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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
NH Acquired Brain Disorder Waiver 2021-2026

C. Waiver Number:NH.4177
Original Base Waiver Number: NH.40177.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
08/01/23
Approved Effective Date of Waiver being Amended: 11/01/21

2. Purpose(s) of Amendment

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

The purpose of this waiver amendment is to update information regarding New Hampshire's 1915(c) Acquired Brain Disorder Waiver related to system structural and operational changes made in order to come into compliance with Conflict Free Case Management and Direct Billing requirements.

New Hampshire's Area Agencies have historically operated as the only Medicaid-enrolled providers for waiver services. In addition, they have served as the primary provider of Service Coordination Services while also offering other direct service provision. To come into compliance with these regulatory requirements, the New Hampshire Department of Health and Human Services, Bureau of Developmental Services (BDS) has worked with stakeholders, including the Area Agencies, to establish updated guidelines in order to distinguish their roles and responsibilities from those of Service Coordination providers, ensure individuals have free choice of any qualified service provider and Service Coordination entity and ensure that all rendering service providers are enrolled with and have the ability to bill directly to Medicaid.

Waiver elements updated through this action to support the aforementioned work include Waiver Administration and Operation, Participant Access and Eligibility, the Crisis Services description, Provider Qualification Standards and Verification, Service Plan Development and Monitoring and Financial Accountability.

None of the proposed actions reduce the amount, scope, frequency or duration of services offered under the approved waiver.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	
☒ **Appendix A Waiver Administration and Operation**	
☒ **Appendix B Participant Access and Eligibility**	
☒ **Appendix C Participant Services**	
☒ **Appendix D Participant Centered Service Planning and Delivery**	
☒ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	
☐ **Appendix G Participant Safeguards**	
☐ **Appendix H**	
☒ **Appendix I Financial Accountability**	
☒ **Appendix J Cost-Neutrality Demonstration**	

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☒ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**
Specify:

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 Acquired Brain Disorder Waiver 2021-2026

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NH.40177
Draft ID: NH.011.06.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 11/01/21
Approved Effective Date of Waiver being Amended: 11/01/21

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:

N/A

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

H. Dual 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 Acquired Brain Disorder (ABD) Waiver is to provide services which maximize the ability and informed decision-making authority of people with acquired brain disorders and which promote the individual's personal development, independence and quality of life in a manner that is determined by the individual.

The waiver incorporates the core beliefs that individuals with acquired brain disorders live, work and pursue their life aspirations within their communities. It is the State's intention to support positive life trajectories, particularly through identified transitions that are known to be challenging, in a manner that ensures that waiver participants 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.

Program Description: Individuals must qualify for the Developmental Services System under RSA 137:K (Brain and Spinal Cord Injuries http://www.gencourt.state.nh.us/rsa/html/X/137-K/137-K-mrg.htm) and He-M 522 (Eligibility Determination and Service Planning for Individuals with an Acquired Brain Disorder http://www.gencourt.state.nh.us/rules/state_agencies/he-m500.htmlr) and 517 (Medicaid-Covered Home and Community Based Care Services for Persons with Developmental Disabilities and Acquired Brain Disorders http://www.gencourt.state.nh.us/rules/state_agencies/he-m500.html), the State Administrative Rules which establish standards and procedures for the determination of eligibility, the development of service agreements, and the provision and monitoring of services. To qualify for services under the ABD Waiver, individuals must be eligible for Medicaid and meet Nursing Facility (NF) level of care.

The State has defined within this waiver a range of home and community-based services which support waiver participants. Individuals and/or their guardians work with Service Coordinators to identify, through a person-centered service planning process, those specific services and supports offered under this waiver that are needed to avoid placement in an institutional setting. The State maintains the ability to control costs and, in conjunction with area agencies, service coordinators and individuals/guardians, establish mutual expectations regarding available resources.

Covered services include: Community Participation Services, Residential Habilitation, Respite, Service Coordination, Supported Employment, Assistive Technology, Community Integration Services, Community Support Services, Crisis Response, Environmental and Vehicle Modification Services, Individual Goods and Services, Non-Medical Transportation, Personal Emergency Response Services, Specialty Services, Wellness Coaching and Removable Prosthodontic Services.

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

The State has identified the functions of the Financial Management Services (FMS) entity, which manages and is the employer of record for support staff under the Participant and Directed Service (PDMS) method of service delivery. FMS will be billed as a Medicaid Administrative function and will be processed through the Department's Center for Medicare and Medicaid Services (CMS) approved Public Assistance Cost Allocation Plan (PACAP). This brings the option for the PDMS method of service delivery into compliance with the NH Corrective Action Plan with CMS. In order to further ensure the overall compliance with CMS' expectations, waiver participants and/or their guardian (if applicable) 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.

The State's activities have been focused on ensuring there is not a conflict of interest regarding the provision of Service Coordination, FMS administrative billing, direct billing options for providers, 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.

Organizational Structure: The waiver is implemented by the State in collaboration with New Hampshire's ten Area Agencies, designated in accordance with New Hampshire administrative Rule He-M 505, to plan, establish and maintain a comprehensive service delivery system. New Hampshire's area Agencies additionally operate as an Organized Health care delivery System and are nonprofit, 501(c)(3) entities that are governed by independent Boards of Directors. One-third of each area agency's Board membership consists of individuals with disabilities and/or family members. Further, area agencies are advised by regional Family Support Councils. NH's long-standing tradition of "local control" is a prominent element of the system and the overarching concepts of choice, control, and self-direction underpin the New Hampshire developmental service system.

