH Waivers: In Home Supports for Children;

2) Develop a timeline and implementation plan to ensure that NH’s Organized Health Care Delivery System (OHCDS) under the following NH Corrective Action Plan (CAP)NH Waiver: 0397- In Home Supports for Children and does the following:

(a) Permits providers to voluntarily waive their right to direct payment and accept payment through the OHCDS; and,
(b) Offer the provision of and system for direct payment for providers without assigning payment to the OHCDS.

The state intends to be in compliance with the CMS approved corrective action plan.

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

NH's ten area agencies are:

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

-Family Driven: Advised by Regional Family Support Councils;

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Bureau of Developmental Services has the primary responsibility to assess the performance of and recommend to the Commissioner of Health and Human Services designation and redesignation of each area agency. Additional ongoing assessments are performed by other entities within the single state Medicaid Agency/Department of Health and Human Services (DHHS) including the Office of Program Integrity, Office of Quality Assurance and Improvement, 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:

As outlined in He-M 505, Establishment and Operation of Area Agencies, BDS conducts redesignation of each area agency on a rotating five-year schedule. The redesignation process involves a review of annual governance desk audit data, on-going quality review of key indicators data, stakeholder forums, surveys and meetings with each area agency Board of Directors.

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

The Governance Desk Audit includes a review of the following:

-Board Composition, including representation on the board by individuals/clients or their family members;
-Current Board by-laws, policies and procedures;
-Executive Director Qualifications;
-Current Area Plan (AKA strategic plan) and any amendments;
-Board of Directors Minutes;
-Information on how the area agency assures individuals, families and stakeholders are involved in planning for the provision of and satisfaction of the services;
-Review of the Human Rights Committee Membership and minutes;
-Information on how the area agency communicates with sub-contract agencies;
-Report of the area agency on-going quality assurance activities;
-Contract compliance; and
-Adherence to New Hampshire’s Corrective Action Plan.

Additionally, the governance desk audit provides a mechanism to track staff and providers who have received comprehensive training regarding the Home and Community Based Services (HCBS) expectations, heightened scrutiny criteria and the training relative to certification and licensing and its relevance to HCBS compliance with Centers for Medicare and Medicaid Services' (CMS) Final Rule. An additional component to the governance desk audit will include incident management data relative to incident, sentinel and mortality notification, documentation and systemic recommendations. Area agencies will be expected to trend the data regarding restraints, seclusion and restrictive measures and to incorporate goals in the area plan which address the reduction and use of prohibited restraints without an approved behavior plan and adequate staff training for safe implementation. The governance desk audit is intended for area agencies to provide BDS with the information it needs to ensure the area plan is meeting the needs of waiver recipients and that it is amended as necessary to achieve better services, quality providers and greater satisfaction of waiver recipients.

Annual service file reviews are conducted to ensure waiver recipients have experienced a comprehensive, assessment based, person centered planning process which results in an individual, unique and tailored plan that identifies services, goals and personal aspirations. The service plan, referred to as an individual service agreement (ISA), is reviewed to ensure goals are being met and that adequate supports are being provided and to assess the recipient’s satisfaction of services. Amendments to the plan should be fluid and reflect any changes in the individual’s clinical need. Waiver and non-waiver services shall be identified and incorporated into the written service agreement. Guiding principles and HCBS Final Rule expectations have been added to the statewide service agreement; both serve as reminders for individuals and teams as they plan supports and services.

The annual service file review is an opportunity for the area agency to perform a self-assessment and identify trends and determine corrective actions and remediation, if necessary. BDS liaisons verify the agency’s responses to the self-assessment. Service file review results are summarized in an annual report provided by the BDS Liaison. It is the expectation that the service file review results will help inform the agency of areas of need, including individual and systemic recommendations, inform policy, and provide areas that need focus in their strategic, (area) plan. The agency’s response and its effectiveness to address areas of remediation are reviewed by BDS.

The area agencies are responsible to provide the following data to BDS per their contract:

-Financial Key Indicators - Monthly Review;
-Medicaid Billing Activity - Monthly Review;

-Waitlist Utilization - Quarterly Review;
-Service Review Audits – Ongoing and a minimum of annually;
-Reports from Human Rights Committee – Annually;
-Reports from Risk Management Committee – Annually;
-Complaint investigations - Annually; reporting inclusive of the twenty day response(s) to recommendation(s);
-Health Risk Screening Tool Data – Annually; and
-Other existing data (National Core Indicator) as available.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care evaluation	☒	☐
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☐
Utilization management	☒	☐
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
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:
The number and percent of designated geographical areas where at least 5% of the new enrollees reside. Numerator: Number of designated geographical areas where at least 5% of the new waiver enrollees reside. Denominator: Total number of designated geographical areas.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waitlist Registry

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of area agencies engaged in a quality improvement process that resulted in a current area plan approved by the agency's Board of Directors. Numerator: Number of area agencies engaged in a quality improvement process that resulted in a current area plan approved by the agency's Board of Directors. Denominator: Total number of area agencies

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

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

		Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of participants enrolled per the New Hampshire Medicaid

Management Information System (MMIS) annual unduplicated count. Numerator: Number of participants enrolled per the NH MMIS annual unduplicated count. Denominator: Total number of participants approved to be served on this waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

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

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 State requires a plan of correction for failure to submit evidence of a formal quality improvement process that informs the agency's area plan.

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

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	0	21	☐
	☒	**Developmental Disability**	0	21	☐
	☒	**Intellectual Disability**	0	21	☐
☐ **Mental Illness**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

As outlined in He-M 524, Eligibility for In Home Supports waiver services is limited to any person who lives at home with his or her family and who has not exited the school system and meets the criteria below:

1.Is found eligible for services by an area agency as outlined in He-M 503:
2.Is found eligible for Medicaid by the NH Department of Health and Human Services;
3.Requires at least one of the following:

a.Services on a daily basis for:

i. Performance of basic living skills;
ii. Intellectual, communicative, behavioral, physical, sensory motor, psychosocial, or emotional, development & well-being;
iii. Medication administration; or
iv. Medical monitoring or nursing care

b.Services on a less than daily basis as part of a planned transition to more independence or to prevent circumstances that could necessitate more intrusive and costly services; and

4.Have a combination of 2 or more factors specific to the individual or a combination of at least one factor specific to the individual and one factor specific to the parent which complicate care of the individual or impede the ability of the care-giving parent to provide care, including:

a. Child/Individual:

i. Lack of age appropriate awareness of safety issues so that constant supervision is required;
ii. Destructive or injurious behavior to self or others;
iii. Inconsistent sleeping patterns or sleeping less than 6 hours per night and requiring supervision when awake; or
iv. Condition that impedes the ability of the care-giving parent to provide care;
v. Inability to participate in local community childcare or activity programs without support(s).

b. Parent Factors:

i. Care responsibilities for other family members with disabilities or health problems;
ii. Age of either parent being less than 18 years or above 59;
iii. Physical or mental health condition which impedes the ability of the care-giving parent to provide care;
iv. Founded child neglect or abuse as determined by a district court pursuant to RSA 169-C:21; or
v. Availability of only one parent for care-giving.

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:

As outlined in RSA-171-A:1-a,I, and He-M 503, for people in school and already eligible for services from the area agencies, funds shall be allocated to them 90 days prior to their graduating or exiting the school system or earlier so that any new or modified services needed are available and provided upon such school graduation or exit. BDS maintains a web based registry for all individuals needing services within the next 5 years and uses the registry to ensure adequate planning for transitions.

Additionally, He-M 524, requires the service coordinator to initiate, collaborate and facilitate the development of a transition plan beginning at age 16, earlier if necessary, so that the individual will be able to access adult supports and services when 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 State employs a child/individual cap of $35,000 and seeks an overall waiver average of approximately $17,000. In cases where an individual's proposed In Home Support waiver services exceeds the waiver cap of $35,000, the area agency will serve the child/individual and family with the authorized funds up to $35,000 and assist the family/individual to access all medically necessary services in accordance with Early Periodic Screening Diagnosis and Treatment (EPSDT) and the NH State Medicaid plan, Local Education Authority (LEA) as well as other non-waiver resources that may address any additional needs.

When the NH legislature approves rate increases in a state budget, the rate increases shall be applied as required by the budget legislation and according to the approved rate methodology and the waiver cap will be adjusted accordingly without requiring amendment submission to CMS if the increase is within the $35,000 cap. If the NH legislative body approves a rate increase that increases the $35K cap, the cap will be modified via an amendment.

Environmental and vehicle modifications that exceed the participant's $35,000 cap per year may be approved, with prior authorization from the Bureau of Developmental Services. There is a limitation of $15,000 in excess of the $35,000 cap per participant over a five year period.

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

- (●) **The following dollar amount:**

  Specify dollar amount: 35000

  The dollar amount *(select one)*

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

    Specify the formula:

    The waiver cap will be adjusted if the NH State legislature changes rates.

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

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

  Specify percent:

- ( ) **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

Individual eligibility, level of care, service plans and proposed costs are reviewed and approved in advance of waiver entrance by state staff to ensure that individual's needs can be adequately addressed within the In Home Supports waiver.

In accordance with He-M 524, any individual who has been denied as a result of not meeting eligibility or service criteria may appeal the decision through his or her parent or guardian by requesting a fair hearing pursuant to He-C 200 within 30 days of the denial letter.

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

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

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

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

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

☒ **Other safeguard(s)**

Specify:

Depending on the clinical need and eligibility of the individual, he/she may be referred to another waiver or may have additional service needs met by the NH Medicaid State Plan. The individual's service coordinator also works with the individual's family to access additional services through the Early Periodic Screening Diagnosis and Treatment (EPSDT), NH Medicaid State Plan, Local Education Authority, Division of Children, Youth and Families, Division of Behavioral Health, and/or other non-waiver resources.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	478
Year 2	490
Year 3	502
Year 4	514
Year 5	527

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of

participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Selection of entrants to the waiver is in accordance with He-M 503 and the state's administrative rule governing eligibility for services, He-M 524 the state's administrative rule governing In Home Supports waiver services.

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

(a) Which is attributable to an intellectual disability, cerebral palsy, epilepsy, autism or a specific learning disability, or any other condition of an individual found to be closely related to an intellectual disability as it refers to general intellectual functioning or impairment in adaptive behavior or requires treatment similar to that required for persons with an intellectual disability; and
(b) Which originates before such individual attains age 22, has continued or can be expected to continue indefinitely, and constitutes a severe disability to such individual’s ability to function normally in society.”

State Administrative Rule He-M 524 defines eligibility for In Home Supports and establishes minimum standards for the provision of Medicaid covered home and community-based personal care and other related supports and services that promote greater independence and skill development for individuals under age 21 who:

(a) Have a developmental disability as determined by the area agency in accordance with He-M 503;
(b) Are eligible for Medicaid;
(c) Have significant medical or behavioral challenges as determined pursuant to He-M 524; and
(d) Live at home with his or her family.

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

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:

In addition to the other groups checked in Appendix B:4, New Hampshire covers the following eligibility groups:

• Medicaid State Plan Infants and Children under the age of 19 (42 CFR 435.118)
• Medicaid State Plan Optional targeted low-income children (42 CFR 435.229)
• Medicaid State Plan Individuals aged 19 or older and under age 65 with income 133% FPL (42 CFR 435.119), through age 21.
• Medicaid State plan Children with adoption assistance, foster care, or guardianship care under IV-E (42 CFR 435.145).
• Medicaid State Plan Former Foster Care (42 CFR 435.150), through age 21.
• Individuals eligible under §1902(a)(10)(A)(i)(VIII) (42 CFR 435.119), through age 21

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:

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:
- ( ) **Other**

  Specify:

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

- (●) **Not Applicable (see instructions)**
- ( ) **The following standard under 42 CFR §435.121**

  Specify:
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

  Specify:
- ( ) **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- (●) **The following standard included under the state plan**

  (*select one*):

  - ( ) **The following standard under 42 CFR §435.121**

    Specify:

  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

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

      Specify percentage:

    - ( ) **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **The following standard under 42 CFR §435.121**

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: 0 If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

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

  Specify:
- **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

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

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

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

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

Select one:

- ◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

Level of Care determinations are made by staff within the Bureau of Developmental Services with a Bachelor's degree from a recognized college or university with a major study in human services, business, or health care administration, and four years' experience in developmental services. Each additional year of required work experience may be substituted for one year of required formal education. Each additional year of relevant formal education may be substituted for one year of required work experience."

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.

Pursuant to State Administrative Rule He-M 524, a child/individual requires ICF/IID level of care if he/she requires, on a daily basis, services for at least one of the following:

-Performance of basic living skills; Intellectual, communicative, behavioral, physical, sensory motor psychological or emotional development; Medication administration; or medical monitoring or nursing care by a licensed professional person.

-Services on a less than daily basis as part of a planned transition to more independence or to prevent circumstances that could necessitate more intrusive and costly services.

Initial requests for HCBS-IHS require area agencies to submit the application for waiver services using the NH Bureau of Developmental Services Functional Screen signed by a licensed practitioner.

The state utilizes the Functional Screen submitted by the area agency to determine if an individual meets the level of care initially, and in the case of a request for redetermination. The Functional Screen details the individual’s diagnosis, support needs in the areas of activities of daily living and instrumental activities of daily living, communication and cognition, behavior, and risk to community safety, and other medical conditions.

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.

The state has a Medical Eligibility Assessment (MEA) tool to evaluate the level of care (LOC) for the ICF/IID criteria. The state uses the Functional Screen(FS) to determine level of care for the In Home Support waiver. The Functional Screen uses the same domains as the MEA with the exception of the area of supervision; which is included in the FS but not in the MEA. The outcome of the determination of the FS is comparable to the valid and reliable MEA because it uses the same domains, and therefore is also reliable and valid.

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

The area agency submits the NH BDS functional screen form to the Bureau of Developmental Services to be reviewed by the Bureau of Developmental Services staff to determine or redetermine the child's/individual's eligibility for the waiver.

Redeterminations are completed annually by the area agency submitting an updated NH BDS functional screen form. The reevaluation process does not differ from the evaluation process.

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

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

Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

The State utilizes the following procedures to ensure timely reevaluations of level of care: The area agencies submit to Medicaid Management Information System (MMIS) reevaluation requests for HCBS-IHS services which include a revised NH BDS functional screen form, service agreement when appropriate and an IHS Community Care Waiver prior authorization (PA) request. NH's MMIS does not allow payments for claims dated beyond the expiration date of the prior authorization. In order for payment under the IHS waiver, a PA must be in place. PAs are issued only when appropriate redetermination documents are submitted to and reviewed and approved by the Bureau of Developmental Services staff.

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

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

If the application for redetermination does not have sufficient evidence for BDS to determine whether the individual continues to meet the level of care requirements, the staff requests additional information from the area agency submitting the application for renewal. The additional information requested would be recent assessments or evaluations that speak to the individual's particular needs, which can include, but are not limited to a neuropsychological evaluation, SIS, or SIB-R. If additional information received does not provide enough evidence for staff to determine the individual meets the level of care, the then request would be denied.

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:

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

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 of IHS Waiver services who receive a level of care (LOC) evaluation prior to the receipt of waiver services. Numerator: The number of applicants who receive a LOC review prior to the receipt of waiver services. Denominator: Total number of all applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Record

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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:
The number and percent of level of care (LOC) reviews that were completed using New Hampshire Bureau of Developmental Services' (BDS) approved processes and forms. Numerator: Number of LOC reviews that were completed using NH BDS' approved processes and forms. Denominator: Total number of LOC reviews completed for participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Record

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Prior to the provision of services, the area agency convenes a meeting during which the family is informed of service options available through this waiver as well as the NH Medicaid State Plan, including institutional setting, community resources, and other alternatives that may be pertinent to the child's/individual's and family's specific situation.

As specified in He-M 524, the signature page of all individual service agreements document informed consent and that the family has been fully informed of community and institutional service alternatives as well as their rights to a fair hearing if they are not in agreement with components of the individual service agreement.

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

The individual's service agreement documents the freedom of choice. The service agreement is stored and located at the area agency.

Appendix B: Participant Access and Eligibility

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

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

State regulation He-M 503 requires informed consent relative to services and service provision. Informed consent necessitates communication in a language that can be readily understood by the individual/guardian. Samples of informational brochures in various languages are available.

He-M 524 requires: Cultural competence described as the "knowledge, attitudes, and interpersonal skills applied to a providers practice methods that allow the provider to understand, appreciate, and work effectively with individuals from cultures other than his or her own."

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

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	**In Home Residential Habilitation**		
Statutory Service	**Service Coordination**		
Other Service	**Assistive Technology**		
Other Service	**Community Integration Services**		
Other Service	**Consultations**		
Other Service	**Environmental and Vehicle Modification Services**		
Other Service	**Individual Goods and Services**		
Other Service	**Non-Medical Transportation**		
Other Service	**Personal Emergency Response Services (PERS)**		
Other Service	**Respite Care Services**		
Other Service	**Wellness Coaching**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

In Home Residential Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

In home residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living and community inclusion that assist the participant to reside in the most integrated setting appropriate to his/her needs. In home residential habilitation also includes personal care and protective oversight and supervision.

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.

This service may be provided in an acute setting, only when the parent or guardian is not available and 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 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 settings 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:

None

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	Direct Service Provider
Individual	Direct Support Professional or Family Managed Employee

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Residential Habilitation

Provider Category:

Agency

Provider Type:

Direct Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Direct Service providers are unlicensed and uncertified personnel.

In the event they are required to administer medications they are trained by a nurse trainer per He-M 1201 and receive certification.

Other Standard *(specify):*

He-M 524.10 provides qualifications and training for providers. Additionally, the employer provides information regarding the staff development as identified in He-M 506 which outlines the state's requirement for staff development.

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency has the primary responsibility to verify the qualifications of direct support staff or family managed employees.

Frequency of Verification:

On an annual basis a sampling of PDMS waiver participant records will be reviewed by BDS to ensure verification of Provider Qualifications.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Residential Habilitation

Provider Category:

Individual

Provider Type:

Direct Support Professional or Family Managed Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Provided by unlicensed assistive personnel.

In the event the staff are required to administer medications they are trained by a nurse trainer per He-M 1201 and receive certification.

Other Standard *(specify):*

He-M 524.10 provides qualifications and training for providers. Additionally, the employer provides information regarding the staff development as identified in He-M 506 which outlines the state's requirement for staff development.