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:

The State provided public notice in accordance with 42 CFR §447.205. Access to the full waiver was made available both electronically (via BDS Website) and hard copy. Public notice was posted via newspaper and email. The public forum hearing process was made available through zoom (remote) access. Public notice was posted as follows:

Newspaper advertisement in two statewide newspapers [NH Union Leader on and The Nashua Telegraph 5/23/21] and via postings to the BDS website (6/1/21) of the formal public input process. Notification was provided directly to stakeholders via email (6/1/21) including:

Medical Care Advisory Committee (MCAC)
State Designated Area Agencies for Developmental Services
Developmental Services Quality Council
Council for Developmental Disabilities
Institute on Disabilities, UCED, University of New Hampshire
Disability Rights Center (DRC)
Office of Public Guardian (OPG)
Tri-County Community Action Program
Private Provider Network (PPN)
ABLE
Family Voices
Parent Information Center (PIC)
Community Support Network Inc. (CSNI)
Family Support Council
Brain Injury Association of NH
Brain Injury Professional Provider Council
Brain and Spinal Cord Advisory Committee

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Notice of Opportunity for Public Comment 6/1/2021-6/30/2021

Notice of Renewal of Section 1915(c) Acquired Brain Disorder (ABD) Waiver
Pursuant to 42 C.F.R. §441.301(c)(6)(iii) notice is hereby given that the New Hampshire Department of Health and Human Services, as the single state Medicaid agency, intends to submit a renewal of its Section 1915(c) Acquired Brain Disorder Waiver to the Centers for Medicare and Medicaid Services (CMS).

This renewal is primarily a continuation of the current Acquired Brain Disorder Waiver and reflects:

• Compliance with recently updated federal regulations
• Service limits for selected services
• Updated Performance Measures
• Additional Covered Services

The Bureau of Developmental Services (BDS) provided public notice of opportunity for public comment for the Acquired Brain Disorder Waiver renewal from 6/1/21- 6/30/21. Forums were held via Zoom, due to Covid-19, on 6/10/21, 6/12/21, 6/17/21 and 6/22/21. Feedback was received and captured during the forums as well as via written submission. A complete summary of the comments received can be found at:
https://www.dhhs.nh.gov/dcbcs/bds/documents/abd-waiver-response.pdf

BDS received comments and feedback regarding the following Waiver areas:

Assistive Technology
- Covered devices and services.

Community Integration Services (CIS)
- Covered services; service limits; transportation coverage within this service.

Community Support Services (CSS)
- Service limits.

Crisis Response Services
- Service limits.

- Update to add that six-month approvals may be renewed based on individual need.

Community Participation Services (CPS)
- Covered services; provider eligibility.

Environmental and Vehicle Modifications Services
- Covered services; service limits and exclusions.

Individual Goods and Services
- Prior authorization process.

Non-Medical Transportation
- Covered transportation within this service and when part of another service and/or State Plan; prior authorization process, process in other states.

Personal Emergency Response Services
- Covered services; service limits; prior authorization process.

Respite
- Service implementation; provider qualifications; service limits.

Service Coordination
- Covered services; service limits.

Supported Employment
- Covered services; provider eligibility.

Wellness Coaching
- Service limits; provider eligibility.

Operationalization of the Waiver
- Service provision in acute care hospitals; Waiver eligibility; prior authorization process; funding process; individual service agreement requirements; nursing requirements and medication administration; provider eligibility; provider qualifications; covered services; Participant Directed and Managed Services (PDMS) termination; program oversight and responsibilities; PDMS assessment tool; Waiver funding allocation.
- Update to clarify monthly monitoring requirements.

Removable Prosthodontic Services Public Input:
The State provided public notice in accordance with 42 CFR §447.205. The Bureau of Developmental Services (BDS) provided public notice of opportunity for public comment for the Acquired Brain Disorder Waiver Removable Prosthodontic Services from 11/9/22 - 12/9/22. Access to the full waiver amendment was made available both electronically (via BDS Website) and hard copy. Newspaper advertisement in two statewide newspapers [NH Union Leader on 11/6/22 and Nashua Telegraph 11/6/22] and via postings to the BDS website were made of the formal public input process. In addition, a forum was held in-person and via Zoom on 11/30/2022. No feedback was received via mail, email or at the forum during the public input period.

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

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

7. Contact Person(s)

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

Last Name:

Lipman

First Name: Henry

Title: State Medicaid Director

Agency: NH Department of Health and Human Services

Address: 129 Pleasant Street

Address 2: Brown Building

City: Concord

State: **New Hampshire**

Zip: 03301

Phone: (603) 271-9434 **Ext:** ☐ **TTY**

Fax: (603) 271-5166

E-mail: Henry.Lipman@dhhs.nh.gov

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

Last Name: Gorton

First Name: Jessica

Title: HCBS Waiver Administrator, 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) 271-8942 **Ext:** ☐ **TTY**

Fax: (603) 271-5166

E-mail: jessica.d.gorton@dhhs.nh.gov

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **New Hampshire**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

In the waiver application, "Residential Habilitation" has replaced the previous covered service named "Residential Habilitation / Personal Support". This change does not eliminate, limit or change previously covered service. This change was made to bring the Residential Habilitation service name into alignment with the other 2 BDS waivers.

Participant Directed and Managed Services (PDMS) has been deleted as a service, however, services outlined in Appendix C are available via PDMS as outlined in Appendix E.

Additional covered services include: Goods and Services, Personal Emergency Response Services (PERS), Non-Medical Transportation, and Community Integration 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 Residential Habilitation that will replace the previous Residential Habilitation / Personal Support 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 received final approval from CMS on 2/14/2023 for its statewide Home and Community Based Services (HCBS) Settings Transition Plan. New Hampshire's plan demonstrates that this waiver complies with federal HCBS Settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6).

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.