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency has the primary responsibility to verify the qualifications of directs support staff or family managed employees.

Frequency of Verification:

On an annual basis a sampling of PDMS waiver participant records will be reviewed by BDS to ensure verification of Provider Qualifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Service Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Service Coordination: Services which will assist eligible individuals in gaining access to needed waiver and or State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source.

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.

This service may be provided in an acute setting, only when the parent or guardian is not available and 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 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 settings 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:

None

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	Service Coordinator
Agency	Service Coordinator

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Service Coordination

Provider Category:

Individual

Provider Type:

Service Coordinator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Each potential service coordinator shall:

(1) Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;
(2) Meet professional certification and licensure requirements of the position, if applicable.

The Service Coordinator is a person chosen or approved by the individual or guardian.

A service coordinator shall not:

(1) Be a guardian of the individual whose services he or she is coordinating;
(2) Have a felony conviction;
(3) Have been found to have abused or neglected an adult with a disability based on a protective investigation performed by the bureau of elderly and adult services in accordance with He-E 700 and an administrative hearing held pursuant to He-E 200, if such a hearing is requested; or
(4) Have a conflict of interest concerning the individual, such as providing other direct services to the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The designated area agency has the primary responsibility to verify the qualification of service providers. If the service coordinator chosen by the individual or guardian is not employed by the area agency or its subcontractor the service coordinator will be employed by an authorized Medicaid provider agency.

Frequency of Verification:

Prior to the delivery of services, the Area Agency verifies qualifications.

If the area agency determines that a subcontracting service coordinator is not acting in the best interest of the individual or is not fulfilling his or her obligations as described in the letter of agreement, the area agency shall revoke the designation of the service coordinator with a 30-day notice and designate a new service coordinator, with input from the individual or guardian.

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

If the area agency determines that an approved Medicaid provider entity which bills Medicaid directly is not fulfilling its obligations the area agency will notify the Program Integrity Unit at DHHS.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Service Coordination

Provider Category:

Agency

Provider Type:

Service Coordinator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual: Each potential service coordinator shall:
(1) Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;
(2) Meet professional certification and licensure requirements of the position, if applicable.

The Service Coordinator is: a person chosen or approved by the individual or guardian.

A service coordinator shall not:
(1) Be a guardian of the individual whose services he or she is coordinating;
(2) Have a felony conviction;
(3) Have been found to have abused or neglected an adult with a disability based on a protective investigation performed by the bureau of elderly and adult services in accordance with He-E 700 and an administrative hearing held pursuant to He-E 200, if such a hearing is requested; or
(4) Have a conflict of interest concerning the individual, such as providing other direct services to the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The designated area agency has the primary responsibility to verify the qualification of service providers. If the service coordinator chosen by the individual or guardian is not employed by the area agency or its subcontractor: the service coordinator will be employed by an authorized Medicaid provider agency.

Frequency of Verification:

Prior to the delivery of services, the area agency verifies qualifications.

If the area agency determines that a subcontracting service coordinator is not acting in the best interest of the individual or is not fulfilling his or her obligations as described in the letter of agreement, the area agency shall revoke the designation of the service coordinator with a 30-day notice and designate a new service coordinator, with input from the individual or guardian.

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

If the area agency determines that an approved Medicaid provider entity which bills Medicaid directly is not fulfilling its obligations the area agency will notify the Program Integrity Unit at DHHS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Assistive technology means an item, piece of equipment, certification and training of service animal, or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve functional capabilities of participants. Assistive technology services means a service that directs/assists a participant in the selection, acquisition or use of an assistive technology device.

Assistive technology includes: (A) The evaluation of the assistive technology needs of a participant including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; (B) Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology/devices for participants. (C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices such as therapies, interventions, or services associated with other services in the service plan. (D) Coordination and use of necessary therapies, interventions or services associated with other services in the service plan. (E) Training or technical assistance for the participant or where appropriate, the family members, guardians, advocates or authorized representatives of the participant; and (F) Training or technical assistance for professional or other individuals who provides services to, employ or are otherwise substantially involved in the major life functions of participants.

Devices, controls, or appliances, specified in the individual service agreement that enable the individual to increase their ability to perform activities of daily living, and/or perceive, control, or communicate with the environment in which they live will be covered. Adaptive equipment may only include items of durable and non-durable medical equipment necessary to address the individual's functional limitations and specified in the plan of care. Adaptive equipment may be covered so long as the equipment is necessary to address the individual's functional limitations and is not to be used for recreational purposes.

May include performance of assessments to identify type of equipment needed by the participant.

This service may be provided in an acute 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 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 settings 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:

There is a service limitation cap of $10,000 over the course of a five year period of time.

An individual may be able to exceed this cap on a case by case basis with the prior approval of BDS. 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.

Assistive technology provided through the waiver is over and above that which is available under the state plan or that is the obligation of the individual's employer.

Individual Service Agreement (ISA) will specify the following:

1) The item;
2) The name of the healthcare practitioner recommending the item;
3) An evaluation or assessment regarding the appropriateness of the item;
4) A goal related to the use of the item;
5) The anticipated environment that the item will be used;
6) Current modifications to item/product and anticipated future modifications and anticipated cost.

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	Assistive Technology Provider
Individual	Assistive Technology Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Specialized training in equipment, item or product.

Verification of Provider Qualifications

Entity Responsible for Verification:

The area agency has the primary responsibility for verifying provider qualifications.

Frequency of Verification:

Annual or other schedule as outlined by law or regulation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Specialized training in equipment, item or product.

Verification of Provider Qualifications

Entity Responsible for Verification:

The area agency has the primary responsibility for verifying provider qualifications.

Frequency of Verification:

Annual or other schedule as outlined by law or regulation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Integration Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

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

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

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

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

Service Definition *(Scope):*

Community integration services utilize activity based interventions to address the assessed needs of an individual as a means to health and well being as outlined in the service agreement. Community integration services are designed to support and enhance a person's level of functioning, independence and life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by a disability.

A pass or membership for admission to community based activities is covered only when needed to address assessed needs. Community based activity passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.

Community integration services include activities that promote and individual's health and well being. Fees for water safety training are allowable. Community based camperships are allowable.

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

Community integration services inclusive of therapeutic services and camperships will have an $8,000 cap.

Any community integration services over $2,000 will require a licensed healthcare practitioner’s recommendation.

A health care practitioner's note is not needed for campership.

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	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The need for community integration services will be detailed in an individual's service agreement by the individual's person centered planning team. Team members consist of, at a minimum, the individual, the legal guardian, the service coordinator, and any other people chosen by the individual and his or her legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Receipt of purchase shall be available during post payment reviews or any time the state of NH requests verification of purchase(s).

Frequency of Verification:

Frequency of verification will be annually during the service file review(s).

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:

Consultations

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

Evaluation, training, mentoring, or special instruction, which maximize the ability of the service provider, family, and/or other caregivers of a specific child/individual to understand and care for that child's/individual's developmental, functional, health and behavioral needs. The administration of the SIS and HRST shall not require prior authorization.

Consultative Services shall not replace services available through the NH Medicaid State Plan, He-W 500 (including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, He-W 546) or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

Support and counseling regarding diagnosis and treatment of the individual to families for whom the day-to-day responsibilities of caregiving are becoming or have become overwhelming and a stressor to the family.

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.

This service may be provided in an acute 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 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 settings 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 limit: 100 hours per calendar year; BDS may authorize additional funds upon the written recommendation of a licensed professional, the recommendation of the area agency and the availability of funds.

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	**Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.**
Agency	**Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.**

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultations

Provider Category:

Individual

Provider Type:

Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.

Provider Qualifications

License *(specify):*

Psychiatrist, psychologist, or other consulting health care or disability professional requiring licensure under state law to practice, the provider is required to have the appropriate licensure and/or certification as outlined in state law.

Certificate *(specify):*

Other Standard *(specify):*

Other consulting health care or disability professionals with specialized knowledge will not need state licensure or certification, but will require meeting the requirements for their specialized field and He-M 524, as applicable. Forensic specialists are master's level clinicians with the expertise and experience to provide supports to individuals with developmental disabilities who are at risk for unsafe sexual behaviors or arson.

Verification of Provider Qualifications

Entity Responsible for Verification:

The area agency has the primary responsibility to verify the qualification of service providers.

Frequency of Verification:

Prior to the delivery of services, the area agency verifies provider qualifications.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultations

Provider Category:

Agency

Provider Type:

Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.

Provider Qualifications

License *(specify):*

Psychiatrist, psychologist, or other consulting health care or disability professional requiring licensure under state law to practice, the provider is required to have the appropriate licensure and/or certification as outlined in state law.

Certificate *(specify):*

Other Standard *(specify):*

Other consulting health care or disability professionals with specialized knowledge will not need state licensure or certification, but will require meeting the requirements for their specialized field and He-M 524, as applicable. Forensic specialists are master's level clinicians with the expertise and experience to provide supports to individuals with developmental disabilities who are at risk for unsafe sexual behaviors or arson.

Verification of Provider Qualifications

Entity Responsible for Verification:

The area agency has the primary responsibility to verify the qualification of service providers.

Frequency of Verification:

Prior to the delivery of services, the area agency verifies provider qualifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental and Vehicle Modification Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

Such adaptations may include the installation of 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, which are necessary for the welfare of the individual.

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

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

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

Relative to vehicle modification, the following are excluded: Those adaptations or improvements to a vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; purchase 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 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 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 settings 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:

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 play area. Exceptions to this service limitation may be made on a case by case basis.

Environmental and vehicle modifications that will cause the participant to exceed the $35,000 cap per year may be approved, with prior authorization from the Bureau of Developmental Services. If approved to exceed the $35,000 cap, the participant may access up to an additional $15,000 over a five year period.

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	Private Contractor, or other similarly qualified provider

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Private Contractor, or other similarly qualified provider

Provider Qualifications

License *(specify):*

As required by state law or local ordinance.

Certificate *(specify):*

As required by state law or local ordinance.

Other Standard *(specify):*

Permits relative to State and or local building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The area agency is responsible for the verification of provider qualifications.

Frequency of Verification:

When environmental modifications are requested, the qualifications of the provider will be verified on an as needed 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:

Individual Goods and Services

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

Individual Directed Goods and Services are services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the individual service agreement (ISA) (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: The item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; and the participant and their family does not have the funds to purchase the item or service is not available through other sources. Must not be an otherwise covered state plan service.

Goods and Services are purchased based on needs identified in the individual service agreement. Experimental or prohibited treatments are excluded. Directed Goods and Services must be documented in the ISA.

The coverage of these services permits a state to authorize the purchase of goods and services that are not otherwise offered in the waiver or the state plan. The goods and services purchased under this coverage may not circumvent other restrictions on the claiming for the costs of room and board.

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

There is an annual $1,500 service limit. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered plan and not exceed the waiver cap of $35,000.

The item or service must be identified as necessary in the individual service agreement. A goal related to the use of the item or service should be available in the individual service agreement, amendments to the service agreement should indicate this item if it wasn't in the original service agreement.

Documentation related to the use of the item should be available for review in monthly notes. This item 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.

The waiver does not cover items that are traditionally the responsibility of parents.

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	Individual
Agency	Person Centered Planning Team

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The need for specific goods and services will be detailed in an individual's service agreement by the individual's person centered planning team. Team members consist of, at a minimum, the individual, the legal guardian, the service coordinator, and any other people chosen by the individual and his or her legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Receipt of purchase shall be available during post payment reviews or any time the state of NH requests verification of purchase(s).

Frequency of Verification:

Frequency of verification will be annually during the service file review(s).

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:

Agency

Provider Type:

Person Centered Planning Team

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The need for specific goods and services will be detailed in an individual's service agreement by the individual's person centered planning team. Team members consist of, at a minimum, the individual, the legal guardian, the service coordinator, and any other people chosen by the individual and his or her legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of Developmental Services.

Frequency of Verification:

Frequency of verification will be annually during the service file review(s).

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

A. Transportation services are designed specifically to improve the person's and the family caregiver's ability to access community activities within their own community in response to needs identified through the individual's service agreement.
B. Transportation services can include, but are not limited to:

1. Orientation service using other services or supports for safe movement from one place to another;
2. Travel training such as supporting the individual and family in learning how to access and use informal and public transport for independence and community integration;
3. 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
4. Prepaid transportation vouchers and cards.

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

The transportation service limit has a $5,000 cap.

When the family is transporting the child, the child is with the family and the only transportation that may be covered is when the transportation that occurs is directly related to the child's disability or specific to a family managed employee providing the transportation to activities determined in the individual service agreement that are not otherwise covered by NH State Plan, including Early Periodic Screening, Development and Training (EPSDT), and Local Education Authority (LEA).

Family Managed Employees will provide proof of insurance, complete all 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	Direct Support Professional or Family Managed Employee

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Direct Support Professional or Family Managed Employee

Provider Qualifications

License *(specify):*

Any direct support professional driving a waiver participant shall have a current driver's license, a driving record check completed, a criminal record check completed, and proof of insurance and a waiver on file, if applicable. The Bureau of Elderly and Adult Services (BEAS) registry is required to be checked for family managed employees (FME).

Certificate *(specify):*

Other Standard *(specify):*

See: License
A transportation agency registered with the state to provide public transportation is an approved standard as a provider for this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The area agency is responsible to verify provider qualifications of direct support staff or family managed employees.

Frequency of Verification:

On an annual basis a sampling of PDMS waiver participant records will be reviewed by BDS to ensure verification of Provider Qualifications.

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 Services (PERS)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Smart technology that may include various types of devices such as electronic devices that enable participants at risk of institutionalization to summon help in an emergency. Covered devices may 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 may include seatbelt 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.

Various 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 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 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 settings 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:

There is an annual $2,000 service limit. An individual may exceed this service limit cap with prior authorization approval from BDS. A prior authorization for the amount requested beyond the service limit cap must include supporting documentation, identify need and correlate to the person centered plan and not exceed the waiver cap of $35,000.

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	N/A
Individual	N/A

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Services (PERS)

Provider Category:

Agency

Provider Type:

N/A

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The individual service agreement will be modified to include the use of a PERS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency is responsible for the verification of the effectiveness of the device.

Frequency of Verification:

The effectiveness of the device shall be documented in the individual service agreement and in quarterly satisfaction notes for a minimum of one year. The receipt of the purchase of the device shall be available during the post payment review or as requested by BDS. The guardian will approve the use of the device. The individual or agency will ensure they have the individual/guardian's documented approval for use of the device.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Services (PERS)

Provider Category:

Individual

Provider Type:

N/A

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The individual service agreement will be modified to include the use of a PERS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency is responsible for the verification of the effectiveness of the device.

Frequency of Verification:

The effectiveness of the device shall be documented in the individual service agreement and in quarterly satisfaction notes for a minimum of one year. The receipt of the purchase of the device shall be available during the post payment review or as requested by BDS. The guardian will approve the use of the device. The individual or agency will ensure they have the individual/guardian's documented approval for use of the device.

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:

Respite Care Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Respite Care services consist of the provision of short-term assistance, in or out of an eligible child's/individual's home, for the temporary relief and support of the family with whom the child/individual lives. Respite can be family arranged or agency arranged. Respite services within the In Home Supports waiver are provided in combination with the other In Home Support Services described in this waiver.

This service may be provided in an acute setting, only when the parent or guardian is not available and 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 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 settings 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 limitation for this service is 20% of the total budget.

Respite shall occur in accordance with He-M 513.

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

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	Respite Care Provider
Individual	Respite Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Applicant must have one unrelated reference and no history of:

a. Felony conviction; or
b. Any misdemeanor conviction involving:
1. Physical or sexual assault;
2. Violence;
3. Exploitation;
4. Child pornography;
5. Threatening or reckless conduct;
6. Theft; or
7. Any other conduct that represents evidence of behavior that could endanger the well-being of an individual.

Respite providers shall have knowledge and training in the following areas:

(1) The value and importance of respite to a family;
(2) The area agency mission statement and the importance of family-centered supports and services as described in He-M 519;
(3) Basic health and safety practices including emergency first aid;
(4) The nature of developmental disabilities;
(5) Understanding behavior as communication and facilitating positive behaviors; and
(6) Other specialized skills as determined by the area agency in consultation with the family.

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

The staff member who visited the provider's home shall complete a report of the visit that includes a statement of acceptability of the following conditions using criteria established by the agency:

(1) The general cleanliness;
(2) Any safety hazards;
(3) Any architectural barriers for the individual(s) to be served; and
(4) The adequacy of the following:
a. Lighting;
b. Ventilation;
c. Hot and cold water;
d. Plumbing;
e. Electricity;
f. Heat;
g. Furniture, including beds; and
h. Sleeping arrangements.

The following criteria shall apply to agency arranged respite providers:

(1) Providers shall be able to meet the day-to-day requirements of the person(s) served, including all of the services listed in He-M 513;
(2) Respite providers giving care in their own homes shall serve no more than 2 persons at one time; and
(3) If respite is provided overnight, respite providers shall identify a person for the agency to contact who, in the judgment of the provider, is responsible and able to assist in providing respite to an individual in the event that the provider is unable to meet the respite needs of the individual or comply with these rules.

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency has the primary responsibility to verify provider qualifications.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Care Services

Provider Category:

Individual

Provider Type:

Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Respite services within the In Home Supports waiver are provided in combination with the other In Home Support Services described in this waiver.

Under family arranged respite, families make their own arrangements for respite services through the use of extended family, neighbors, or other people known to the family.

All arrangements shall be at the discretion of, and be the responsibility of, the family. The respite service provider shall be trained in medication administration, if applicable.

The State's responsibilities with regard to oversight and monitoring of respite services when provided by the family are accomplished through service review audits of individual In Home Supports record's documentation to ensure that the services provided are in keeping with the needs identified in the individual service agreement and that appropriate screenings, as described in section C-2 have been completed.

Under agency arranged respite care, the following criteria applies:

Providers shall be able to meet the day to day requirements of the child/individual served, including:

-Activities normally engaged in by the child/individual and any special health, physical and communication needs. ·

The agency will arrange for training of respite care providers in the following areas:

-The value and importance of respite care to a family;
-Mission statement;
-Emergency first aid;
-The nature of developmental disabilities;
-Behavior management; and
-Communicable diseases.

Other specialized skills may be required of the provider, as determined by the agency in consultation with the family in need of respite care.

Training identified above shall be required unless the provider's experience or education has included such training or the respite care provider has, in the judgment of the agency and the family, sufficient skills to provide respite care for a specific person.

Medication administration shall be in compliance with applicable state laws and regulations, including delegation of tasks by a nurse to unlicensed providers per NH RSA 326.

Respite care providers giving care in their own homes shall serve no more than 2 people at one time. If respite care is provided overnight, respite care providers shall have a responsible person to contact who, in the judgment of the provider, is able to assist in providing care to a child/individual in the event that the provider is unable to meet the respite needs of the child/individual or comply with states respite rules. ·

Liability insurance shall be maintained and documented as follows:

-Providers providing respite care in their own homes shall maintain liability insurance coverage within their homeowners or tenant's insurance policies;
-Providers who will be transporting children/individuals in their own automobiles shall so inform the family or guardian and shall carry automobile liability insurance;
-Providers shall send written proof of required liability insurance to the agency; and
-The agency shall carry liability insurance to cover potential liabilities in the provision of respite care related services.

The following criteria shall apply to family arranged respite:

-Any family or individual determined to be eligible and approved by the agency to receive respite care may make its own arrangements for respite care through the use of extended family, neighbors, or other people known to the family.
-In circumstances where the family arranges for respite care, all arrangements shall be at the discretion of, and be the responsibility of, the family except as noted below.
-The agency shall establish, and inform the family of, compensation amounts and procedures for family arranged respite care.
-If respite care is to be provided in a residence certified by the state, the provider shall be trained in medication administration in compliance with the States Nurse Practice Act, NH RSA 326.

Verification of Provider Qualifications

Entity Responsible for Verification:

The family has the primary responsibility to ensure family arranged respite providers have the appropriate knowledge and training necessary to support their family member.

The agency has the primary responsibility to verify the qualifications of service providers arranged by the agency.

BDS provides additional verification upon on-site service audit/record reviews.

Frequency of Verification:

Prior to the delivery of services, the agency verifies qualifications. Families verify the qualifications for family arranged respite providers prior to delivery of services. BDS conducts on-site service audit/record reviews 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:

Wellness Coaching

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

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

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

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

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

Service Definition *(Scope):*

Plan, direct, coach and mentor individuals with disabilities in community based, inclusive exercise activities based on a licensed recreational therapist or certified personal trainer's recommendation. Develop specific goals for the individual's service agreement, including activities that are carried over into the individual's home and community; demonstrate exercise techniques and form, observe participants, and explain to them corrective measures necessary to improve their skills. Collaborate with the individual, his or her family and other caregivers and with other health and wellness professionals as needed. The Services must not otherwise be covered by NH State Plan.

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

Service limit: 100 hours per calendar year; BDS may authorize additional funds upon the written recommendation of a licensed professional, the recommendation of the area agency and the availability of funds.

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	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Coaching

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The need for wellness coaching will be detailed in an individual's service agreement by the individual's person centered planning team. Team members consist of, at a minimum, the individual, the legal guardian, the service coordinator, and any other people chosen by the individual and his or her legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Receipt of purchase shall be available during post payment reviews or any time the state of NH requests verification of purchase(s).

Frequency of Verification:

Frequency of verification will be annually during the service file review(s).

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):

In accordance with He-M 524.10 (b), the State's Administrative Rule which governs staff qualifications in the In Home Support, all providers, including providers who are family members, shall, prior to a final hiring decision:
(1) Be required by the employer to consent to:
a. A New Hampshire criminal records check to ensure that the applicant has no history of a felony conviction or misdemeanor conviction involving:
1. Physical or sexual assault;
2. Violence or exploitation;
3. Child pornography;
4. Threatening or reckless conduct;
5. Theft; or
6. Any other conduct that represents evidence of behavior that could endanger the well-being of an individual; and
b. A check of the state registry of founded reports of abuse, neglect, and exploitation, as established by RSA 161-F:49, to ensure that the applicant has no history of such actions; and
(2) Be either:
a. A minimum of 18 years of age; or
b. With the agreement of the individual or representative, and area agency, aged 15 through 17.

Additionally, He-M 506.03 provides minimum staff qualifications for all provider agency staff.

Pursuant to He-M 506.03(f), a provider agency may hire a person with a criminal record for a single offense that occurred 10 or more years ago in accordance with (g) and (h) below. In such instances, the individual, his or her guardian if applicable, and the area agency shall review the person's history prior to approving the person's employment.

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

(1) Is approved by the individual, his or her guardian if applicable, and the area agency;
(2) Does not negatively impact the health or safety of the individual(s); and
(3) Does not affect the quality of services to individuals.
(h) Upon hiring a person pursuant to (f) above, the provider agency shall document and retain the following information in the individual's record:
(1) Identification of the region, according to He-M 505.04, in which the provider agency is located;
(2) The date(s) of the approvals in (f) above;
(3) The name of the individual or individuals for whom the person will provide services;
(4) The name of the person hired;
(5) Description of the person's criminal offense;
(6) The type of service the person is hired to provide;
(7) The provider agency's name and address;
(8) The certification number and expiration date of the certified program, if applicable;
(9) A full explanation of why the provider agency is hiring the person despite the person's criminal record;
(10) Signature of the individual(s), or of the legal guardian(s) if applicable, indicating agreement with the employment and date signed;
(11) Signature of the staff person who obtained the individual's or guardian's signature and date signed;
(12) Signature of the area agency's executive director or designee approving the employment; and
(13) The signature and phone number of the person being hired.

The State ensures that criminal background checks and state registry screenings were completed during In Home Support Waiver service record audits.

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

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

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

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

Appendix C: Participant Services

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

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

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

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.*

Payment for provision of In Home Residential Habilitation shall be available to the parent or legal guardian of a child with a developmental disability when the following extraordinary conditions are met:

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

a. The child's level of dependency in performing activities of daily living, including the need for assistance with toileting, eating or mobility, exceeds that of his or her developmentally disabled peers as determined by the Functional Screen

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

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

(2) The parent has at least one of the following factors:

a. The parent has exhausted all options for obtaining in home support assistance due to the lack of availability of qualified providers; or

b. The child's need for care has an imminent, negative effect on a parent's ability to maintain paid employment.

Examples of lack of availability of qualified providers include the following:

(1) A family lives in a rural or remote area and cannot secure providers;
(2) The extensive medical or behavioral needs of the child prevent the recruiting and maintaining of providers;
(3) A family whose cultural background is different from the culture of the overall pool of providers cannot secure providers who are culturally competent;
(4) A family's work schedule requires that providers be available during evening, overnight, weekend and holiday hours, thus making it impossible to retain providers;
(5) A family's needs are such that no provider agency can be identified or is available to provide the required service; and
(6) Any other circumstance or condition of a parent or child or of local provider agencies that results in a family being unable to obtain in-home support assistance.

The provider agency shall administer payments to parents for direct support and submit requests for payment to BDS for prior authorization.

Payments to parents shall apply solely to the provision of direct support services under residential habilitation.

He-M 524 identifies other services that are not eligible for payments to parents.

(l) When a parent is paid to provide In Home Residential Habilitation, the number of hours for which a parent will receive payment shall be specified in the child's individual service agreement.

When parents are paid for the provision of direct support, they are contracted or employed as direct support providers of the provider agency. On an annual basis a sampling of PDMS waiver participants records will be reviewed by BDS to ensure verification that payments are only made for services rendered.

☒ **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 direct support providers of the provider agency. On an annual basis a sampling of PDMS waiver participants records will be reviewed by BDS 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:

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

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

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

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the 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:
Number and percent of providers demonstrating initially and continually that required certification and/or licensure standards were met. Numerator: Number of providers demonstrating initially and continually that required certification and/or licensure standards were met. Denominator: Number of 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 =

		a statistically valid representative sample with a 95% confidence level and the margin of error is +/- 5% using the RaoSoft sampling methodology.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
The number and percent of Human Resource records reviewed that demonstrated that non-licensed/non-certified providers met waiver requirements. Numerator: Number of Human Resource records reviewed that demonstrated that non-licensed/non-certified providers met waiver requirements. Denominator: Total number of non-licensed/non-certified provider Human Resource records reviewed.

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

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

		The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
The number and percent of provider records reviewed that included evidence that the provider met the training requirements per He-M 506. Numerator: Number of provider records reviewed that included evidence that the provider met the training requirements per He-M 506. Denominator: Total number of provider records reviewed.

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

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

		The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 Developmental Services will communicate any area found to be out of compliance to the area agency via written report. If necessary, a corrective action plan will be requested within 30 days of receipt of the written report.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

New Hampshire's Bureau of Developmental Services (BDS) has implemented service caps in the areas of respite, assistive technology, goods and services, non-medical transportation, consultation services, environmental and vehicle modifications, community integration services, personal emergency response services, and wellness coaching. The service caps manage and preserve the primary use of the In-Home Supports waiver for In Home Residential Habilitation services which assist the individual to develop skills that promote greater independence, community participation, and the ability to remain living at home with their family.

Service limits are as follows: Respite – 20% of the individual's budget; Assistive technology - $10,000 over a five year period; Goods and services - $1,500; non-medical transportation – $5,000; Consultation services – 100 hours per calendar year; Environmental and Vehicle Modification - 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 play area. Exceptions to this service limitation may be made on a case by case basis. Environmental and vehicle modifications that will cause the participant to exceed the $35,000 cap per year may be approved, with prior authorization from the Bureau of Developmental Services. There is a limitation of $15,000 per participant over a five year period; Community Integration Services-$8,000; Personal Emergency Response Services - $2,000; Wellness coaching – 100 hours per calendar year.

☒ **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.

The state proposes the waiver has a $35,000 per participant, per year limitation. The state limits prior authorizations to the $35,000 cap and monitors claiming in the Medicaid Management Information System (MMIS) to ensure that claims are not paid for services over the amount outlined in the prior authorization.

The individual is provided the opportunity to fully participate in the decision making process regarding the development of the individual service agreement. If there is an identification of a concern, such as missing or incomplete monthly progress notes or services are not provided per the written service agreement, a remediation strategy may be implemented by the agency. There is also an expectation that the agency that is providing financial management services (FMS) to the individual/family and will inform and ensure that they understand the rights and responsibilities of using Medicaid funds for services. This includes understanding fraud and or misuse of funds.

When a service agreement for a waiver participant is being established, the cost of services are identified. Each service agreement contains projected units/expenses for each waiver service included in the plan. Specific cost estimates are based on the customary regional costs for the services being planned and must remain within the service limits identified.

The State ensures consistent application of service limits through review of initial service agreements when an individual enters services and upon annual renewal thereafter; the state also conducts on-site service audit/record reviews. One component of this review is post-payment review to ensure that the service cap and any service limits are adhered to. The agency may require a family to delegate their services to a third party if remediation within the Participant Directed and Managed Services (PDMS) model is unsuccessful or poses a risk to the individual.

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

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

All of the children, adolescents, and young adults receiving In Home Supports are living at home in their home communities with their families.

Based upon the State's assessment of the HCB Settings in this waiver, the state confirms that services in this waiver are rendered in an HCB setting. Waiver participants reside in private home dwellings located in the community. This waiver does not provide services to participants in either congregate living facilities, institutional settings or on the grounds of institutions. Therefore, no further transition plan is required for this waiver.

NH's Statewide Transition Plan summary, final submission and public comments can be viewed at:
https://www.dhhs.nh.gov/dcbcs/bds/transition.htm

Original Statewide Transition Plan PUBLIC NOTICE:

New Hampshire’s 30 day public notice and comment period ran from January 11, 2015 to February 16,2015.

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

Four public comment sessions were held, one on January 20, 2015 at the DHHS Brown Building Auditorium in Concord, NH one on February 10, 2015 at the New Hampshire Hospital Association in Concord, NH, one on February 19th and one on February 25th. Phone and webinar participation were available at the first session; due to technical difficulties, the second session had only in-person attendance, the final two sessions were done by webinar only. Four additional opportunities were provided for feedback and included People First, the state-wide self-advocacy group, the Developmental Disabilities Council, Service Coordination Supervisors, and the Association of Residential Care Homes.

Comments were received and responded to regarding the following:

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

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

The State assures that the settings transition plan included with this renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and if necessary, will make changes to the waiver upon submission of the next amendment or renewal.

New Hampshire has drafted and submitted to CMS a Statewide Transition Plan to show how the state will establish compliance with these new regulations. It is important to note that the HCB Settings requirement does not apply to participants of IHS as one of the requirements of IHS is that individuals live at home with their family.

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 and family members to monitor and support the development and progress of the transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Service Agreement

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

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

NH utilizes ten area agencies to provide service delivery statewide. These area agencies are referred to NH's organized health care delivery system (OHCDS). The area agencies are responsible for service plan development and in some cases the area agency may subcontract with an agency (such as an independent case management agency) if directed to do so by the individual and/or the guardian. The area agencies in many cases also provide direct waiver services to the participants.

NH is currently under a Corrective Action Plan (CAP) that establishes the process to develop a system for the State of NH that is compliant with conflict of interest regulations and direct pay rules. CMS approved the CAP on April 21, 2017, and amended 4/27/2018. Per the approved CAP, NH had a plan for compliance with the implementation date of 8/31/2021. Due to Covid-19 setbacks, CMS has granted NH an extension on the CAP to 7/1/2023.

Safeguards to ensure that service plan development is conducted in the best interest of the participant include the following:

1. The Individualized Service agreement (ISA) is housed within the Health Risk Screening Platform (HRS) and is a statewide template that all Service Coordinators (Case Managers) must utilize. The template for the ISA requires that individual choice of provider is offered as an option during the person centered planning process.
2. Annually during the person centered planning process, the individual and his/her legal guardian is informed of their "client rights" which include choice of services and providers.
3. As part of the CAP, staff at the Bureau of Developmental Services (BDS) will be reviewing that choice of providers is offered during annual quality oversight process.
4. The BDS Complaint Process is in place if an individual/guardian feels as though his/her rights are being violated and/or needs are going unmet. The complaint process is utilized to improve quality of services statewide.
5. For those agencies that are providing both service plan development and other direct waiver services, BDS is requiring as part of the CAP, that agencies have a firewall in place to mitigate conflict as part of the Only Willing and Qualified Provider (OWQP) policy. Additionally, during the person centered planning process, individuals/guardians will be educated on conflict of interest requirements in cases where a conflict is present.

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.

He-M 503 requires that the Service Coordinator maximize the extent to which an individual participates in his or her person centered service planning process by:

-Explaining to the individual his or her rights;
-Explaining to the individual the service planning process;
-Eliciting information from the individual 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 service planning meetings; and
-Explaining to the individual the limits of the decision-making authority of the guardian as described in He-M 310, 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.

Individuals are invited and assisted to determine the service planning process; the individual or guardian determine the following elements of the service planning process:

-The number and length of meetings;
-The location and time of meetings;
-The meeting participants;
-Topics to be discussed;
-Whether any additional assessments or evaluations are necessary; and
-Reflect level of support needed to choose and direct services.

In addition, as outlined in He-M 503, at the quarterly meeting or at least 45 days prior to the annual person-centered service planning process, the service coordinator must:

-Ensure that all evaluations are up to date and then shared and discussed with the individual and guardian;
-Identify risk factors and plans to minimize them, if applicable;
-Assess the individual's interest in, or satisfaction with, employment; and
-Discuss the individual's progress on goals and prepare for the development of new goals to be included in the new service agreement.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Before services are provided to the individual and family under He-M 524, the area agency staff must provide an orientation to In-Home Supports to the individual or family to discuss the services and supports available through He-M 524, the services available outside of He-M 524, service limits, requirements and responsibilities of Participant Directed and Managed Services; the person-centered planning process; an explanation of alternative approaches to behavioral intervention, and medication administration requirements, if applicable.

Within 30 days of the determination of eligibility, the service coordinator holds an initial service planning meeting with the individual and family and any other person chosen by the individual/family. The basic service agreement is written with 14 days of the initial service planning meeting, and a meeting to prepare the expanded service agreement for In Home Support services is held within 20 business days of the initiation of services.

The expanded service agreement is written within 10 business days following said service planning meeting. Copies of relevant evaluations and reports are sent to the individual and family at least 5 business days before any service planning meeting. All service agreements will be documented on the Health Risk Screening statewide service agreement template and modifications will be documented using the electronic amendment form.

Within 5 business days of completion of the expanded service agreement, the service coordinator sends the individual and family a copy of the executed agreement signed by required parties, the name, address, and phone number of the service coordinator or service provider(s) who may be contacted to respond to questions or concerns, and the process for challenging the proposed service agreement. The individual and family have 10 business days to respond in writing indicating either approval or disapproval with the proposed service agreement.

The service coordinator is responsible for monitoring services identified in the service agreement and assessing individual, family, or representative satisfaction quarterly. Service agreement meetings can be requested when the individual/family response to services indicates the need, a change to another service is desired, the individual has crisis, or the service agreement is not being carried out.

All service planning occurs through a person-centered planning process that:

-Maximizes the decision-making of the individual and family,
-Is directed by the individual and family,
-Facilities personal choice by providing information and support to assist the individual and family to direct the process, including information describing the array of services and service providers available and options regarding self-direction of services,
-Includes participants freely chosen by the individual and family,
-Reflects cultural considerations of the individual is conducted in clearly understandable language and form,
-Occurs at times and a location of convenience to the individual and family,
-Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants,
-Is consistent with the individual's rights to privacy, dignity, respect, and freedom from coercion and restraint,
-Includes a method for the individual and family to request amendments to the plan,
-Records the alternative home and community based settings that were considered by the individual or representative,
-Includes information obtained through utilization of the SIS, when applicable, and HRST,
-Includes information obtained through a risk assessment if applicable,
-Includes information from specialty medical and health assessments and clinical assessments as needed,
-Includes information for personal safety assessments if applicable,
-Includes strategies to address co-occurring severe mental illness or behavioral challenges which are interfering with the individual's functioning,
-Includes individualized back up plans and strategies for when usual providers are unavailable,
-Provides a method to request updates,
-Includes strategies for solving disagreements,
-Uses a strengths based approach to identify the positive attributes of the individual and family,
-Includes the provision of auxiliary services as applicable,
-Addresses the individual's concerns about current or contemplated guardianship or other legal assignment of rights.