NH continues operationalizing the goals identified in the plan to ensure that all settings are in compliance with the HCBS Settings rule by March 17, 2024.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from Main, 2. (Program Description)

Service Delivery Methods:

Initial application for Acquired Brain Disorder services eligibility shall be submitted to the Bureau of Developmental Services (BDS). BDS shall review the referral made pursuant to He-M 522.05(h)(1) and shall, within 15 business days of receipt of the referral, make a decision on eligibility. If found eligible for services under He-M 522, application for access to the Acquired Brain Disorder (ABD) Waiver is submitted to BDS. Following determination that an individual meets the level of care for the ABD waiver, an individualized Service Agreement (ISA) and budget are developed using a person-centered service planning process. Individual budget proposals are submitted to BDS, which makes all final budget determinations based on the cost effectiveness of proposed services. With an approved individualized budget, the individual and/or guardian selects from all qualified and willing providers, and the entity or person(s) to provide services are outlined in the service agreement.

Waiver participants will work with their chosen Service Coordinator to identify, through an assessment based, person-centered service 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.

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.

Per NH's corrective action plan for conflict of interest compliance, provider selection will enable individuals/guardians to choose from a variety of resources by having access to a statewide electronic listing (provider directory) of all willing and qualified providers.

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).

Temporary provision of services in acute care hospitals, based on an individual's needs has been added to this Waiver as identified in Appendix C. All Home and Community Based Services in this Waiver are not duplicative of services available in the acute hospital setting. Services that may be temporarily provided in acute hospitals include: Community Participation Services, Residential Habilitation, Service Coordination, Supported Employment, Assistive Technology, Community Integration Services, Community Support Services, Crisis Response Services, Individual Goods and Services, Specialty Services, Wellness Coaching and Removable Prosthodontic Services. These services are provided to meet needs of the individual that are not met through the provision of acute care hospital services; Are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide; Will be identified in the individual’s person-centered service plan; and will be used to ensure smooth transitions between acute care hospitals and community-based settings and to preserve the individual’s functional abilities.

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

The following services may be provided through telehealth: Community Participation Services, Residential Habilitation, Service Coordination, Supported Employment, Assistive Technology, Community Integration Services, Community Support Services, Crisis Response Services, Individual Goods and Services, Specialty Services, and Wellness Coaching.

The Bureau of Developmental Services is developing a state administrative rule relative specifically to provision of 1915 (c) Waiver services delivered via remote access methods. The rule will require that all remote access methods are in compliance with HIPAA requirements. The rule is in the process of being drafted and targeted to be approved by December of 2023.

BDS has created a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered service planning process and that the individual is not isolated. The checklist will ensure that the planning process considered assessed service needs and if the identified needs can be met by using a remote method of service delivery. If the Waiver participant’s needs cannot be met via remote service delivery because physical, in-person assistance is required to support the Waiver participant's assessed needs, then participation in services

remotely shall not be an option and in-person service delivery will be the method of service delivery. This will ensure that services are delivered in the amount, frequency and duration that is identified in the service agreement. This determination may be made per service. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered service planning process and outlined in the individual service agreement. The Remote Services checklist will include consideration of the Waiver participant's privacy expectations with respect to the location where they will participate in the service via remote methods and where the devices will be stored when not in use. The Checklist will also outline the protocols necessary to prepare and participate in services via remote access as well as the steps to end the service, including disconnecting from the service and storing of devices. The Remote Services Checklist will include a contingency plan that identifies the steps if there is a connectivity or device problem during services and who to notify when support is needed. BDS does not have the ability to remotely activate or view cameras in the participant's device.

The Service Coordinator will complete the Remote Services Checklist during the person-centered service planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522. Service provision via remote access is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

He-M 522 requires monthly contact and quarterly visits for service coordination. The provision of Home and Community Based Services via remote service delivery will be reviewed and approved by the person-centered service planning team on a quarterly basis. Remote access as a method of service delivery will be allowable for as long as it meets the need of the individual. As indicated in the service definition, remote access is an available method of service delivery to ensure services are delivered while considering individual choice, cost effectiveness, compliance with CMS requirements and identified in the individual's service agreement.

___

B-3-a: The projected numbers in this section, for WY1-WY5,mirror the CMS approved current ABD Waiver due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served.

___

E-1-n: The projected number in this section, for WY1-WY2, mirror the CMS approved current ABD Waiver due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served.

The state will utilize a 95% confidence level with a 5% margin of error unless otherwise indicated, such as a 100% review. BDS will utilize RaoSoft sampling calculator as advised by CMS to ensure that the sample size is representative.

An approved Electronic Visit Verification (EVV) system was not implemented by January 1, 2021. The State has been paying the penalty for Personal Care and Respite services since January 1, 2021.

If anomalies are found, during on-site reviews, which require further review, a referral will be made to Program Integrity (PI), which is part of the Bureau of Improvement and Integrity. PI provides oversight and monitoring of MCO contracts for fraud, waste and abuse. PI also does queries on services and looks for anomalies on all Medicaid services, including Home and Community Based Care Services. If they find anomalies they follow up with provider to do an audit on them. In addition, they audit providers if they get referrals or complaints.

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.

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 137-K and 171-A establish the program requirements and direct the NH Department of Health and Human Services (DHHS), which is the single state Medicaid agency, in its performance of ensuring that the waiver program requirements are met. As required by RSA 137-K, DHHS has adopted administrative rules (He-M 522) which define how the BDS must establish, implement, and maintain a comprehensive service delivery system for people with acquired brain disorders.

The BDS Bureau Administrator reports to the Director of the Division of Long Term Supports and Services (DLTSS). Frequent and ongoing communications occur between the State Medicaid Director and the Director of DLTSS.