The individual or representative determines the following elements of the service planning process:

-Number and length of meetings,
-Location, date, and time of meetings,
-Meeting participants,
-Topics to be discussed, and
-Whether any additional assessments or evaluations are necessary.
-Reflect level of support needed to choose and direct services.

Service agreements shall describe the reporting mechanisms under He-M 524.08 In-Home Supports Service Agreement:

(a) The service agreement describing services provided pursuant to He-M 524.04 shall:

(1) Be jointly developed by the family, individual, representative, providers, service coordinator, and consultants in accordance with the individual's interests, preferences, and needs and the family's and individual's or representative's priorities;

(2) Be incorporated into the existing document, if the individual already has an IFSP pursuant to He-M 510.07 or service agreement pursuant to He-M 503.11;

(3) Include the following:

a. A list of specific activities to be carried out, including those regarding safety;

b. The specific schedule for the provision of services;

c. Name(s) of the person(s) responsible for providing the services;

d. Specific documentation requirements;

e. Specific contingency plans for assuring provision of service when the usual providers are not available;

f. Emergency contact information; and

g. An individualized budget which specifies:

1. Service components;

2. Duration and frequency of services required; and

3. Itemized cost of services;

(4) Be amended at any time by the individual, family, representative, service providers, service coordinator, and others involved in the care of the individual through joint discussion, written revision, and with indication of consent as shown by the signature of the individual or representative; and

(5) Be reviewed, and if necessary, amended, as required under (4) above, but at least annually, with:

a. Formal discussion of the individual's progress in developing greater independence and life skills;

b. Documentation of the family's, representative's, and individual's satisfaction with the service provision; and

c. Provision and review of information regarding personal rights and the complaint process.

(b) Upon completion of the service agreement, the individual or representative and area agency executive director or designee shall indicate approval by signing the agreement.

(c) The signature page of the service agreement shall document the individual's or representative's informed consent and that the individual or representative has been fully informed of community and institutional service alternatives and of the

right to a hearing, as defined in He-C 201.02 (i), to dispute any component of the service agreement.

(d) If either the individual or representative, or area agency executive director, or designee, disapproves of the service agreement or an amendment proposed pursuant to (a)(4) above, the dispute shall be resolved:

(1) Through informal discussions among the individual, family, representative, service coordinator, and area agency executive director;

(2) By reconvening a service planning meeting; or

(3) By the individual or representative filing a complaint pursuant to He-M 202.

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.

In accordance with He-M 503 and He-M 524, service agreements for participants are completed at least annually, or as changes warrant. The service plan addresses all aspects of the individual's service needs.

He-M 503.08 requires that at least 45 days prior to the expiration of the service agreement, the service coordinator ensure all assessments, including risk assessments have been completed, and also requires the identification of risk factors and plans to minimize them.

He-M 503.09 requires service planning to include information obtained through a risk assessment, which shall be administered as follows:

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

1. Sexual offending;

2. Violent aggression; or

3. Arson;

b. Upon the earlier of said individual’s entry onto the wait list or the individual’s receiving services under He-M 500;

c. Prior to any significant change in the level of the individual’s treatment or supervision;

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

e. By an evaluator with specialized experience, training, and expertise in the treatment of the types of behaviors referenced in a. above;

Additionally, 503.09 also requires that service planning include individualized backup plans and strategies.

503.10 requires that service plans include, if applicable, risk factors and the measures requires to be in place to minimize them, including backup plans and strategies.

He-M 524.08 also requires that the service plan include a list of activities to be carried out, including those regarding safety, and specific contingency plans for assuring service provision when the usual providers are not available.

The service plan must also include the number of visits to be performed by the service coordinator. Health Risk Screening Tools are required to be completed annually and a Health Care Level must be indicated in the participant's file and reviewed annually.

Additionally, area agencies 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.

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

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

When making provider selections, or at any time subsequent to initial selection, service coordinators will work closely with individuals/guardians to assist them to access available listings of all qualified providers. Individuals/guardians select the provider they wish to interview among all qualified providers.

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

-Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;
-Agree to 1 reference check;
-Meet certification and licensure requirements of the position, if any;
-Agree to a criminal records check, prior to a final hiring decision, to ensure that the applicant has no history of a felony conviction;
-A check of the state Bureau of Elderly and Adult Services for founded reports of abuse, neglect and exploitation; and
-Be a minimum of eighteen years of age. However, on an individual basis and upon agreement between the family and the area agency, persons as young as fifteen may be chosen as a provider.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

One hundred percent of service agreements are reviewed by BDS staff, annually. Thereafter, a full review is conducted whenever significant changes occur, as indicated by the annual level of care redetermination, and annually.

All HCBS services must be approved by BDS and included in the service agreement to be billable.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☒ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

Specify:

The responsible area agency maintains service agreement history and all service agreements are electronically maintained in the Medicaid Management Information System as part of the area agency submission for level of care determination/redeterminations and service authorizations.

Additionally, the Health Risk Screening (HRS) platform will be used to maintain all service agreements, statewide.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

When a service agreement has been approved by the individual or guardian and area agency director, services are implemented and monitored as follows:

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

On at least a monthly basis, the service coordinator has written or verbal communications to monitor the implementation of the service agreement with individual and or guardian.

On at least quarterly, or more frequently if specified in the service agreement, the service coordinator documents whether services:

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

He-M 524.11(b) indicates that the service coordinator shall document satisfaction with:

(1) Staff and providers such as their availability, compatibility, and adherence to the provisions of the service agreement;

(2) Progress on achieving the outcomes specified in the service agreement;

(3) Communication among the individual, family, area agency, and providers;

(4) The individual’s health and safety supports as identified in the service agreement; and

(5) The utilization of allocated funds.

The service coordinator ensures that service documentation is maintained pursuant to He-M 503.
Based on this information, the Service Coordinator determines whether or not the Service Agreement needs to be revised.

At a minimum, service agreements are reviewed and updated with the participation of all team members on an annual basis.

Service agreements may be amended at any time; an area agency director, service coordinator, service provider, individual/family all have authority to request a service planning/team meeting when the individual's/family's responses to services indicate a need, when a change is desired, when a personal crisis has developed for the individual/family, or when a service agreement is not being carried out in accordance with its terms. Amendments are made with the input and written consent of the individual and his or her guardian. Amendments will be documented using a drop down menu to itemize the reason for the amendment.

In accordance with He-M 524 and He-M 503, service coordinators are required to assist with recruiting, hiring and training providers.

In addition, He-M 524 requires that the area agency include in the individual service agreement specific contingency plans for assuring provision of service when the usual providers are not available.

The back-up plan is assessed and monitored on several different levels:

-Primary monitoring is conducted by the family and the results communicated to the service coordinator.
-Quarterly review of this occurs through additional monitoring by the service provider and the service coordinator to ensure that the plan is effective and problems are addressed.
-Monitoring of the provision of non-waiver services that are identified in the plan is conducted through monthly service coordination discussions with the family.

In addition, the BDS Liaison to the area agency is a mechanism for receiving and following up on areas of individual or systemic concern. Families have access to area agency as well as State BDS Liaisons to discuss issues and concerns.

Systemic issues are also identified and addressed during the annual service file review as well as the five year area agency redesignation process.

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the 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:
The number and percent of service agreements reviewed that address participants' assessed needs including health and welfare risks. Numerator: Number of service agreements reviewed that address participants' assessed needs including health and welfare risks. Denominator: Number of service agreements reviewed.

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

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(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 = The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **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**

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

Performance Measure:
The number and percent of service agreements that address participants' individualized goals. Numerator: Number of service agreements reviewed that address participants' individualized goals. Denominator: Number of service agreements 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 = The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of participants with a Health Care Level (HCL)3 or over who have received a clinical review by a nurse trainer within 60 days of the score. Numerator: Number of participants with a Health Care Level (HCL)3 or over who received a clinical review by a nurse trainer within 60 days. Denominator: Total number of participants with a Health Care Level (HCL)3 or over.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HRST customized report

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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 service agreements that were updated and revised when warranted by changes in the waiver participant's needs. Numerator: Number of service agreements that were updated and revised when warranted by changes in the waiver participant's needs. Denominator: Total number of participant records that reflect a change in the participant's needs.

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 = The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of service agreements that have been updated at least annually or had an approved amendment on file which extended the annual review.
Numerator: Number of service agreements that have been updated at least annually or had an approved amendment on file which extended the annual review.
Denominator: Total Number of reviewed service agreements.

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 =

		The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

		The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 percentage and number of participants whose service agreements document that they have been provided choice among waiver services and providers. Numerator: The number of participants whose service agreements document that they have been provided choice among waiver services and providers. Denominator: Total number of service agreements 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 =

		The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 Developmental Services will communicate any area found to be out of compliance to the area agency via written report. If necessary, a corrective action plan will be requested within 30 days of receipt of the written report.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- (●) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

In NH, there are three methods of service delivery within the PDMS model.

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 describe 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.

3.) Agency of Choice Model with Agency Management: Under this model, the participant, or a representative of their choosing, chooses to delegate their individual budget (budget authority) to a vendor to manage all of the participant's staffing. The participant/representative selects the vendor responsible for staffing and program oversight. The participant/representative may recommend a staff but does not set the rate of pay nor do they manage their schedule, hire, supervise or formally dismiss their support worker(s).

The state is familiar with all state and federal requirements pertaining to FMS.

Participant Directed and Managed Services (PDMS) is available statewide 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-M 524 and He-M 506.

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.

Two types of support are available to facilitate participant direction. The support furnished as a Medicaid administrative activity are in accordance with NH’s approved cost allocation 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 annual audits during the service file reviews conducted by the BDS.

The services available through the In Home Support Waiver are delivered through the participant directed and managed service delivery model. Participants are defined as: (a) the individual youth acting independently on their own behalf; (b) the parent(s) of a minor child accessing the waiver and acting on behalf of the child; (c) a legal guardian or representative acting on the waiver recipient's behalf; and, (d) 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 his or her family and are respectful of the personal values and lifestyle of the family/participant.

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

Responsiveness to family/participant preferences and requests occur within the context of state and federal laws and regulations and policies of the Area Agency.

Beginning with the initial discussion and education about In Home Supports, Area Agency staff share information with the family/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.

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

PDMS enables people to maximize 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.

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

The participant, guardian, family, area agency, private provider agencies and the Bureau of Developmental Services (BDS) 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.

Service Coordinators work with individuals and their team to develop an Individualized Service Agreement 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.

Individual Service Agreements (ISA) are created for all individuals and include the following:

- The participant, guardian, and in most cases, the family can decide what services are needed based on assessments/evaluations such as the Support Intensity Scale (SIS), Health Risk Screening Tool (HRST), Risk Assessments, etc. and how those services are provided within the scope of available resources;
- Funding is portable and service rates will be consistent statewide based on level of need;
- Utilization review is conducted by BDS to ensure the maximization of funding; and
- Allocated funds will be directed and spent where needed.

For participants that have a HRST, Health Care Level (HCL) score of 3 or over, a clinical review will be conducted by the area agency nurse trainer. The individuals team may determine the number of home site visits per year, with a minimum of two visits conducted and documented per year.

Area agencies will be responsible to educate and hold families accountable on fraud, waste, and abuse. In cases where criterion for PDMS is not met, a transition policy will be implemented to assist families in the delegation of PDMS services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who**

decide not to direct their services.

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

Specify the criteria

In NH, there are three methods of service delivery within the PDMS model.

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 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 registries 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 Service (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 Financial Management Services (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 describe 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.

3.) Agency of Choice Model with Agency Management: Under this model, the participant, or a representative of their choosing, chooses to delegate their individual budget (budget authority) to a vendor to manage all of the participant's staffing. The participant/representative selects the vendor responsible for staffing and program oversight. The participant/representative may recommend a staff but does not set the rate of pay nor do they manage their schedule, hire, supervise or formally dismiss their support worker(s).

Participant Directed and Managed Services (PDMS) is available statewide and provides for the selection of two basic participant direction opportunities and these opportunities may be used in combination, which is common.

A self-assessment will be implemented to assist participant/families in determining the level of assistance they need to manage and direct their services.

An orientation and training manual will be provided to participants/families to educate them regarding the documentation and management requirements associated with the use of Medicaid funds for Medicaid services.

An Orientation, Remediation and Transition policy will be implemented, as needed, to ensure the expectations of service delivery are met.

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.

In conjunction with He-M 524, families interested in the In Home Supports Waiver are provided orientation to the In Home Support waiver and the Participant Directed and Managed Services (PDMS) model. Interested families are provided the following by the responsible Area Agency:

(a) The services and supports available to the individual and family through He-M 524;
(b) Services available outside of He-M 524 including other departmental services, community resources and institutional alternatives that might be pertinent to the individual's and family's specific situation;
(c) The benefits and limitations, and any applicable cost of care requirements of (a) and (b) above, relative to the family's needs;
(d) The features under He-M 524, including:
(1) That services are participant-directed and managed;
(2) That the person-centered plan (service agreement) is developed to include components listed in He-M 524;
(3) Area agency oversight of services provided;
(4) The completion of criminal background checks on all prospective service providers;
(5) Responsibilities of providers and family members in the provision of services and supports;
(6) The flexibility offered to families to identify possible providers, including people known to the family such as extended family, neighbors, or others in the local community; and
(7) The process of having providers coming into the home environment.

(e) If applicable, an explanation of alternative approaches to behavioral intervention, including a description of the theory, practice, strengths and expected outcomes of the methods; and
(f) If the individual is taking medication, the supports available to administer the medication safely.

A PDMS long term supports and services committee will be developed with broad stakeholder participation.

The goal(s) of the committee will include the:

1.) Identification of a self-assessment tool to assist families to determine if PDMS is something they would opt.
2.) Development a PDMS Participant Handbook

The handbook will include all relevant information for a family to understand the use of Medicaid funds. The handbook will include the rights and responsibilities associated with the management of Medicaid funds, onboarding staff including the recruitment, training, supervision, and necessary background checks, as well as covered services in the approved waiver.

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
In Home Residential Habilitation	☒	☒
Service Coordination	☒	☒
Personal Emergency Response Services (PERS)	☒	☒
Environmental and Vehicle Modification Services	☒	☒
Assistive Technology	☒	☒
Community Integration Services	☒	☒
Non-Medical Transportation	☒	☒
Consultations	☒	☒
Respite Care Services	☒	☒
Individual Goods and Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

State designated area agencies are the only types of entities in New Hampshire that will be allowed to furnish financial management services (FMS) as an Medicaid administrative activity.

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

Costs related to FMS are a Medicaid administrative billing activity.

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:

Assists with processing criminal background checks on prospective workers.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **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.

BDS conducts a post payment review of In Home Support services.

The post payment review starts with a self-assessment process conducted by the area agency and then verified by BDS on-site monitoring. Post payment review includes:

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

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

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

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

-that all expenditures are IHS Waiver allowable expenses;

-review of utilization within the service authorization to confirm that families are provided with regular reports of actual spending versus allocated funding amount.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

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

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

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
In Home Residential Habilitation	☐
Service Coordination	☒
Personal Emergency Response Services (PERS)	☐
Wellness Coaching	☐
Environmental and Vehicle Modification Services	☐
Assistive Technology	☐
Community Integration Services	☐
Non-Medical Transportation	☐
Consultations	☐
Respite Care Services	☐
Individual Goods and 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:

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

People First of New Hampshire's mission is to assist individuals to take control of their lives through learning how to make decisions and choices which increase their level of independence as well as becoming aware of both their rights and responsibilities. People First exists to help individuals speak up and speak out about their beliefs and needs and believe in a more accessible future, where disability is just another form of diversity. In 2017, they changed their mission statement to read as follows: "We are multi-cultural champions of equality who advocate for people with disabilities to achieve their full potential".

Advocate New Hampshire:
As a result of a summit hosted by the Administration on Developmental Disabilities and Self Advocates Becoming Empowered, NH established a group named, Advocate NH. More than half of the members of this group are individuals with intellectual or developmental disabilities. The others are representatives of the University Centers for Excellence in Developmental Disabilities, DHHS/Bureau of Developmental Services, NH state disability councils, and Protection and Advocacy agencies. Advocate NH has hosted an annual statewide advocacy conference since 2013 and continues to host this conference on an annual basis. This is the only conference in NH where the spotlight session presenters include an individual with disabilities and an individual without disabilities.

Self-Advocacy Leadership Team (SALT):
SALT began as a task force of the New Hampshire Council on Developmental Disabilities and has since taken on a life of its own. The group consists of more than 10 adults with disabilities who are committed to ensuring that disability does not prevent them or anyone else from living life to the fullest. The mission of SALT is to support people who have disabilities to ensure they have the ability to live quality lives in the community.

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

In accordance with He-M 503, an individual or guardian may withdraw voluntarily from any service(s) at any time or from participant direction of any service. Likewise, an individual or guardian may withdraw voluntarily from the In Home Support waiver.

In this waiver renewal, there is a new provision which identifies how an individual or family may delegate their service delivery to a third entity of their choosing. There is a process being developed for individual(s) and family/guardian(s) that will further detail an orientation to PDMS and, identify area(s) of remediation and the ability to transition to delegating oversight to a third entity.

The IHS waiver is designed to support individuals and families to be involved with Participant Directed and Managed Services to the extent they wish, and this may be altered at any time. This waiver is for individuals and families who wish 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 to transition to an alternate service delivery method.

The service coordinator will assist the family to access the alternate services which might include agency managed services, state plan services or other DD waiver services such as respite or environmental modifications.

The state assures continuity of services and participant health and safety during the transition to increased delegation to a third entity, if applicable. Specific attention to the individual's health and welfare is provided through on-going contacts with the parent or guardian by the service coordinator.

Upon request of the individual or guardian, the area agency director shall resume services to the individual if funding is available.

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.

The NH Developmental Services system focuses on prevention of circumstances that may require termination of participant direction. Prior to accepting In Home Support Services, extensive discussions take place between the family and the area agency in an effort inform and orient individuals and parents of the intent, expectations, and requirements of participating in the IHS program.

He-M 524 elaborates on the process of educating families relative to In Home Supports and participant direction. He-M 524 requires that once an individual and family chooses to participate and is authorized to receive In Home Support services, a service coordinator is chosen and approved by the individual and family. Additionally, He-M 524 requires that the individual service agreement be jointly developed by the family, individual, providers, service coordinator, and consultants in accordance with the individual’s interests, preferences and needs and the family’s priorities.