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, New Hampshire’s ten Area Agencies, designated in accordance with New Hampshire administrative Rule He-M 505, plan, establish and maintain a comprehensive service delivery system. New Hampshire's Area Agencies operate as an Organized Health Care Delivery System and each serves as the single point of entry for acquired brain disorder services within the area agency's designated catchment area.

The Centers for Medicare and Medicaid Services had previously determined that New Hampshire was out of compliance with direct pay and conflict of interest requirements and the Acquired Brain Disorder Waiver (NH.4177) was operationalized under a CMS-approved corrective action plan. As of 7/1/2023, ABD waiver operations are in compliance with these requirements.

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 planning, establishing and monitoring a comprehensive service system 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 New Hampshire Administrative Rule He-M 505, "Establishment and Operation of Area Agencies", the Bureau of Developmental Services (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, ongoing quality review of key indicator data, stakeholder forums, surveys and meetings with each area agency Board of Directors.

In addition to the five-year redesignation schedule, BDS has developed an annual quality review process that includes elements of the redesignation process. Information from the annual quality reviews informs the redesignation process and provides meaningful data on an ongoing basis to help inform the performance of area agencies and identify issues with compliance.

The Governance Desk Audit includes a review of the following:

- Area Agency Board of Directors composition
- Area Agency Board by-laws, policies and procedures;
- Area Agency Executive Director qualifications;
- Current Area Plan (AKA strategic plan) and any amendments;
- Board of Directors meeting minutes;
- Information on how the Area Agency assures individuals, families and stakeholders in its region 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, Area Agency data is collected to demonstrate satisfactory performance in other key areas, including:
- Monthly review of financial indicators
- Billing activity
- Quarterly funding utilization
- Annual reports from Human Rights Committees
- Annual Health Risk Screening Tool Data; and
- Other existing data, 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	☒	☒

Function	Medicaid Agency	Local Non-State Entity
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 area with at least 4% of new enrollees.
Numerator: Number of designated geographical areas with at least 4% of new enrollees;
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:

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

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 residency agreements reviewed which met the specifications required by 42 CFR 441.301(c)(4)(vi)(A). Numerator: The number of residency agreements which met the specifications required by 42 CFR 441.301(c)(4)(vi)(A). Denominator: Total number of residency 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 =
☐ **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 requires a plan of correction for failure to submit evidence of a formal area plan (strategic plan).

According to He-M 505, the plan must be reviewed by the area board every 2 years and may be amended by the area board at any time, with such amendments submitted to the commissioner for approval if:

a. The area board proposes to change, discontinue, or expand services to individuals and their care giving families; or
b. Amendment is necessary to reflect changes in area-wide consumer needs, legislation or in area demographics, vendors, or funding.

The State will review the area plan and issue a plan of correction to an area agency whose plan 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**
	☐ **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**	22		☒
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

The target group(s) for this waiver are those specified in NH Law RSA 137:K. Pursuant to He-M 522.02 (a)(3), the acquired brain disorder shall have occurred prior to the age of 60.

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and

community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

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

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

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

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

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

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

  [ ]

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

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

    Specify dollar amount: [ ]

    The dollar amount *(select one)*

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

      Specify the formula:

      [ ]

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	287
Year 2	292
Year 3	297
Year 4	302
Year 5	307

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 state administrative rule He-M 517, which is entitled Medicaid-Covered Home and Community-Based Care Services for Persons with Developmental Disabilities and Acquired Brain Disorders, and state administrative rule He-M 522 governing eligibility for acquired brain disorder services.

He-M 517 provides in part that eligibility for the waiver is contingent on the availability of funding. He-M 522 incorporates the language of State law RSA 171-A:1-a,I, which provides the criteria for funding for services and limitations on wait lists. Individuals are prioritized on the waiting list based on a number of objective factors.

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:

Individuals eligible under §1902(a)(10)(A)(i)(VIII) (42CFR 435.119)

Medicaid State Plan Individuals aged 19 or older and under age 65 with income 133% FPL (42 CFR 435.119)

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

☒ **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 Standard of Need, as outlined by the NH Department of Health and Human Services, is the limit for individuals who live in homes owned and/or operated by providers unrelated to the individual by ancestry, marriage, or other legal arrangement. The income standard for those individuals who live independently or with their families, is the special income level for the institutionalized person of 300% of SSI (FBR).

○ **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:

The State uses the same reasonable limits as specified in He-W 530, "Service Limits, Co-Payments and Non-Covered Services"

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:

The Standard of Need, as outlined by the NH Department of Health and Human Services, is the limit for individuals who live in homes owned and/or operated by providers unrelated to the individual by ancestry, marriage, or other legal arrangement. The income standard for those individuals who live independently or with their families, is the special income level for the institutionalized person of 300% of SSI (FBR).

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:

The State uses the same reasonable limits as specified in He-W 530, "Service Limits, Co-Payments and Non-Covered Services"

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:

The Standard of Need, as outlined by the NH Department of Health and Human Services, is the limit for individuals who live in homes owned and/or operated by providers unrelated to the individual by ancestry, marriage, or other legal arrangement. The income standard for those individuals who live independently or with their families, is the special income level for the institutionalized person of 300% of SSI (FBR).

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 (BDS) 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 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 517, an individual requires a skilled nursing facility level of care, which means requiring skilled nursing or skilled rehabilitative services on a daily basis for at least one of the following:

1. Services on a daily basis for:

(i) Performance of basic living skills;

(ii) Intellectual, physical, or psychological development and well-being;

(iii) Medication administration and instruction in, or supervision of, self-medication by a licensed medical professional; or

(iv) Medical monitoring or nursing care by a licensed professional person;

2. Services on a less than daily basis as part of a planned transition to more independence; or

3. Services on a less than daily basis but with continued availability of services to prevent circumstances that could necessitate more intrusive and costly services.

Initial requests for HCBS-ABD 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, 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 uses the Bureau of Developmental Services (BDS) Functional Screen (FS) tool to make level of care (LOC) determinations for the Acquired Brain Disorder (ABD) Waiver. The BDS FS tool is comparable to the Medical Eligibility Assessment (MEA) utilized for LOC determinations for non-community based institutions, such as nursing facilities. 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 Bureau of Developmental Services (BDS) Functional Screen (FS) form to BDS to be reviewed in order to determine or redetermine the individual's eligibility for the Acquired Brain Disorder Waiver.

Reevaluations are completed annually through the submission of an updated NH BDS FS 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 Bureau of Developmental Services (BDS) utilizes the following procedure to ensure timely reevaluations of level of care: To request reevaluation for Acquired Brain Disorder (ABD) Waiver services for an individual, a revised Functional Screen (FS) must be submitted at least 30 days prior to expiration of the current determination.

If the Functional Screen does not have sufficient information for BDS to determine whether the individual continues to meet the level of care requirements, the BDS staff requests that additional information be provided. The additional information requested could include, but is not limited to, recent assessments or evaluations that speak to the individual's assessed needs such as neuropsychological evaluations, Supports Intensity Scale, or SIB-R. If additional information received does not provide enough evidence for staff to determine the individual meets the level of care, the request would be denied.

BDS staff review all Functional Screen forms for each waiver participant at least annually, or more often when there are changes in needs.

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:
 # & % of applicants for whom there is a reasonable indication that there may be services needed in the future who received a LOC. Numerator: # of applicants for whom there is a reasonable indication that there may be services needed in the future who received a LOC. Denominator: Total number of all applicants for whom there is reasonable indication that services may be needed in the future.

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

Performance Measure:
Number and percent of level of care (LOC) reviews for which a current functional screen has been used appropriately, as outlined in the approved Waiver, to determine LOC. Numerator: Number of LOC reviews for which a current functional screen has been used appropriately, as outlined in the approved Waiver, to determine LOC. Denominator: Total number of LOC reviews completed for 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 service coordinator convenes a meeting during which the individual or legal guardian is informed of service options available through this waiver as well as the New Hampshire Medicaid State Plan, including institutional settings, community resources, and other alternatives that may be pertinent to the specific situation of the individual.

As part of the person-centered service planning process outlined in State Administrative Rule He-M 522, all individual service agreements document evidence of the individual or guardian's informed consent of community and institutional service alternatives.

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

An individual's service agreement documents freedom of choice. The service agreement is stored in the individual's record which is located at the Service Coordination 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 522 requires informed consent relative to services and service provision. It reads "All service planning shall occur through a person-centered planning process that: Reflects cultural considerations of the individual and is conducted in clearly understandable language and form". Samples of informational brochures in various languages are available.

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	Community Participation Services		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Service Coordination		
Statutory Service	Supported Employment		
Other Service	Assistive Technology		
Other Service	Community Integration Services		
Other Service	Community Support Services		
Other Service	Crisis Response Services		
Other Service	Environmental and Vehicle Modification Services		
Other Service	Individual Goods and Services		
Other Service	Non-Medical Transportation		
Other Service	Personal Emergency Response Services		
Other Service	Removable Prosthodontic Services		
Other Service	Specialty 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:

Day Habilitation

Alternate Service Title (if any):

Community Participation Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

All community participation services shall be designed to:

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

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

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

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

Traveling safely in the community;

Managing personal funds;

Participating in community activities; and

Other life skills identified in the service agreement;

Promote the individual's health and safety;

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

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

Levels of Day Habilitation/Community Participation Services include:

Level I: Intended primarily for individuals who require intermittent supports on a regular basis;
Level II: Intended for individuals who require supports and supervision throughout the day;
Level III: Intended for individuals who require substantial supports and supervision;
Level IV: Intended for individuals who require frequent supports and supervision;
Level V: Intended for individuals who have significant medical and /or behavioral needs and require critical levels of supports and supervision; and
Level VI: Intended for individuals with the most extraordinary medical and behavioral needs and require exceptional levels of supervision, assistance and specialized care.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Community Participation Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive

Community Participation Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years,
from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that
are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Community Participation Services may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

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

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Participation Services (CPS)
Agency	Community Participation Services (CPS)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Participation Services

Provider Category:

Individual

Provider Type:

Community Participation Services (CPS)

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

In the event that a Community Participation Services Provider is required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

Other Standard *(specify):*

State Administrative Rule He-M 507 provides qualifications and training required for CPS providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Participation Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

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

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Participation Services definition and provider qualification criteria.

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

Frequency of Verification:

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

The Bureau of Health Facilities Administration verifies provider qualifications at certification site visits.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Participation Services definition and provider qualification criteria.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Participation Services

Provider Category:

Agency

Provider Type:

Community Participation Services (CPS)

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

In the event that a Community Participation Services Provider is required to administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

Other Standard *(specify):*

State Administrative Rule He-M 507 provides qualifications and training required for CPS providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Participation Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

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

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Participation Services definition and provider qualification criteria.

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

Frequency of Verification:

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

The Bureau of Health Facilities Administration verifies provider qualifications at certification site visits.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Participation Services definition and provider qualification criteria.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Residential Habilitation includes a range of individually tailored supports to assist with the acquisition, retention, or improvement of community living skills including but not limited to: Assistance with activities of daily living and personal care such as meal preparation, eating, bathing, dressing, personal hygiene, medication management, community inclusion, transportation, social and leisure skills, and adaptive skill development to assist the individual to reside in the setting most appropriate to his/her needs.