As conditions and circumstances change, the service agreement may be modified at any time by the family, service providers, service coordinator, and others involved in the care of the individual through joint discussion, written revision, and consent.

Ultimately, if issues arise that cannot be resolved and if these are such that the State believes that Participant Directed and Managed Services is no longer in the best interest of the child, steps would be taken to transition Participant Directed Services to an alternative service delivery method or assist the family to delegate service provision to an entity.

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		400
Year 2		425
Year 3		450
Year 4		475
Year 5		500

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Both strategies are supported.

The individual and family retains ultimate authority over delivery of services when participating in a co-employer or a participant common law arrangement in that payment for services to the employee, provider, or the employing agency is contingent upon signature verification of the individual or family that the services have been provided as agreed by all parties.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The Bureau of Developmental Services has an arrangement with the NH Department of Safety for reduced fee criminal records checks. In addition, BDS participates directly in paying half the cost of the reduced fee; the remaining cost is paid by the area agency as part of its administrative responsibilities.

☒ **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:

The state's method to conduct background checks does not vary from as described in 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.

BDS' method for establishing the amount of the Participant Directed and Managed Services budget is as follows:

As outlined in He-M 503 preliminary planning to determine the services needed occurs with the individual and family at the time of intake or during subsequent discussions. Preliminary evaluations are completed and preliminary recommendations for services are made within 21 days of the application for service or within 5 days of the eligibility determination.

Within 5 business days of the determination of eligibility, the area agency conducts preliminary planning with the individual and guardian to identify and document the specific services needed. Information and evaluations shared by the family that may have been conducted through the participant's school or private practitioner, evaluations conducted as part of the eligibility determination process, and results from the Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST) and any other relevant evaluations form the basis for support level of need and service authorization.

As part of the person centered planning process, the family/individual is provided the opportunity to fully participate and have the lead voice in the decision-making process.

The method that BDS uses to consistently apply budget development to each participant is based on the average cost for services within this waiver (currently approximately $17,000). Budgets are adjusted either up to the cap of $35,000 or down to match the individual's needs.

While in home residential habilitation services are the primary service within PDMS, individuals and families have the flexibility to reallocate among the approved services within the service agreement, including increasing or decreasing the hourly wage of direct service providers to meet specific needs of the individual. A strength of this approach is that families and individuals can negotiate different payment levels for staff and providers, based on provider skill set and the individual's needs. The statewide average for an in home direct support professional is $12.60 with a range of $10.00 - $15.50 per hour. If a child, adolescent, or young adult based on assessments requires staffing expertise that exceeds this range, a justification must be included in the service agreement.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The service level process starts with identification of the individual's and care-giving family's service needs as part of the person-centered planning process. Information gathered through the eligibility process, the family (which may include existing evaluations through the participant's school or private practitioner), the Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), and any other relevant evaluations needed to determine appropriate services and support level needed.

The Individual Service Agreement (ISA) is developed jointly using the information outlined in the above paragraph with the individual/family and area agency staff. Service needs that are identified by the team drive the development of an individualized funding amount which is submitted to BDS for review/approval/denial/renegotiation.

Once the service level is approved by BDS, the communication of funding approval to the individual/family is done through the area agency.

If an individual's service needs change as demonstrated by assessments, adjustments are made to his/her service agreement via an amendment to the service agreement. If additional service funding is needed, subsequent requests follow the same process as an initial funding request in that the area agency develops with the family the revised service agreement based on changes in needs and this is costed out and submitted to BDS for approval.

In accordance with He-M 524, individuals/families always retain the right to appeal BDS' decisions.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The area agency, particularly through the Service Coordinator and Business Office, communicates with the family relative to available funds remaining in the individual's budget. Monthly reports of the status of each individual's budget and expenditures are provided to the family. Discrepancies relative to planned spending versus actual spending are addressed by the area agency and family jointly. Utilization is carefully monitored by the area agency.

If additional funds are needed as a result of increased service needs, the service agreement is modified and a request for additional funding is submitted to BDS.

Conversely, when funds are projected to be underutilized on a short term basis, the underutilized funding amount may be reallocated to another waiver eligible individual for one time needs (such as an Environmental Modifications).

Flexibility in this regard plays a significant role in the Participant Direct and Managed Services model. If significant changes are desired, for example, ending one service and adding a new service not previously included in the service agreement, a modification of the service agreement would be required. As long as these changes are budget neutral, meet the requirements for IHS, and do not exceed service limits, there may be no need for BDS to review/approve such changes. All budgets and service arrangements are reviewed on at least an annual basis.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The area agency, particularly through the Service Coordinator and Business Office, communicate with the family relative to available funds. Monthly reports of the status of each individual's budget and expenditures are provided and discussed with the family. Utilization is carefully monitored by the area agency.

If a participant/family appear to be utilizing the funding at a higher/lower rate than the monthly average, the service coordinator/business office monitors the spending and works with the family to understand if the over spending or under spending in any given quarter is related to changes in service needs.

If additional funds are needed as a result of increased service needs, the service agreement is modified (based on updated assessments) and a request for additional funding is submitted to BDS. All requests for increased funds must be accompanied by appropriate justifications to support the change in need and cannot exceed the overall cap of $35,000 per child. This should include information from recent or updated assessments/evaluations/screenings such Supports Intensity Scale, Health Risk Screening Tool, risk assessments, and/or any other relevant evaluation(s).

If funds are consistently underutilized, a permanent reduction of a participant's overall budget will be discussed with the participant/family and may be initiated by the area agency if the underutilization occurs for two consecutive years and is a direct result of a participant not needing the level of services identified in the person centered plan. Permanent budget reductions will not be made if the underutilization is the result of circumstances beyond the control of the participant and their family such as turnover of staff or family crisis.

Conversely, when funds are projected to be underutilized on a short term basis, the underutilized funding amount may be reallocated to another waiver eligible individual for one time needs (such as an Environmental Modification).

If a participant has not fully utilized the allocated funding for two consecutive years, the area agency must discuss and initiate with the participant and family, a reduction to the total allocated budget.

Discrepancies relative to planned spending vs. actual spending are addressed by the area agency and family jointly on an on-going basis.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Any Medicaid recipient who has been denied waiver services because he/she does not meet the eligibility criteria may appeal the decision by requesting a fair hearing per He-C 200. If a fair hearing is requested, the following actions occur:

For current waiver services recipients, services and payments continue as a consequence of an appeal for a fair hearing until a decision has been made; and

If BDS' decision is upheld, benefits will cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later.

As outlined in He-M 503, Within 3 days of determination of an applicant's ineligibility, the area agency must convey to each applicant, guardian, or representative a written decision that describes the specific legal and factual basis for the denial, including specific citation of the applicable law or department rule, and advise them of their appeal rights under He-M 503.

In each instance when eligibility is denied, information on the reason for denial, the right to appeal, and the process for appealing the decision shall be provided, including the names, addresses, and phone numbers of the Administrative Appeals Unit, Office of Client and Legal Services, and advocacy organizations which the individual or guardian may contact for assistance in appealing the decision.

Decisions made by BDS (waiver eligibility determinations, redeterminations of eligibility, appeals relative to service agreement disputes, termination, or suspension of services) may be appealed as outlined in He-M 524 to the DHHS Administrative Appeals Unit.

Copies of any materials related to the above actions would be located in the Medicaid Management Information System (MMIS) system under the applicant's name and/or within the area agency file depending on which stage of the eligibility process the denial was issued.

Procedure for appeals is as follows:

(a) An individual or representative may choose to pursue informal resolution to resolve any disagreement with an area agency, or, within 30 business days of the area agency decision, she or he may choose to file a formal appeal pursuant to (e) below.

Any determination, action, or inaction by an area agency may be appealed by an individual or representative.

(b) The following actions shall be subject to the notification requirements of (d) below:

(1) Adverse eligibility actions under He-M 524.03;
(2) Area agency disapproval of service agreements or proposed amendments to service agreements pursuant to He-M 524.08 (d); and
(3) Denial of services by the bureau pursuant to He-M 524.14 (c).
(c) The bureau or an area agency shall provide written and verbal notice to the applicant and representative of the actions specified in (b) above, including:

(1) The specific rules that support, or the federal or state law that requires, the action;

(2) Notice of the individual’s right to appeal in accordance with He-C 200 within 30 days and the process for filing an appeal, including the contact information to initiate the appeal with the bureau administrator;

(3) Notice of the individual’s continued right to services pending appeal, when applicable, pursuant to (g) below;

(4) Notice of the right to have representation with an appeal by:

a. Legal counsel;
b. A relative;
c. A friend; or
d. Another spokesperson;

(5) Notice that neither the area agency nor the bureau is responsible for the cost of representation;
(6) Notice of organizations with their addresses and phone numbers that might be available to provide legal assistance and advocacy, including the Disabilities Rights Center and pro bono or reduced fee assistance; and

(7) Notice of individual's right to request a second formal risk assessment from a qualified evaluator.

(d) Appeals shall be submitted, in writing, to the bureau administrator in care of the department's office of client and legal services within 30 days following the date of the notification of an area agency's decision. An exception shall be that appeals may be filed verbally if the individual is unable to convey the appeal in writing.
(e) The office of client and legal services shall immediately forward the appeal to the department's administrative appeals unit which shall assign a presiding officer to conduct a hearing or independent review, as provided in He-C 200. The burden shall be as provided by He-C 203.14.

(g) If a hearing is requested, the following actions shall occur:

(1) For current recipients, services and payments shall be continued as a consequence of an appeal for a hearing until a decision has been made; and
(2) If the bureau's or area agency's decision is upheld, benefits shall cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later.

Appendix F: Participant-Rights

Appendix F-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.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

Pursuant to 171-A:19 the NH Department of Health and Human Services has established a Client and Legal Services Section; its functions and responsibilities include but are not limited to:

-Assisting the Commissioner in responding to inquiries and complaints by or on behalf of mentally ill or developmentally disabled persons;
-Assisting the Commissioner in securing needed services and information for mentally ill persons, developmentally disabled persons, or their respective families; and
-Assisting the Commissioner in assuring that the human rights of mentally ill persons and of developmentally disabled clients in the service delivery system are protected.

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

The Office of Client and Legal Services (OCLS) administers and directly implements the complaint system outlined in He-M 202. OCLS maintains a 24 hour hot line to receive complaints. User friendly brochures are shared with all participants, family, area agency staff, providers, and stakeholders on an on-going basis to ensure awareness of the process and numbers to call.

Complaints are generally reported when there is an allegation, assertion, or indication that the following have occurred with respect to an individual:
abuse, neglect, exploitation, or a rights violation pursuant to He-M 310 by an employee of, or contractor, consultant, or volunteer for an area agency or program; DHHS, the area agency, or any other program.

The OCLS has 3 people designated as complaint investigators at all times. Additional investigators are hired if more are needed to carry out all the duties of the complaint investigation process within the timelines required by He-M 202.

OCLS assigns each complaint to a complaint investigator as soon as possible but not later than one business day following receipt of the complaint.

Complaints involving abuse, neglect, or exploitation are investigated prior to any other complaints and the compliant is also shared with Adult Protective Services or the Division for Children, Youth and Families depending on the age of the participant. Other complaints are investigated in the order in which they are received.
In any complaint, area agencies are required to assure participants are protected pending completion of any investigation.

The complaint investigator investigates and attempts to resolve the complaint to the satisfaction of the individual or his or her guardian or representative within 15 business days following the process outlined in He-M 202.07. A formal report must be issued within the 15 business day timeline. The timeline may be extended by an additional 10 business days if any of the following factors makes it impossible to issue a report as required:

(1) The number of allegations to be investigated;
(2) The number or availability of witnesses to be contacted;
(3) The availability of evidence; or
(4) Other similar complicating circumstances.

The full report is provided to the individual or his or her guardian, the area agency executive director, and the program involved, if any. If the report includes recommendations for resolution that require area agency or program action, the action must be taken within 20 business days of the date of the final report, unless a shorter timeline is specified. The area agency or program must send written documentation of such actions to the complaint investigator. If implementation of the action will take longer than 20 days, the area agency or program shall send documentation to the complaint investigator of the planned action within 20 business days from the date of the report, and shall send written documentation demonstrating implementation of the action to the complaint investigator upon completion.

As part of the overall complaint investigation process, the following is also required in He-M 202 and He-M 503:

Each area agency must annually share information to all programs, participants, families, and stakeholders the procedures and contact information for filing a complaint. Additionally, each area agency must have this information posted internally within their offices and to their website.

At a a minimum, the service coordinator must discuss and provide information in writing, to the individual, guardian, and family the procedures and contact information for filing a complaint during the annual person-centered planning meeting.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

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

Pursuant to State Administrative Rule He-M 202, any agency staff who suspects a participant has been the victim of abuse, neglect or exploitation must call in a complaint to the Office of Client and Legal Services (OCLS).

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 Developmental Services (BDS) are required to report sentinel events that involve an individual who is receiving BDS funded services; has received BDS funded services within the preceding 30 days; is employed in a BDS funded program; or is visiting a BDS funded program when an event occurs.

Notification shall be provided to the BDS 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

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities

when the participant may have experienced abuse, neglect or exploitation.

The rights of all individuals with developmental disabilities to be free from abuse, neglect, and exploitation are detailed in NH State Administrative Rule He-M 310. In accordance with He-M 310 and He-M 503, provider agencies are required to notify individuals and guardians or representatives of individuals' rights in accordance with He-M 310 upon initial participation in any service, upon any change in provider agency or community residence, and at least once a year after initial participation. The required notification also includes informing individuals, their guardian or representative, of the process for filing a complaint pursuant to State Administrative rule He-M 202.

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 Office of Client and Legal Services (OCLS) receives complaints of abuse, neglect, and exploitation. OCLS maintains a 24 hour hot line to receive such complaints. The OCLS has 3 persons designated as complaint investigators at all times. Additional investigators are hired if more are needed to carry out all the duties of the complaint investigation process within the timelines required by He-M 202.

OCLS assigns each complaint to a complaint investigator as soon as possible but not later than one business day following receipt of the complaint.

The complaint investigator investigates and attempts to resolve the complaint to the satisfaction of the individual or his or her guardian or representative within 15 business days following the process outlined in He-M 202.07. The timeline may be extended by an additional 10 business days if any of the following factors makes it impossible to issue a report as required:
(1) The number of allegations to be investigated;
(2) The number or availability of witnesses to be contacted;
(3) The availability of evidence; or
(4) Other similar complicating circumstances.

At the conclusion of the investigation, the complaint investigator prepares a report that includes:
(1) A summary of the issues presented, including any issues that arose during the investigation;
(2) The names of persons interviewed during the investigation;
(3) A list of all documents and other evidence reviewed;
(4) The dates of any reports made to BEAS or DCYF, if applicable;
(5) Investigatory findings of fact;
(6) A discussion of the investigatory findings of fact, a determination of whether the allegations are founded or unfounded, and an explanation of why such determination was made;
(7) A discussion of systemic factors that caused, contributed to, or exacerbated the violation; and
(8) The proposed resolution and, as applicable, the proposed corrective action by the area agency, program, or bureau.

The full report is provided to the individual or his or her guardian, the area agency executive director, and the executive director of the program involved, if any. If the report includes recommendations for resolution that require area agency or program action, the action must be taken within 20 business days of the date of the final report, unless a shorter timeline is specified. The area agency or program must send written documentation of such actions to the complaint investigator. If implementation of the action will take longer than 20 days, the area agency or program shall send documentation to the complaint investigator of the planned action within 20 business days from the date of the report, and shall send written documentation demonstrating implementation of the action to the complaint investigator upon completion.

The BQAI policy for reporting Sentinel Events requires the community agencies (Area Agencies) 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 BDS that do not require a complaint investigation in accordance with He-M 202, the BDS clinical administrator will review the sentinel event and assure it is provided to the appropriate BDS staff for follow up with the area agency and/or program.

Each agency is expected to complete its own review of a reportable sentinel event consistent with the applicable DHHS administrative rules and its agency policies regarding incidents and events that are consistent with the BQAI 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 BDS 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.

If complaint investigation reports issued by the Office of Client and Legal Services (OCLS) contain recommendations for remedial action, the agency is required to provide a response to the plan, and documentation to demonstrate the actions to comply with the remedial action. The OCLS maintains a database that includes whether agencies provide the required documentation to support the remedial action.
During the redesignation process, the Bureau of Developmental Services reviews Area Agency compliance with all rules, including He-M 202. If the Area Agency is determined to not be in compliance with providing documentation to support compliance, BDS will note this and require remedial action.

During annual governance audits, BDS staff require area agencies to provide their policy to demonstrate compliance with the BQAI sentinel event reporting policy. In addition, BQAI maintains a database of all reported sentinel events.

In the individual complaint investigation reports, the OCLS complaint investigators note any systemic factors that contributed to the complaint and include recommendations to prevent similar occurrences in the future.

Building a stronger incident management system is a priority for BDS. The state is working with Health Risk Screening (HRS) to build a module into the existing HRS platform to track incident reports electronically which will allow for streamlined data collection and reporting. Oversight of incident reporting/sentinel event reporting and complaint outcomes are ongoing.

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).

Pursuant to He-M 310, individuals are assured the right to freedom from restraint including:

a. For individuals under the age of 18, the right to limitations on the use of restraint pursuant to RSA 126-U; and
b. The right to be free from seclusion and physical, mechanical, or pharmacological restraint except that in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:

1. Such means of restraint as are authorized by a prescribing practitioner and approved by a human rights committee pursuant to RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and

2. The minimum necessary degree of restraint may also be used:

(i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
(ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
(iii) When the person is involuntarily admitted in accordance with RSA 171-B.

RSA 171:A requires that each area agency have a Human Rights Committee (HRC)of 5 or more people, the majority of the members are peoples who represent the interests of individuals with developmental disabilities and who are not employees of the department.

The duties of the HRC include, but are not limited to:

-Evaluating the treatment and habilitation provided;
-Regularly monitoring the implementation of individual service agreements;
-Monitoring the use of restrictive or intrusive interventions designed to address challenging behavior;
-Fostering the capacity of individuals served by the area agency to exercise more choice and control in their lives; and
-Promoting advocacy programs on behalf of the clients.

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 Developmental Services (BDS) monitors the authorized and unauthorized use of restraints through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committee (HRC) within each area agency that identifies monitoring and review of any use of authorized restraints and unauthorized restraints broken down by waiver. The report must identify follow-up action if an unauthorized restraint was used.