Services and supports may be furnished in the home or outside the home. Services are provided to eligible individuals with the following general assistance needs:

Level I: Intended primarily for individuals who require intermittent supports on a daily basis;
Level II: Intended for individuals who require supports and supervision throughout the day;
Level III: Intended for individuals who require substantial supports and supervision;
Level IV: Intended for individuals who require frequent supports and supervision;
Level V: Intended for individuals who have significant medical and /or behavioral needs and require critical levels of supports and supervision; and
Level VI: Intended for individuals who have extraordinary medical and behavioral needs and require exceptional levels of assistance and specialized care.
Level VII: intended for individuals with the most extensive and extraordinary medical or behavioral management needs.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Residential Habilitation in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Residential Habilitation in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Residential Habilitation may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined

during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

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

This waiver service is not available to individuals who are eligible to receive such service through the Medicaid State Plan.

Payment is not made for the cost of room and board, building maintenance, upkeep or improvement.

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 Service Provider
Agency	Direct Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Individual

Provider Type:

Direct Service Provider

Provider Qualifications

License *(specify):*

If services are being provided in conjunction with a practice act, provider must comply with the State's licensure and certification laws as appropriate.

Certificate *(specify):*

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 state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

Other Standard *(specify):*

State Administrative Rule He-M 1001 provides qualifications and training required for direct service providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Residential Habilitation, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

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

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Residential Habilitation service definition and provider qualification criteria.

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

Frequency of Verification:

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

The Bureau of Health Facilities Administration verifies provider qualifications at certification site visits.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Residential Habilitation service definition and provider qualification criteria.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Direct Service Provider

Provider Qualifications

License *(specify):*

If services are being provided in conjunction with a practice act, provider must comply with the State's licensure and certification laws as appropriate.

Certificate *(specify):*

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

Ongoing supervision and quality assurance are conducted by an RN to ensure continued competency. This regulation and the accompanying curriculum have been approved by the New Hampshire Board of Nursing.

Other Standard *(specify):*

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

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

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

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

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Residential Habilitation, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Residential Habilitation, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

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

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Residential Habilitation service definition and provider qualification criteria.

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

Frequency of Verification:

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

The Bureau of Health Facilities Administration verifies provider qualifications at certification site visits.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Residential Habilitation service definition and provider qualification criteria.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

In accordance with He-M 513, Respite Services consist of the provision of short-term care for participants unable to care for themselves because of the absence or need for relief of those persons who live with and normally provide care for the participant. Respite services can be provided in or out of the participant's home. Respite services should be provided in accordance with He-M 513.04 and/or He-M 513.05.

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

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

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

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

The 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
Individual	Respite Provider
Agency	Respite Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Respite Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

Respite providers are unlicensed and uncertified personnel. In the event respite providers administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

Other Standard *(specify):*

State Administrative Rule He-M 513 provides qualifications and training required for respite providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

The agency has the primary responsibility to verify provider qualifications when respite is arranged by the area agency.

Frequency of Verification:

Verification of provider qualification happens prior to service delivery.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

Respite providers are unlicensed and uncertified personnel. In the event respite providers administer medications, they are trained by a nurse trainer per state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

Other Standard *(specify):*

State Administrative Rule He-M 513 provides qualifications and training required for respite providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

The area agency has the primary responsibility to verify provider qualifications when the area agency has arranged the respite service.

Frequency of Verification:

Verification of provider qualification happens prior to service delivery.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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.

As outlined in, "Brief Waiver Description, B. Optional, Service Coordination may be provided remotely through telehealth as determined necessary to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

Service coordination activities completed as required in He-M 522.11 (m) (2) may be completed via telehealth service delivery through telephone contact or video-call platforms. Service coordination activities completed as required in He-M 522.11 (m) (3) may be completed via telehealth service delivery through a video-call platform in order to ensure face-to-face contact. Service Coordination activities completed as required in He-M 522.11 (m) (4) must be completed in-person. Participant Directed and Managed Services home visits must be completed in-person.

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

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

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

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):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

State Administrative Rule He-M 522 and 506 provides qualifications and training required for service coordinators. State administrative rule He-M 525 contains requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

Frequency of Verification:

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):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

State Administrative Rule He-M 522 and 506 provides qualifications and training required for direct service providers. State administrative rule He-M 525 contains requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Employment services will provide access to community-based employment and make available, based upon individual need and interest: employment supports, transportation to work, training and educational opportunities, the use of co-worker supports and generic resources to the maximum extent possible.

All employment services shall be designed to:

Assist the individual to obtain employment, customized employment or self-employment, including the development of microenterprises that are integrated in the community, that is based on the individual's employment profile and goals in the service agreement;

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

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

Creating a resume and employment portfolio;

Practicing job interviews; and

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

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

Developing accommodations;

Utilizing assistive technology; and

Creating and implementing a plan to fade services;

Help the individual to:

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

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

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

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

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

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

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

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

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

Traveling safely in the community;

Managing personal funds;

Utilizing public transportation; and

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

Promote the individual's health and safety;

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

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

SEP Level I: Intended primarily for individuals whose level of functioning is relatively high but who still require intermittent supports on a regular basis;
SEP Level II: Intended for individuals whose level of functioning requires substantial supports and supervision;
SEP Level III: Intended for individuals with the most extensive and extraordinary medical or behavioral management needs.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Supported Employment in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Supported Employment in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Supported Employment may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the

Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

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

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	Employment Consultant
Agency	Employment Consultant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Employment Consultant

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

State Administrative Rule He-M 506 and 518 provides qualifications and training required for direct service providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Supported Employment, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Supported Employment service definition and provider qualification criteria.

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

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Supported Employment service definition and provider qualification criteria.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Employment Consultant

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

State Administrative Rule He-M 506 and 518 provides qualifications and training required for direct service providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Supported Employment, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Supported Employment service definition and provider qualification criteria.