Complaint Investigations are conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS waiver participants. Reports indicate if an unauthorized use of restraint was used and recommendations for corrective action are made.

As described in section G-1(b), if an incident occurred that falls under the definition of the DHHS Sentinel Event process, BDS would be immediately notified. The outcome of the Sentinel Event Review would indicate corrective actions necessary.

Health information is reviewed and updated at least annually (by the area agency) using the Health Risk Screening Tool that includes utilization of psychotropic medications. BDS runs quarterly reports to monitor changes in health risk screening levels.

As part of service review audits, service agreements are reviewed along with progress notes, approved behavior plans, documentation of approval from the HRC, satisfaction surveys, and data from all relevant evaluations, assessments and screenings including the Supports Intensity Scale, Health Risk Screening Tool, Risk Assessment (if applicable)and any other relevant evaluations.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

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

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

Pursuant to He-M 310, individuals are assured the right to freedom from restraint including:

a. For individuals under the age of 18, the right to limitations on the use of restraint pursuant to RSA 126-U; and
b. The right to be free from seclusion and physical, mechanical, or pharmacological restraint except that in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:

1. Such means of restraint as are authorized by a prescribing practitioner and approved by a human rights committee pursuant to RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and
2. The minimum necessary degree of restraint may also be used:

(i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
(ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
(iii) When the person is involuntarily admitted in accordance with RSA 171-B.

RSA 171:A requires that each area agency have a Human Rights Committee of 5 or more people, the majority of the members are people who represent the interests of people with developmental disabilities and who are not employees of the department.

The duties of the HRC include, but are not limited to:

·Evaluating the treatment and habilitation provided;
·Regularly monitoring the implementation of individual service agreements;
·Monitoring the use of restrictive or intrusive interventions designed to address challenging behavior;
·Fostering the capacity of individuals served by the area agency to exercise more choice and control in their lives; and
·Promoting advocacy programs on behalf of the clients.

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:

BDS monitors the authorized and authorized use of restrictive interventions through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committees (HRCs) within each area agency that identifies monitoring and review of any use of authorized restraints and unauthorized restraints broken down by waiver. The report must identify follow-up action if an unauthorized restraint was used.

Complaint Investigations conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS waiver participants. Reports indicate if an unauthorized use of restraint was used and recommendations for corrective action are made.

As described in section G-1(b), if an incident occurred that falls under the definition of the DHHS sentinel event process, BDS would be immediately notified. The outcome of the sentinel event review would indicate corrective actions necessary.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on*

restraints.)

○ **The state does not permit or prohibits the use of seclusion**

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

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Pursuant to He-M 310, individuals are assured the right to freedom from restraint (and seclusion) including:

a. For individuals under the age of 18, the right to limitations on the use of restraint pursuant to RSA 126-U; and
b. The right to be free from seclusion and physical, mechanical or pharmacological restraint except that in cases of emergency such as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide where no less restrictive alternative would be effective:

1. Such means of restraint as are authorized by a prescribing practitioner and approved by a human rights committee pursuant to RSA 171-A:17, II(c), may be used as part of a treatment plan to which the individual or individual's guardian or representative, if any, has consented, having made an informed decision to do so; and
2. The minimum necessary degree of restraint may also be used:

(i) In an emergency to prevent harm to the individual or others or prevent substantial damage to property;
(ii) As part of a behavior change program that limits an individual's rights and is approved by a human rights committee pursuant to RSA 171-A:17, II, (c); or
(iii) When the person is involuntarily admitted in accordance with RSA 171-B.

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

BDS monitors the authorized limited use of seclusion through the following mechanisms:

Quarterly reports are submitted from each Human Rights Committees (HRC) within each area agency that identifies monitoring and review of any use of seclusion broken down by waiver. The report must identify follow-up action if seclusion was used.

Complaint investigations conducted by the NH Office of Client and Legal Services for all allegations of abuse, neglect or exploitation of all BDS waiver recipients. Reports indicate if unauthorized use of seclusion was used and recommendations for corrective action are made.

As described in section G-1(b), if an incident occurred that falls under the definition of the DHHS Sentinel Event process, BDS would be immediately notified. The outcome of the Sentinel Event Review would indicate corrective actions necessary.

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 a waiver participant opts for staff that is employed directly by a provider agency, and is expected to administer medication, staff must be He-M 1201 trained for medication administration.

The employer of the medication authorized staff is responsible for the ongoing monitoring of participant medication regimens. Training, medication monitoring and oversight is conducted by a Registered Nurse trainer who is employed or contracted with the associated area agency in accordance with He-M 1201.

All authorized medication providers must have a review of competency and a direct observation of a medication pass by a Registered Nurse Trainer completed annually. The Registered Nurse Trainer completes a quality review no less than every six months in accordance with He-M 1201.

All medication errors must be reported in accordance with He-M 1201. Each provider agency submits a six month nurse trainer report and each area agency submits a six month agency report to the Medication Committee. These reports address all medication errors within a specific six month time frame, identify trends within the region and inform the Medication Committee of the number of individuals within that region who are receiving 4 or more psychotropic and/or antipsychotic medications.

When any behavior modifying medication is being used (pharmaceutical restraint) the Human Rights Committee (HRC) at the area agency must review and approve the use of the medication. The Registered Nurse Trainer must develop a PRN protocol consistent with the physician’s order that outlines the perimeters and indications for when that medication can be administered. All staff who are authorized to administer those PRN medications must receive training on the PRN protocol and instruction, specific to the individual receiving the medication, from the Registered Nurse Trainer.

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.

Semi-annual medication administration reports are submitted by the area agencies and reviewed by the statewide medication committee and co-facilitated by the BDS Nurse Administrator and the BDS Medical Director.

All medication errors must be reported in accordance with He-M 1201. Each provider agency submits a six month nurse trainer report and each area agency submits a six month agency report to the Medication Committee. On a scheduled semiannual basis, representatives from each area agency meet with the Medication Committee to review their submitted reports and collaborate on recommendations, concerns or corrective action if applicable.

The Medication Committee may request additional follow up, unannounced visits to a specific setting or interim reporting be completed as a quality assurance measure.

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).

Area Agencies and vendor agencies through their State designated nurse trainers in conjunction with State Administrative Rule He-M 1201: Administration of Medications or under certain circumstances, State Administrative Rule NUR 404, Delegation of Medication Administration.

Nurse Trainers are required to have 2 years of licensed nursing experience within the past 5 years, at least one of which was as a registered nurse and to have completed a 6-hour orientation program conducted by the Division of Developmental Services.

The scope of monitoring is specific to timely and accurate administration of medications.

Medication administration practices that are potentially harmful identified and managed in the quality review process noted below.

All medications not administered by family members must be administered in conjunction with He-M 1201 which requires a number of overlapping protective practices.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

The Bureau of Developmental Services has appointed a medication committee to review information regarding medication errors. This committee is co-chaired by the medical director of the bureau, the nurse administrator of the bureau, two registered nurses from provider agencies and two non-nurse representatives from provider agencies. NH He-M 1201.11 governs the Medication Committee and the oversight of the Committee.

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

A medication error is defined as any deviation in the administration of a medication as prescribed or in the documentation of such administration, with the exception of an individual's refusal. This includes: wrong medication, wrong time, wrong dose, wrong person, wrong route, omission of a medication and documentation errors involving a medication. All such errors must be reported to a nurse trainer and recorded as such.

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

In accordance with He-M 1201, specific forms are provided for medication error reporting to the medication committee. The type of errors that must be reported to the state on these forms are: wrong medication, wrong time, wrong dose, wrong person, wrong route, omission of medication and documentation error involving a medication. Each error type has a required field on the provided forms that must be completed. Accompanying information is required if any adverse effects or outcomes occurred as a result of a medication error. Additionally, patterns of non-compliance and identified negative trends with medication administration are also required to be reported to the medication committee.

○ **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.

He-M 1201 requires a Quality Review including:

(a) A registered nurse shall review the following for all individuals whose medications are administered by authorized providers:
(1) Documentation that the provider administering the medication(s) holds a current authorization;
(2) Medication orders and PRN protocols;
(3) Medication labels and medications listed on the medication log to ensure that they match the prescribing practitioner's orders;
(4) Medication logs to ensure that documentation indicates:
a. That medication was administered as prescribed;
b. Refusal by the individual to take medication, if applicable;
c. Any medication occurrences; and
d. The full signatures of all authorized providers who initial the log; and
(5) Medication storage to ensure compliance with He-M 1201.07.
(b) Reviews pursuant to (a) above shall be performed according to the following timeframes:
(1) For family residences with 3 or fewer individuals and services provided pursuant to He-M 521 or He-M 524, reviews shall occur at least semiannually; and
(2) For all other settings in which authorized providers administer medications, reviews shall occur at least monthly.
(c) The review pursuant to He-M 1201.08(a) shall be documented, dated, and signed by the registered nurse and retained for at least 6 years by the provider agency.

He-M 1201.10 outlines the requirement for a State Medication Committee:
(a) The Director shall appoint a medication committee
(b) The committee shall be composed of at least the following:
(1) The medical director of the division or physician designee who shall serve as chairperson of the committee;
(2) Two registered nurses from provider agencies;
(3) Two non-nurse representatives from provider agencies; and
(4) A representative of the Division.
(c) Each provider agency shall complete and submit semiannually to the area agency Form 1201-a according to table 12.1.1 for each service in which authorized providers administer medications.
(d) Form 1201-a required by (c) above shall include the following:
(1) The name of the provider agency;
(2) The name and type of service;
(3) The dates during which information was collected;
(4) The number of individuals receiving medications from authorized providers;
(5) The total number of doses administered;
(6) The total number of providers authorized;
(7) The average number of hours of supervision provided by the nurse trainer per month;
(8) The number and type of department-issued He-M 1201 certification deficiencies pursuant to He-M 1001.14 and He-M 507.03;
(9) The total number of medication occurrences listed by specific medication(s) involved, type of occurrence, and the immediate corrective action taken;
(10) A narrative summary of systemic trends, if any, associated with occurrences within the setting;
(11) A corrective action plan that identifies specific steps to be taken to prevent future occurrences;
(12) The signature of the nurse trainer completing the form; and
(13) The signature of the provider agency director or designee and the date on which the report is submitted.
(e) Using Form 1201-b, an area agency shall report on each provider agency's performance regarding medication administration based on the information submitted through 1201-a forms. The area agency shall submit Forms 1201-a and 1201-b to the medication committee semiannually, according to table 12.1.1.
(f) The Form 1201-b required by (e) above shall include the following:
(1) The name of the area agency and the provider agency;
(2) The type of service;
(3) The dates during which information was collected;
(4) The total number of doses administered;
(5) The total number of providers authorized;
(6) A summary of the number and type of medication occurrences for each provider agency;

(7) A summary of the provider agency's corrective action plan;
(8) The area agency's plan for monitoring, oversight and quality improvement; and
(9) The signature of the area agency director or designee.

Identify areas of non-compliance and recommend to the Director that corrective action be taken by those provider agencies that, as demonstrated by the reports, have failed to comply with the provisions of He-M 1201.
(j) For those provider agencies for which areas of non-compliance have been identified, the medication committee shall make recommendations regarding the area agency's plan for monitoring, oversight and quality improvement.
(k) The Director shall review all recommendations for corrective action made pursuant to (i)(3) and (j) above. For those provider agencies for which corrective action has been identified, the Director shall require such action to be taken if he or she determines that the action is necessary for the provider agency to be in compliance with the provisions of He-M 1201.
(l) An agency which is in receipt of a requirement for corrective action from the Director pursuant to (k) above shall, within 30 days of such receipt, forward a corrective action plan to the medication committee and begin implementation of such a plan.

Appendix G: Participant Safeguards

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 instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number & percent of participant records reflecting documentation of an annual discussion about rights, including how to report a complaint regarding abuse, neglect or exploitation. N: The number of participant records reflecting documentation of an annual discussion about rights, including how to report a complaint regarding abuse, neglect or exploitation. D: Number of participant records reviewed

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

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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 = The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

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

Performance Measure:
The number and percent of abuse, neglect and exploitation complaints that were investigated within the required timelines. Numerator: Number of abuse, neglect and exploitation complaints that were investigated within the required timelines. Denominator: Total number of abuse, neglect and exploitation complaints that were investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Abuse, neglect and exploitation complaints

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of complaint investigations in which documentation of implementation and recommendations were received. Numerator: Number of complaint investigations in which documentation of implementation of recommendations were received. Denominator: Total number of complaint investigations with recommendations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Implementation plan(s) received from the area agency.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of sentinel events regarding abuse, neglect, exploitation, and unexplained death that were referred to investigative entities. Numerator: The number of sentinel events regarding abuse, neglect, exploitation, and unexplained death that were referred to investigative entities. Denominator: The number of sentinel events regarding abuse, neglect, exploitation, and unexplained death.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Supplemental form provided with submission of sentinel event forms.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The 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 sentinel events that are analyzed to identify trends. Numerator: The number and percent of sentinel events that are analyzed to identify trends. Denominator: Number of sentinel events.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bureau of Developmental Services (BDS) Sentinel Event Data

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

Performance Measure:
The number and percent of sentinel event trends identified from the sentinel event analysis that received recommendations of systemic interventions. Numerator: The number of sentinel event trends for which systemic interventions were recommended. Denominator: Number of sentinel event trends identified.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bureau of Developmental Services (BDS) Sentinel Event Data

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of reduced sentinel events with shared trends as a result of systemic intervention. Numerator: The number of reduced sentinel events with shared trends as a result of systemic intervention. Denominator: The number of sentinel events with shared trends.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Bureau of Developmental Services (BDS) sentinel event data

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

Data Aggregation and Analysis:

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

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

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 area agencies with documentation that policies are in place regarding the use of restraint and prohibition of seclusion. Numerator: Number of area agencies with documentation that policies are in place regarding the use of restraint and prohibition of seclusion. Denominator: Total number of area agencies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The agencies will provide the above policies to BDS during the governance audit.

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

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of instances of restrictive interventions (including restraint

and seclusion) in which state policies and procedures were followed. Numerator: Number of instances of restrictive interventions (including restraint and seclusion) in which state policies and procedures were followed. Denominator: Total number of restrictive interventions (including restraint and seclusion).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quarterly data submission from area agency

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
The number and percent of participants who have an active Health Risk Screening Tool (HRST) completed. Numerator: Number of participants who have an HRST completed. Denominator: Total number of participants receiving IHS services.

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 = The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of participants over 16 years of age who have a Supports Intensity Scale (SIS) assessment on file. Numerator: Number of participants over 16 years of age with a SIS assessment on file. Denominator: Total number of participants over 16 years of age.

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 = The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 state has policies and procedures in place that require reporting of 100% of suspected incidents of abuse, neglect, or exploitation and an administrative rule, He-202, which outlines the State's Rights Protection procedures. BDS' legal counsel, Office of Client and legal services, tracks 100% of all reported incidents. BDS' Office of Client and Legal Services, through Bureau Liaisons provide feedback in individual cases when appropriate, issues a report twice per year identifying trends and addresses systemic improvements, and reports findings to the Quality Council for Developmental Services twice per year.

The DHHS also utilizes a Sentinel Event Reporting Protocol for unexpected occurrences involving the death or serious physical or psychological injury which may signal the need for immediate investigation and response.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 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.

NH has had a multi-prong approach to address its continued quality improvement initiatives.

NH has worked with the oversight and assistance of the Centers for Medicaid and Medicare Services (CMS), to ensure waiver participants are receiving services that do not present a conflict of interest (COI). The ability for providers to direct bill is included in the Corrective Action Plan (CAP), the state is progressing toward compliance, accordingly.

The HCBS' Final Rule and all of its elements have been the primary focus of many committees' efforts during the past four years. Provider selection, case management, an increase in independent case management, rate structures and defining the Financial Management Service responsibilities along with the designated area agencies responsibilities has been a significant undertaking with solid results.

New Hampshire (NH) was the recipient of an Aging and Community Living (ACL) grant written and managed by the NH University Center for Excellence in Disability (UCED), Institute on Disability (IOD) to ensure a strong infrastructure to address a number of quality measures, but most importantly to address the Office of Inspector General's (OIG) concerns related to incident management.

Resources from the ACL grant have been prioritized to target BDS improvements of incident management over the course of five years. NH is in its second year of implementing the quality framework plan and there has been progress in the adoption of a new incident management system by the area agencies, and newly implemented data points regarding waiver participant's experiences of selecting their services and their providers. BDS works closely with the IOD whose mission includes the advancement of policies and practices that improve the quality of life for children and adults with disabilities.

NH has been inspired by Wisconsin's, "I Respect I Self Direct" (IRIS) program and will be developing an ongoing statewide Participant Directed and Managed Services (PDMS) Committee that reviews and adopts relevant sections of the program to enhance the long terms supports and services for NH's waiver recipients.

The goal of the Participant Directed and Managed Services Committee is to assist families to support their loved ones at home and receive the necessary assistance to manage the many aspects of budget authority and employment authority that accompany a participant directed and managed service model.

The committee will be responsible for understanding the feedback from the listening sessions and public comment and ensure that concerns by families inform future policies. The adoption of a comprehensive educational manual with clear rights and responsibilities including understanding fraud will be a component of the manual that will be developed as part of NH's Quality Improvement Strategy.

The adoption of a statewide self-assessment tool for potential PDMS families is worthy of consideration and should be determined by the PDMS committee. This may aid agencies in better understanding the supports that families need to be successful with their employer and budget authorities. In addition to understanding the importance of approving expenses, a focus on timesheets and timeliness of monthly progress reports will be substantive.

The ability to transition services so that the participant delegates the above authorities to a third party, as noted in E-1, shall be available after a very thorough and documented examination of the needs of the family have been identified, shared with the family, and a remediation plan has been documented. In the event the areas of concern(s) are not addressed the family may be asked to transition services to a third entity. The PDMS committee would review He-M 524 to make recommendations to BDS in order to best support waiver recipients who utilize PDMS and a transition policy will be developed and implemented as necessary.