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

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Supported Employment service definition and provider qualification criteria.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

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

Service Definition *(Scope):*

This service covers assistive technology and any related assistive technology services. Assistive technology means an item, piece of equipment, certification and training of a service animal (service animal as defined by the American Disabilities Act (ADA)), 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.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Assistive Technology in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Assistive Technology in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Assistive Technology may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered

plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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
Individual	Assistive Technology Provider
Agency	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:

Individual

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Specialized training in equipment, item or product.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Assistive Technology, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Assistive Technology service definition and provider qualification criteria.

Frequency of Verification:

Annual or other schedule as outlined by law or regulation.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Assistive Technology service definition and provider qualification criteria.

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.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Assistive Technology, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Assistive Technology service definition and provider qualification criteria.

Frequency of Verification:

Annual or other schedule as outlined by law or regulation.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Assistive Technology service definition and provider qualification criteria.

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:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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.

The coverage of this service authorizes the purchase of goods and services that are not otherwise offered in the waiver or the state plan. The specific goods and services that are purchased under this coverage must be documented in the service agreement.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Community Integration Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Community Integration Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Community Integration Services may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities

required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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 single community integration service over $2,000 will require a licensed healthcare practitioner's recommendation.

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

The coverage of this service authorizes the purchase of goods and services that are not otherwise offered in the waiver or the state plan.

Individual service agreement (ISA) will specify the following:

1) The service;
2) The name of the healthcare practitioner recommending the item (for single services $2,000 and over);
3) An evaluation or assessment regarding the appropriateness of the service;
4) A goal related to the use of the service;

"Community Based Campership" is defined as a Summer Camp which is a disability-specific setting that is based in the community that provides opportunities for skill building, socialization, development and maintenance of independence and other activities that meet the needs of the individual as outlined in the Individualized Service Agreement and based on an assessed need as determined by the individual's disability. The setting must be selected by the individual from among setting options including non-disability settings.

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	Community Integration Services (CIS) Provider
Individual	Community Integration Services (CIS) Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

Community Integration Services (CIS) Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Specialized training in equipment, item service or product.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Integration Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Integration Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Integration Services service definition and provider qualification criteria.

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:

Community Integration Services (CIS) Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Specialized training in equipment, item service or product.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Integration Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Integration Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Integration Services service definition and provider qualification criteria.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Community Support Services are intended for the individual who has developed, or is trying to develop, skills to live independently within the community. Community Support Services consist of assistance provided to an individual to improve or maintain his or her skills in basic daily living, transportation and community integration; to enhance his or her personal development and well being in accordance with goals outlined in the individual's service agreement.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Community Support Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Community Support Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Community Support Services may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Telehealth Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a telehealth method of service delivery. If the individual requires hands-on assistance, telehealth service delivery shall not be an option. The Telehealth Checklist will include consideration of the percentage of time that telehealth service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Telehealth service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

This service may be provided in an acute care hospital, 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 acute care hospital services;
(C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
(D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

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

Community Support Services are capped at 30 hours per week.

Services may begin and continue for up to 24 consecutive months (two years) while the individual is still residing with his/her family.

This service does not include costs related to room and board.

The BDS Administrator reserves the right to exceed the cap and/or time limitations placed on this service on a case by case basis.

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 Support Professional
Individual	Direct Support Professional

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Support Services

Provider Category:

Agency

Provider Type:

Direct Support Professional

Provider Qualifications

License *(specify):*

None

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 state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

Other Standard *(specify):*

State Administrative Rule He-M 506 provides qualifications and training required for direct service providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Support Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Support Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Support Services service definition and provider qualification criteria.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Support Services

Provider Category:

Individual

Provider Type:

Direct Support Professional

Provider Qualifications

License *(specify):*

None

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 state administrative rule He-M 1201 to obtain certification to administer medications. Under the Participant Directed and Managed Services method of service delivery, NUR 404 will be followed.

Other Standard *(specify):*

State Administrative Rule He-M 506 provides qualifications and training required for direct service providers. He-M 506 provides qualifications and training required for all providers. State administrative rules He-M 521 and He-M 525 contain requirements for service provision when the individual chooses the participant directed and managed model of service delivery (PDMS).

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

All providers of this service must be an enrolled Medicaid provider.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Community Support Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Community Support Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Community Support Services service definition and provider qualification criteria.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Crisis Response Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Includes direct consultation, clinical evaluation, staffing supports and transportation to individuals who are experiencing a behavioral, emotional or medical crisis or challenge. These services are intended to address the individual's specific problems, thereby reducing the likelihood of harm to the individual or others, and assisting the individual to return to his/her pre-crisis status.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Crisis Response Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Crisis Response Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Crisis Response Services may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

Authorized provision of Crisis Response Services with review by BDS prior to service authorization may be

provided for no more than 5 days, in accordance with the Crisis Policy, and only to ensure health and welfare of an individual.

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

This waiver service is not available to individuals who are eligible to receive such service through the Medicaid State Plan.

Limited to six month approval. Six month approvals may be renewed based on individual need.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Clinician, or consultant, behavioral specialist, or direct support staff
Individual	Clinician, or consultant, behavioral specialist, or direct support staff

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Response Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certain provider types may require certification depending on service provided.

Other Standard *(specify):*

Direct service staff would be required to meet, at minimum, requirements as outlined under day and residential habilitation.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Crisis Response Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Crisis Response Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Crisis Response Services service definition and provider qualification criteria.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Response Services

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certain provider types may require certification depending on service provided.

Other Standard *(specify):*

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

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Crisis Response Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Crisis Response Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Crisis Response Services service definition and provider qualification criteria.