The implementation of the quality framework has included the addition and modification of various templates to address consistency across the geographical areas of the state. Specifically, the addition of the statewide service agreement template, amendment template and adoption of the Planning Process and Acknowledgement Form have successfully provided uniformity resulting in a comprehensive, assessment based, person centered planning process for each individual resulting in a tailored written service agreement. The statewide service agreement template has been amended to include information related to Home and Community Based Services (HCBS) settings expectations, the inclusion of the Health Risk Screening Tool's (HRST) service and training and

considerations, the Support Intensity Scale (SIS) results as well as the symbol for a trajectory of one's life.

As part of the BDS internal analysis of existing quality improvement processes, BDS determined that there was opportunity to improve the overall approach to quality assurance and added routine service file reviews for all waivers and the adoption of an annual governance audit for the area agencies.

The previous methodology relied on the Area Agency Redesignation process that occurred over a complete review of all 10 area agencies over a 5 year period, with two regional area agencies reviewed per year. As part of the overhaul of the area agency redesignation process, as outlined in He-M 505, BDS created an annual quality improvement process that systematically reviews essential data from several key areas to inform the BDS, area agencies, DHHS, stakeholders and CMS on the overall performance, quality, and satisfaction with services.

Information from the annual service file reviews serve to inform the redesignation process and also provides meaningful data on an on-going basis to help inform BDS regarding the performance of area agencies. The annual service file reviews identify issues with compliance and/or quality of services that ultimately assists individuals to receive the services within their written service agreement and provide information for area agencies to update their area plans, also referenced as strategic plans, to ensure area agency services are meeting waiver participant's needs. The standardized and timely reporting schedule of redesignation and service file reviews provides BDS with the opportunity to review and discuss the results and develop recommendations and or remediation plans of correction.

Discussions related to the results of quality initiatives are an important aspect of regular internal and external meetings such as regularly scheduled meetings with the Bureau Liaisons, joint meetings with certification staff from DHHS Licensing and Certification, monthly meetings with AA Executive Directors, Business Managers, Service Coordinator Supervisors, NH Quality Council, and every other month with the NH Developmental Disabilities Quality Council.

New criteria has been developed for individuals with a Health Care Level of 3 or over. The criterion includes:

- A clinical review by a 1201 nurse trainer: and
- A request to the Managed Care Organization for complex care coordination.

New criteria has been developed for all waiver participants. The criterion includes:

-A minimum of two home visits per year; one of the two visits may be established as the result of the assessment based person centered planning process if it takes place in the home.
-A face to face contact is expected to take place during the home visit.
-Service coordinators will complete and document home visits and will ensure home visits are documented in the participant's service file.

The following topics are related to the ongoing quality assurance practices by BDS:

- Area agency board composition
- Current board by-laws, policies, and procedures
- Executive Director qualifications
- Current area plan and any amendments
- Board of Directors minutes
- Information on how the area agency assures individuals, families and stakeholders are involved in planning for the provision of and satisfaction of the services
- Information on how area agencies communicate with sub-contract agencies
- Report of the area agency's on-going quality assurance activities
- Contract Compliance
- Compliance with NH's conflict of interest Corrective Action Plan

The Key Indicators Data includes a review of the following:

- Financial Key Indicators - Monthly Review

- Medicaid Billing Activity - Monthly Review
- Certification Data from Bureau of Health Facilities Administration - Annual Review
- Waitlist Utilization - Quarterly Review
- Service File Reviews - Annual Review
- Human Rights Committee Reports – Quarterly Review
- Complaint Investigations Reports – Semi -annual data, indicating that recommendations have been implemented and or adhered to per the investigative findings.
- HRST Data - Custom reports indicating who received a nurse trainer clinical for participants with a health care level of 3 or more.
- Regional forum(s) are held for individuals and incorporated into self-advocacy meeting agendas.
- Regional forum(s) are held for families/guardians and incorporated into family support committee meeting agendas.
- Surveys are conducted with provider agencies, individuals and families/guardians.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: On going.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

As indicated in section a. System Improvements above, a systematic and standardized approach for reviewing Key Indicator data is reviewed by internal DHHS staff, area agency staff and stakeholders at the frequency outlined. The data is reviewed as part of regularly scheduled meetings to engage all levels of the system to better understand performance data and the importance of remediation, as necessary, to ensure a meaningful and timely quality improvement process.

BDS will remain engaged with all of its stakeholders in its efforts to continuously monitor and improve the quality of and satisfaction with services. The new approach will also be subject to continuous evaluation and refinement as we learn lessons from implementation.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

At least annually, the BDS Waiver Manager will review the information needed to assess waiver quality and whether aspects of the quality improvement system require revision. The analysis and any recommendations, if necessary, will be shared with the BDS Management Team and staff for initial review and then broadly shared with area agencies and stakeholders.

Appendix 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).*

The State requires each provider of HCBS Waiver services to submit an annual independent financial audit. The results of this independent audit are submitted to the State within 30 days of conclusion of the independent audit.

Additionally, the State Office of Program Integrity ensures that annual audits are conducted in accordance with the provisions of the Single Audit required under OMB Circular A-133 for state agencies.

Providers are selected for further review on the basis of their monthly financial reporting if ratios, days of cash on hand or other negative financial signals are noted. The Bureau of Developmental Service Finance Unit works in conjunction with the Bureau of Program Improvement and Integrity.

New Hampshire holds a contract with each area agency. The contract provides the explanation of ratios, days of cash on hand, and other financial metrics that are required. "Negative financial signal" is in reference to the area agency not meeting the financial metrics outlined in the contract. The contract provides in part the following guidance from BDS relative to Fiscal Integrity:

2.14. Maintenance of Fiscal Integrity
2.14.1. In order to enable the Department to evaluate the Contractor's fiscal integrity, the Contractor agrees to submit to the Department monthly,
the Balance Sheet, Profit and Loss Statement, and Cash Flow Parent Corporation of the developmental services provider organization. The Profit and Loss Statement shall include a budget
column allowing for budget to actual analysis. These statements shall be individualized by providers, as well as a consolidated (combined) statement that includes all subsidiary organizations. Area Agencies that operate as dual agencies for Behavioral Health and Developmental Disabilities services shall break out these statements separately for Developmental Disabilities (DD) & Bureau of Mental Health Services (BHMS). Statements shall be submitted within thirty (30) calendar days after each month end.
2.14.2. The Contractor agrees to financial performance standards as follows:
2.14.2.1. Days of Cash on Hand:
a. Definition: The days of operating expenses that can be covered by the unrestricted cash on hand.
b. Formula: Cash, cash equivalents and short-term investments divided by total operating expenditures, less depreciation/amortization and in-kind plus principal payments on debt divided by days in the reporting period. The short-term investments as used above must mature within three (3) months and should not include common stock.
c. Performance Standard: The Contractor shall have enough cash and cash equivalents to cover expenditures for a minimum of thirty (30) calendar days with no variance allowed.
2.14.2.2. Current Ratio:
a. Definition: A measure of the Contractor's total current assets available to cover the cost of current liabilities.
b. Formula: Total current assets divided by total current liabilities.
c. Performance Standard: The Contractor shall maintain a minimum current ratio of 1.5:1 with 10% variance allowed.
2.14.2.3. Debt Service Coverage Ratio:
a. Rationale: This ratio illustrates the Contractor's ability to cover the cost of their current portion of their long-term debt.
b. Definition: The ratio of Net Income to the year to date debt service.
c. Formula: Net Income plus Depreciation/Amortization Expense plus Interest Expense divided by year to date debt service (principal and interest) over the next twelve (12) months.
d. Source of Data: The Contractor's Monthly Financial Statements identifying current portion of long-term debt payments (principal and interest).
e. Performance Standard: The Contractor shall maintain a minimum standard of 1.2:1 with no variance allowed.
2.14.2.4. Net Assets to Total Assets:
a. Rationale: This ratio is an indication of the Contractor's ability to cover their liabilities.
b. Definition: The ratio of the Contractor's net assets to total assets.
c. Formula: Net assets (total assets less total liabilities) divided by total assets.
d. Source of Data: The Contractor's Monthly Financial Statements.
e. Performance Standard: The Contractor shall maintain a minimum ratio of .30:1, with a 20% variance allowed.
2.14.3. In the event that the Contractor does not meet either:
2.14.3.1. The standard regarding Days of Cash on Hand and the standard regarding Current Ratio for two (2) consecutive months; or
2.14.3.2. Three (3) or more of any of the Maintenance of Fiscal Integrity standards for one
(1) consecutive month,
2.14.3.3. The Department may require that the Contractor meet with Department staff to explain the reasons that the Contractor has not met the standards.

2.14.3.4. The Department may require the Contractor to submit a comprehensive corrective action plan within thirty (30) calendar days of notification that Section 2.16.3.1 and 2.16.3.2 has not been met. The Contractor shall update the corrective action plan at least every thirty
(30) calendar days until compliance is achieved.
2.14.3.5. The Department may request additional information to assure continued access to services. The Contractor shall provide requested information in a timeframe agreed upon by both parties.
2.14.4. The Contractor shall inform the Department by phone and by email within twenty-four (24) hours of when any key Contractor staff learn of any actual or likely litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the Contractor to perform under this Agreement with DHHS.
2.14.5. The monthly Balance Sheet, Profit & Loss Statement, Cash Flow Statement, and all other financial reports shall be based on the accrual method of accounting and include the Contractor's total revenues and expenditures whether or not generated by or resulting from funds provided pursuant to this Agreement. These reports are due within thirty (30) calendar days after the end of each month.

In accordance with He-M 505 and the State's contract with BDS each area agency is required to provide the State an annual independent audit performed by a Certified Public Accountant. The contracts are with the area agencies, therefore these reviews are conducted with area agencies and not all provider agencies.

Financial reporting requirements in the area agency contracts includes the following:

On a monthly basis: Balance Sheet, Summary of Revenues and Expenditures, and their State Fiscal Year approved budget to actual analysis within 30 days of the preceding month's end.

On a quarterly basis: A statistical report, and program reports within 30 days of the preceding quarter's end.

On a quarterly basis: For entities which are controlled by, under common ownership with, or an affiliate of, or related party to the area agency, the area agency must submit a Summary of Revenues and Expenditures and a Balance Sheet within 30 days of the preceding quarter's end.

On an on-going basis: BDS collects and analyzes area agency and provider certified financial audits. Reviews are completed by the Bureau of Improvement and Integrity. As a result, a Statewide Report of Financial Condition is prepared. This report represents the financial condition of the developmental services system. It assists the system in several respects, including:

·Serving as an early warning system for financially distressed services providers;
·Evaluating the economic impact of policy decisions that affect reimbursement or expenditures;
·Assessing the overall financial health of the service system and critical statewide operating trends over a five-year period;
·Establishing important objectives and specific criteria that can be used by BDS in contract negotiations;
·Developing standards and best practices that can be used by providers and BDS for benchmarking; and
·Informing providers, legislators, and other interested parties.

Program Integrity (PI) provides oversight and monitoring of MCO contracts for fraud, waste and abuse. PI 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 provider to do an audit on them. In addition, they audit providers if they get referrals or complaints.

The waiver unit operates as the BDS contact for Medicaid Management Information System (MMIS), NH's Medicaid financial intermediary. This role requires that the waiver unit be able to address provider billing issues relative to procedure codes, Medicaid, HCBS-IHS eligibility, Medicaid eligibility determination, and claims processing interfaces. Conduent is contracted with the State of NH DHHS to oversee their MMIS as the NH's fiscal intermediary for Medicaid payments.

As part of the annual service file reviews, BDS conducts an annual representative sample review utilizing a 95% confidence level with a 5% margin of error (unless otherwise indicated, such as a 100% review)of IHS area agency billing to assure Medicaid payments align with attendance/service provision records indicating date(s) of service, units of service, service provider, and that the required contact notes/progress notes are complete. On those occasions where Medicaid payment has been made but service records are not adequate upon review/audit, recoupments are made.

Area agencies and direct service providers are enrolled Medicaid providers within the NH MMIS. Area agencies and direct service providers must have a current BDS approved and issued Prior Authorization to bill for HCBS-IHS. Payment for claims without an appropriate Prior Authorization would be denied by MMIS, NH's fiscal intermediary for Medicaid payments.

As noted earlier, there are multiple steps in the approval of a Prior Authorization for HCBS-IHS waiver services. BDS utilizes databases that contain budget and service information for every NH HCBS-IHS participant. This information is maintained by BDS Liaisons and is verified for each request for a Prior Authorization by BDS staff.

In addition to multiple programmatic tasks, BDS Liaisons also have responsibilities including:

-Area Agency contract monitoring;
-Approving area agency requests for Prior Authorizations of HCBS-IHS services from the standpoint of available funds and appropriateness of proposed services; and
-Approval of proposals for changes in individual budgets.

In conjunction with their financial responsibilities, BDS Liaisons review a sample of Medicaid HCBS-IHS service authorizations as part of the annual service file reviews. An area agency may neither exceed the authorization on any given Prior Authorization for any given individual nor the aggregate amount of services as defined in each BDS contract, which is in accordance with the HCBS-IHS waiver cap for each waiver year.

Business Managers representing all 10 area agencies meet with members of the BDS Management Team each month to explore system, program, financial management and accountability issues in an effort to enhance statewide consistency in methodology and operations related to Medicaid. Topics addressed include:

-Review of Key Financial Indicator Reports: Monthly Medicaid Utilization Report and Monthly/Quarterly AA Fiscal Health Reports;
-Budget development;
-Other financial monitoring;
-Documentation requirements to support Medicaid billing;
-System modification requests;
-Implementation of legislative and legal initiatives;
-Fiscal intermediary operations; and
-Prior Authorization Process.

NH sought a good faith exemption to delay implementation of Electronic Visit Verification (EVV) until January 1, 2021, which was approved by CMS on November 21, 2019. Services that are subject to EVV include Personal Care and Respite.

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. Numerator: Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator: Number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology*
☐ ***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 coded claims paid for individuals that are enrolled and eligible for services. Numerator: Number of coded claims paid for individuals that are enrolled and eligible for services. Denominator: Number of claims reviewed.

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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***

☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of claims paid for services with sufficient documentation that services were actually rendered. Numerator: Number of claims paid for services with sufficient documentation that services were actually rendered. Denominator: Number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *The state will utilize a 95% confidence level with a 5% margin of error in accordance with RaoSoft sampling methodology*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

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

Performance Measure:
The number and percent of waiver rates that follow the approved methodology.
Numerator: Number of waiver rates that follow the approved methodology.
Denominator: Number of waiver rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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 Improvement and Integrity 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 conducts reviews to determine if recipients are inappropriately using certain types of medications.

The Bureau of Improvement and 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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Since its inception, the In Home Supports Waiver has had a per person annual cap of $30,000 per child. Beginning 1/2021, the per person annual cap per child is $35,000, inclusive of statutory and other covered services as outlined in Appendix C-1. There are service limits for specific categories of covered services outlined in Appendix C-1. This waiver outlines the constructs of an Independence Plus Waiver with full budget authority, the state allows families to develop a budget, including rates of payment for services being planned. All IHS rates are independently determined based on individual's needs using customary costs within their region.

The state's public hearing process for the IHS Waiver renewal provided opportunity for public comment on rates and the service limits articulated in this waiver. Comments can be found in the state's summary of public comments. Please see Main Section 6-I for the public input process for this renewal.

Once a service agreement for a waiver participant is established, the area agencies prepare a budget based on provider(s) costs to provide the services identified in the individual's service agreement. The completed budget template is sent to their BDS Liaison, who reviews and approves. A prior authorization packet is then prepared and sent in for the prior authorization unit to approve.

As is the case with planning of services, the family/individual is provided the opportunity to fully participate and have the lead voice in the decision making process.

Each service agreement contains projected costs for each identified service. As noted previously, these estimates are based on the customary regional costs for the services being planned.

Proposed service agreements are submitted to the BDS for the necessary State approval.

Once the child/individual is found eligible for the waiver and his/her funding level is approved by BDS, required information regarding prior-authorization of services is submitted to the New Hampshire's Medicaid fiscal intermediary, currently, Conduent. Conduent is contracted with the State of NH DHHS to oversee their MMIS as the NH's fiscal intermediary for Medicaid payments.

This information identifies the proposed total waiver payments for the child's/individual's services under the PDMS category. Based on the prior-authorization issued and actual provision of services, the area agency submits claims and may be reimbursed, for actual services provided, on a weekly basis.

Fee Schedules are located on the MMIS website by visiting MMIS at https://nhmmis.nh.gov: To view, from the Main MMIS screen click on Documentation, Documents & Forms and Scroll down to Fee Schedules or using this direct link: https://nhmmis.nh.gov/portals/wps/portal/!ut/p/c5/04_SB8K8xLLM9MSSzPy8xBz9CP0os3hXX-cwF3cfQwMLAz9LAyNjC0fvIFcDg0ALI6B8pFm8AQ7gaEBAdzjIPtwq3M0h8njM9_PIz03VL8iNMMgycVQEADqTPrw!/dl3/d3/L2d

As the rates are independently determined, they reflect the amount needed for provider(s) to provide the service(s) as stated in the individual's service agreement and budget from providers within the geographic area in which the individual is receiving services. Due the services being delivered in a participant directed and delivered service method, having independently determined rates allows providers to give efficient quality care, while also maintaining provider capacity.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

While the NH Developmental Services System utilizes in excess of 65 private developmental services agencies and hundreds of private subcontractors, at this time it is the area agencies in their capacity as Organized Health Care Delivery System (OHCDS), State of NH designated agencies that have a Medicaid Provider Agreement with the NH State Medicaid Agency and are enrolled in the MMIS. As of 7/1/2023, all Medicaid waiver service providers, including area agencies, will be enrolled as NH Medicaid providers with the option of directly billing Medicaid or choosing a third party biller to bill Medicaid on their behalf.

Area agencies and or service providers must have a current BDS approved and issued Prior Authorization and documentation that services were provided, in order to bill for any individual receiving HCBS-IHS services.

Medicaid billing is implemented on a fee for service basis utilizing a set of service rates and Medicaid Administrative rate(s). Supporting documentation for every claim/invoice submitted must be maintained and available for review by the State Medicaid Agency.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

All HCBS billing is processed through the NH Medicaid Management Information System (MMIS). All billing for HCBS-IHS services requires a Prior Authorization be open and current in MMIS. Prior Authorizations include only the services outlined in the individual's service agreement. If an individual's Medicaid status changes, claims are not paid until or unless the individual has open Medicaid status for the time period included on the claim(s).

Area agencies are not authorized to bill for services without documentation that the services have been provided. As part of the service file reviews, BDS conducts a sample of post-payment reviews each year to ensure that for paid claims there is documentation that services were actually provided. The state will utilize a 95% confidence level with a 5% margin of error. The post payment review report lists any recoupments needed and BDS ensures the recoupments are made.

Recoupments are made through MMIS, which goes through the Department's Public Assistance Cost Allocation Plan (PACAP) and then reflected on the CMS-64.

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:

In accordance with RSA 171-A and He-M 505, BDS contracts with 10 private, non-profit community 501-3 (c) providers known as area agencies.

Area agencies are:

-Locally Controlled: Governed by independent Boards of Directors made up of volunteer families and community business professionals;
-Family Driven: Advised by Regional Family Support Councils;
-Regionally Based: Responsible for providing services to individuals with developmental disabilities and their families within their catchment area; and
-Overseen by the Bureau of Developmental Service: Redesignated every 5 years.

Area agencies are considered successful, operating efficiently and eligible for redesignation when:

-There is a high level of involvement of those who use and depend on services in all aspects of system planning, design, and development;
-The area agency demonstrates through its coordination of services and supports a commitment to a mission which embraces community membership for persons with developmental disabilities;
-Ongoing inquiry regarding individual and family satisfaction is a common practice;
-Recipients of services and supports are satisfied;
-The area agency is fiscally sound and manages resources effectively to support its mission;
-The area agency board of directors demonstrates effective governance of the agency management and functions;
-Supports and services are flexible and represent the needs, preferences, and capacities of individuals and families;
-The area agency promotes preventative services and supports which reduce the need or the intensity of long-term care;
-The area agency, through multiple means, demonstrates its commitment to individual rights and safeguards;
-The area agency seeks to achieve continuous quality improvement in managing its operations and services; and
-There is adherence to state and federal requirements.

Approval of an area agency's request for redesignation is granted if, based on the following information, the area agency is found to be in compliance with He-M 505:
-Public comments regarding the area agency's demonstrated ability to provide local services and supports to people with developmental disabilities and their families;
-A comprehensive self-assessment of the area agency's current abilities and past performance;
-Input from a wide range of individuals, agencies, or groups who are either recipients, providers, or people who collaborate in the provision of services and supports;
-Documentation pertaining to area agency operations available regionally and at the department; and
-Input from department staff who have direct contact with and knowledge of area agency operations.

As noted above, each participant in the NH Developmental service system is afforded choice of service provider(s). An individual or guardian may select any person, any agency, or another area agency as a provider to deliver one or more of the services identified in the individual's service agreement. An area agency may not deny any willing and qualified provider. As a result, families have full choice of any qualified provider and they may add any new provider who meets the same qualifications; there are no obstacles to any willing and qualified provider to be selected to provide direct supports under this waiver.

Currently, the NH Developmental Services System currently utilizes approximately 65 private developmental services agencies, at this time it is the area agencies in their capacity as Organized Health Care Delivery System (OHCDS), State of NH designated agencies that have a Medicaid Provider Agreement with the NH State Medicaid Agency and are enrolled in the MMIS.

Direct service providers enter into a contractual agreement with the area agency which specifies the roles of the area agency and private services agency/provider in service planning, provision and oversight including:

-Implementation of the service agreement;
-Specific training and supervision required for the service providers;
-Compensation amounts and procedures for paying providers;
-Oversight of the service provision, as required by the service agreement;
-Documentation of administrative activities and services provided;
-Fiscal intermediary services provided by the area agency or private agency to facilitate the delivery of participant directed services;
-Quality assessment and improvement activities as required by rules pertaining to the service provided;
-Compliance with applicable laws and rules, including delegation of tasks by a nurse to unlicensed providers pursuant to RSA 326-B and He-M 1201;
-Service coordination provided by the area agency or direct service provider;
-Procedures for review and revision of the service agreement as deemed necessary by any of the parties; and

-Provision for any of the parties to dissolve the contract.

Safeguards in place to ensure that the OHCDS subcontractors possess the required qualifications are being addressed through direct bill as part of the Department's Corrective Action Plan. All subcontractors will be required to become enrolled Medicaid providers and meet the necessary qualifications to provide each specific service they seek to provide. As of 7/1/2023, all Medicaid waiver service providers, including area agencies, will be enrolled as NH Medicaid providers with the option of directly billing Medicaid or choosing a third party biller to bill Medicaid on their behalf.

Individual's Prior Authorizations list all waiver services/procedure codes approved for that individual. No payments are made for any HCBS-IHS waiver service without a current Prior Authorization. Payment for claims without an appropriate Prior Authorization would be denied by the MMIS.

Prior Authorizations are issued for a period not to exceed one year and are only issued by State staff who have determined Level of Care after the approval of the State BDS Liaison.

As noted earlier, there are multiple steps in the approval of a Prior Authorization for HCBC-IHS Waiver services.

BDS utilizes databases which contain all budget and service information for every NH HBCS-IHS individual. This information is maintained by BDS Liaisons and is verified for each request for a Prior Authorization by BDS staff. In addition to the multiple programmatic tasks, BDS Liaisons also have responsibilities including:

-Annual/Biennium, 1-2 years: Area Agency contract development
-Review of service units for all HCBC-IHS eligible individuals
-Review of area agency revenues and expenses
-Approving area agency and or service providers requests for Prior Authorizations of HCBC-IHS services from the standpoint of available funds and appropriateness of proposed services
-Approval of proposals for changes in individual budgets
-Maintenance of a database of changes to area agency budgets and Prior Authorizations
-Review of financial reports and audits from area agency.

BDS conducts periodic billing audits to confirm that no billing occurs without accurate attendance/service provision records indicating: date(s) of service, units of service, service provider, and the required contact notes/progress notes are complete. On those occasions where Medicaid payment has been made but service records are not adequate upon review/audit, recoupments are made.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the***

delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***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:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	15303.66	28719.77	44023.43	125114.48	54371.99	179486.47	135463.04
2	15166.99	27400.72	42567.71	126763.61	54862.71	181626.32	139058.61
3	15065.87	26142.25	41208.12	128434.48	55357.86	183792.34	142584.22
4	14956.53	24941.58	39898.11	130127.37	55857.48	185984.85	146086.74
5	14820.51	23796.05	38616.56	131842.58	56361.61	188204.19	149587.63

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(1 of 9)*

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	478	478
Year 2	490	490
Year 3	502	502
Year 4	514	514
Year 5	527	527

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 FY2018. These actual ALOS were used to calculate an average trend, for FY2014 through FY2018, of 1.33%. This trend was used to calculate FY2019 through FY2025. The updated yearly ALOS are as follows:

FY	Projected ALOS per FY
2021	300.9
2022	304.9
2023	309.0
2024	313.1
2025	317.3

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's equals totals in J-2-d divided by total projected participants in each year of the waiver.

Due to the In Home Supports waiver being small in units and dollars, looking at each individual service for a trend is too fine of a detail and therefore it cannot be broken down that way. In addition, by working at that fine of a detail the results are unstable and not credible program wise. As a result, a trend of 1.4%, from SFY18-19, was used for overall Total Expenditures for FY20-25. In addition, historically the total spend for IHS has been under $8m per year. If an increase is given each year to the Average cost of services, then NH will be around $14m+ by year 5, which NH does not believe to be realistic, nor within historic expenditures.

The 3.1% rate increase, given to all services that are rate based, is as a result of the State's Biennial budget legislation of 2019.

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 State used the actual D' as submitted on 372's for FY2016 through FY2018. These actual D' were used to calculate an average trend for D', for FY2016 through FY2018, of -4.59%. This trend was used to calculate FY2019 through FY2025 numbers. In addition, the 2020 & 2021 numbers were increased by the rate increases of 3.1% given January 1, 2020 & January 1, 2021.

IHS Waiver Renewal Years

Factor D'
2021 $ 28,719.77
2022 $ 27,400.72
2023 $ 26,142.25
2024 $ 24,941.58
2025 $ 23,796.05

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 IHS Waiver. In addition, managed care is making a difference in community based care, with costs being deferred to the MCO, thus reducing Factor D'.

The State met with Conduent, numerous times as their MAR and 372 experts are new to New Hampshire. Conduent data analysis began in FY2016 so Factors D', G & G' projections all used data beginning with FY16.

The 3.1% rate increase for January 1, 2020 and an additional 3.1% rate increase on January 1, 2021 are as a result of the State's Biennial budget legislation of the laws of 2019.

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 State calculated the ICF/IID, Cedarcrest, weighted averages and average trend using actual MMIS claims data per state fiscal year (SFY) 2016-2020. The average trend is 1.32%. This trend was used to calculate FY2021 through FY2025.

IHS Waiver Renewal Years

Factor G
2021 $ 125,114.48
2022 $ 126,763.61
2023 $ 128,434.48
2024 $ 130,127.37
2025 $ 131,842.58

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 State met with Conduent, numerous times as their MAR and 372 experts are new to New Hampshire. After meeting, Conduent revised the G', in MMIS, to calculate G' to include all fee for service (FFS) non-nursing home claims, with current MMIS claims data. It was determined that the MMIS data used will include MCO capitation and financial transactions and exclude MCO encounter data. The updated numbers were used to calculate an average trend, for FY16-18, of 0.90%. This trend was used to calculate FY2019 through FY2025 numbers. In addition, the 2020 & 2021 numbers were increased by the rate increases of 3.1% given January 1, 2020 & January 1, 2021.

IHS Waiver Renewal Years

Factor G'
2021 $ 54,371.99
2022 $ 54,862.71
2023 $ 55,357.86
2024 $ 55,857.48
2025 $ 56,361.61

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	
In Home Residential Habilitation	
Service Coordination	
Assistive Technology	
Community Integration Services	
Consultations	
Environmental and Vehicle Modification Services	
Individual Goods and Services	
Non-Medical Transportation	
Personal Emergency Response Services (PERS)	
Respite Care Services	
Wellness Coaching	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In Home Residential Habilitation Total:						**2069625.60**
In Home Residential Habilitation	Hour	464	10.00	446.04	**2069625.60**	
Service Coordination Total:						**1142386.56**
Service Coordination	Month	464	9.00	273.56	**1142386.56**	
Assistive Technology Total:						**260000.00**
Assistive Technology	Item	26	1.00	10000.00	**260000.00**	
Community Integration Services Total:						**1128854.88**
Community Integration Services	Each	144	1.00	7839.27	**1128854.88**	
Consultations Total:						**356466.46**
Consultations	Each	353	7.00	144.26	**356466.46**	
Environmental and Vehicle Modification Services Total:						**126144.30**
Environmental and Vehicle Modification Services	Each	15	1.00	8409.62	**126144.30**	
Individual Goods and Services Total:						**37500.00**
Individual Goods and Services	Each	25	1.00	1500.00	**37500.00**	
Non-Medical Transportation Total:						**564387.12**
Non-Medical Transportation	Each	72	11.00	712.61	**564387.12**	
Personal Emergency Response Services (PERS) Total:						**876719.88**
Personal Emergency Response Services (PERS)	Month	261	79.00	42.52	**876719.88**	
Respite Care Services Total:						**620191.68**
Respite Care Services	15 Mins	348	8.00	222.77	**620191.68**	
Wellness Coaching Total:						**132875.00**
Wellness Coaching	1 Hour	25	100.00	53.15	**132875.00**	

GRAND TOTAL:	**7315151.48**
Total Estimated Unduplicated Participants:	**478**
Factor D (Divide total by number of participants):	**15303.66**
Average Length of Stay on the Waiver:	301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In Home Residential Habilitation Total:						**2098569.00**
In Home Residential Habilitation	Hour	475	11.00	401.64	**2098569.00**	
Service Coordination Total:						**1167006.96**
Service Coordination	Month	474	9.00	273.56	**1167006.96**	
Assistive Technology Total:						**270000.00**
Assistive Technology	Item	27	1.00	10000.00	**270000.00**	
Community Integration Services Total:						**1144659.60**
Community Integration Services	Each	147	1.00	7786.80	**1144659.60**	
Consultations Total:						**361478.72**
Consultations	Each	362	8.00	124.82	**361478.72**	
Environmental and Vehicle Modification Services Total:						**126144.32**
Environmental and Vehicle Modification Services	Each	16	1.00	7884.02	**126144.32**	
Individual Goods and Services Total:						**39000.00**
Individual Goods and Services	Each	26	1.00	1500.00	**39000.00**	
Non-Medical Transportation Total:						**572341.90**
Non-Medical Transportation	Each	74	13.00	594.95	**572341.90**	
Personal Emergency Response Services (PERS) Total:						**885521.52**
Personal Emergency Response Services (PERS)	Month	267	78.00	42.52	**885521.52**	
Respite Care Services Total:						**628912.62**
Respite Care Services	15 Mins		9.00	195.74	**628912.62**	

GRAND TOTAL:	**7431824.64**
Total Estimated Unduplicated Participants:	**490**
Factor D (Divide total by number of participants):	**15166.99**
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		357				
Wellness Coaching Total:						**138190.00**
Wellness Coaching	1 Hour	26	100.00	53.15	**138190.00**	
				GRAND TOTAL:		**7431824.64**
				Total Estimated Unduplicated Participants:		**490**
				Factor D (Divide total by number of participants):		**15166.99**
				Average Length of Stay on the Waiver:		305

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In Home Residential Habilitation Total:						**2127961.11**
In Home Residential Habilitation	Hour	487	11.00	397.23	**2127961.11**	
Service Coordination Total:						**1199013.48**
Service Coordination	Month	487	9.00	273.56	**1199013.48**	
Assistive Technology Total:						**280000.00**
Assistive Technology	Item	28	1.00	10000.00	**280000.00**	
Community Integration Services Total:						**1160684.15**
Community Integration Services	Each	151	1.00	7686.65	**1160684.15**	
Consultations Total:						**366548.00**
Consultations	Each	371	10.00	98.80	**366548.00**	
Environmental and Vehicle Modification Services Total:						**129700.80**
Environmental and Vehicle Modification Services	Each	16	1.00	8106.30	**129700.80**	
				GRAND TOTAL:		**7563065.02**
				Total Estimated Unduplicated Participants:		**502**
				Factor D (Divide total by number of participants):		**15065.87**
				Average Length of Stay on the Waiver:		309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services Total:						**40500.00**
Individual Goods and Services	Each	27	1.00	1500.00	**40500.00**	
Non-Medical Transportation Total:						**580337.52**
Non-Medical Transportation	Each	76	14.00	545.43	**580337.52**	
Personal Emergency Response Services (PERS) Total:						**897086.96**
Personal Emergency Response Services (PERS)	Month	274	77.00	42.52	**897086.96**	
Respite Care Services Total:						**637728.00**
Respite Care Services	15 Mins	365	10.00	174.72	**637728.00**	
Wellness Coaching Total:						**143505.00**
Wellness Coaching	1 Hour	27	100.00	53.15	**143505.00**	
				GRAND TOTAL:		**7563065.02**
				Total Estimated Unduplicated Participants:		**502**
				Factor D (Divide total by number of participants):		**15065.87**
				Average Length of Stay on the Waiver:		309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In Home Residential Habilitation Total:						**2157775.80**
In Home Residential Habilitation	Hour	499	12.00	360.35	**2157775.80**	
Service Coordination Total:						**1245792.24**
Service Coordination	Month	506	9.00	273.56	**1245792.24**	
Assistive Technology Total:						**280000.00**
				GRAND TOTAL:		**7687656.31**
				Total Estimated Unduplicated Participants:		**514**
				Factor D (Divide total by number of participants):		**14956.53**
				Average Length of Stay on the Waiver:		313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology	Item	28	1.00	10000.00	280000.00	
Community Integration Services Total:						1176935.15
Community Integration Services	Each	155	1.00	7593.13	1176935.15	
Consultations Total:						371685.60
Consultations	Each	380	11.00	88.92	371685.60	
Environmental and Vehicle Modification Services Total:						131516.48
Environmental and Vehicle Modification Services	Each	16	1.00	8219.78	131516.48	
Individual Goods and Services Total:						40500.00
Individual Goods and Services	Each	27	1.00	1500.00	40500.00	
Non-Medical Transportation Total:						588481.92
Non-Medical Transportation	Each	78	16.00	471.54	588481.92	
Personal Emergency Response Services (PERS) Total:						904825.60
Personal Emergency Response Services (PERS)	Month	280	76.00	42.52	904825.60	
Respite Care Services Total:						646638.52
Respite Care Services	15 Mins	374	11.00	157.18	646638.52	
Wellness Coaching Total:						143505.00
Wellness Coaching	1 Hour	27	100.00	53.15	143505.00	

GRAND TOTAL:	7687656.31
Total Estimated Unduplicated Participants:	514
Factor D (Divide total by number of participants):	14956.53
Average Length of Stay on the Waiver:	313

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In Home Residential Habilitation Total:						**2187958.92**
In Home Residential Habilitation	Hour	511	12.00	356.81	**2187958.92**	
Service Coordination Total:						**1258102.44**
Service Coordination	Month	511	9.00	273.56	**1258102.44**	
Assistive Technology Total:						**290000.00**
Assistive Technology	Item	29	1.00	10000.00	**290000.00**	
Community Integration Services Total:						**1193411.07**
Community Integration Services	Each	159	1.00	7505.73	**1193411.07**	
Consultations Total:						**376894.32**
Consultations	Each	389	12.00	80.74	**376894.32**	
Environmental and Vehicle Modification Services Total:						**133357.86**
Environmental and Vehicle Modification Services	Each	17	1.00	7844.58	**133357.86**	
Individual Goods and Services Total:						**42000.00**
Individual Goods and Services	Each	28	1.00	1500.00	**42000.00**	
Non-Medical Transportation Total:						**596700.00**
Non-Medical Transportation	Each	80	17.00	438.75	**596700.00**	
Personal Emergency Response Services (PERS) Total:						**927446.24**
Personal Emergency Response Services (PERS)	Month	287	76.00	42.52	**927446.24**	
Respite Care Services Total:						**655718.40**
Respite Care Services	15 Mins	384	12.00	142.30	**655718.40**	
Wellness Coaching Total:						**148820.00**
Wellness Coaching	1 Hour	28	100.00	53.15	**148820.00**	

GRAND TOTAL:	**7810409.25**
Total Estimated Unduplicated Participants:	**527**
Factor D (Divide total by number of participants):	**14820.51**
Average Length of Stay on the Waiver:	317