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:**

Service Definition *(Scope):*

Environmental and Vehicle Modification Services: Include those physical adaptations to the private residence of the participant, or vehicle that is the waiver participant's primary means of transportation, required by the individual's 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.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Environmental and Vehicle Modification Services in another state, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual’s community during person-centered planning, the participant may receive Environmental and Vehicle Modification Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire’s State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the
previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical
needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

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

(A) Identified in an individual’s person-centered service plan;
(B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
(C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or

under Federal or State law, or under another applicable requirement; and
(D) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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 area.

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

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Contractor, or other similarly qualified provider
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:

Agency

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.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Environmental and Vehicle Modification Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Environmental and Vehicle Modification Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Environmental and Vehicle Modification Services service definition and provider qualification criteria.

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.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Environmental and Vehicle Modification Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Environmental and Vehicle Modification Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Environmental and Vehicle Modification Services service definition and provider qualification criteria.

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:**

Service Definition *(Scope):*

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

Individual 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. Individual 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.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Individual Goods and Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Individual Goods and Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the
previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical
needs that are not covered by the Waiver.
• A plan that will articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Individual Goods and Services may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

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

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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.

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.

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):*

None

Certificate *(specify):*

None

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 (if applicable), the service coordinator, and any other people chosen by the individual and/or his or her legal guardian.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Individual Goods and Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

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

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Individual Goods and Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Individual Goods and Services service definition and provider qualification criteria.

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):*

None

Certificate *(specify):*

None

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 (if applicable), the service coordinator, and any other people chosen by the individual and/or his or her legal guardian.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Individual Goods and Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Individual Goods and Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Individual Goods and Services service definition and provider qualification criteria.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

1. Transport for safe movement from one place to another;
2. Travel training such as supporting the individual 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.
5. Parking and toll fees

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Non-Medical Transportation in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Non-Medical Transportation in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the
previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical
needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

Payment for transportation under the waiver is limited to the costs of transportation needed to access a waiver service included in the participant's service plan or access to other activities and resources identified in the service plan.

Non-Medical Transportation is capped at $5,000 annually.

Up to $10,000 annually is allowable for individuals that require specialized transportation including wheelchair van/lift and/or a van that allows the individual being transported to "not" be within arm's reach of the driver for safety reasons. Verification of an individual's need for specialized transportation will be required upon request to the Bureau of Developmental Services.

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

When the provider is transporting the individual, the individual is with the caretaker and the only transportation that may be covered is when the transportation that occurs is directly related to the individual's disability or specific to a caretaker providing the transportation to activities determined in the individual service agreement.

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

The following are specifically excluded:
1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Coverage of non-medical transportation may be permitted when non-medical transportation is not otherwise available through a service in the waiver or the state plan.

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
Agency	Direct Support Professional

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

Provider Qualifications

License *(specify):*

Any direct support professional driving a waiver participant shall have a current driver's license.

Certificate *(specify):*

None

Other Standard *(specify):*

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

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Non-Medical Transportation, the following documentation must be provided:

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Non-Medical Transportation service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Non-Medical Transportation service definition and provider qualification criteria.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Direct Support Professional

Provider Qualifications

License *(specify):*

Any direct support professional driving a waiver participant shall have a current driver's license.

Certificate *(specify):*

None

Other Standard *(specify):*

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

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Non-Medical Transportation, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Non-Medical Transportation service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Non-Medical Transportation service definition and provider qualification criteria.

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

HCBS Taxonomy:

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

Service Definition *(Scope):*

Smart technology including electronic devices that enable participants at risk of institutionalization to summon help in an emergency. Covered devices include wearable or portable devices that allow for safe mobility, response systems that are connected to the participant's telephone and programmed to signal a response center when activated, staffed and monitored response systems that operate 24 hours/day, seven days/week and any device that informs of elopement such as wandering awareness alerts. Other covered items include 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.

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

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Personal Emergency Response Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Personal Emergency Response Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the
previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical
needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

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

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

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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.

Any device that might be considered restrictive will be part of a modification plan (behavior plan) and will be approved by the individual, guardian and the local Human Rights Committee.

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	Private Contractor, or other similarly qualified provider
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: Personal Emergency Response Services

Provider Category:

Agency

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):*

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Personal Emergency Response Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Personal Emergency Response Services service definition and provider qualification criteria.

Frequency of Verification:

Provider qualifications will be verified prior to the delivery of services and annually thereafter.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Personal Emergency Response Services service definition and provider qualification criteria.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response 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):*

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Personal Emergency Response Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Personal Emergency Response Services service definition and provider qualification criteria.

Frequency of Verification:

Provider qualifications will be verified prior to the delivery of services and annually thereafter.

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Personal Emergency Response Services service definition and provider qualification criteria.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Removable Prosthodontic Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

Removable Prosthodontic Services are intended to assist individuals as a means to prevent functional limitations in order to support community integration and avoid isolation or institutionalization and when, if not otherwise provided:
-The individual's health would be compromised through reduced food options and result in restrictive nutritional intake, impacting overall health; and/or
-When considerations interfere with supported employment or social development. For example, an individual who has a severe dental deformity may receive
treatment if during person-centered-planning, it is determined that provision of dentures would enhance the individual's opportunities for community
integration.

Covered services include:
-Complete Dentures, including immediate prosthetic appliances and routine post-delivery care
-Partial Dentures, including immediate prosthetic appliances and routine post-delivery care
-Adjustments to dentures
-Repairs to complete and partial dentures
-Denture rebase procedures
-Denture reline procedures

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

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

A goal is not required in the individual's service agreement, however, the need for this service shall be reflected. If this service was selected to support community integration and prevent isolation, the decision to select this service shall be made by the individual and guardian, as applicable, during the person-centered planning process. All treatment notes, radiographic images, laboratory prescriptions and laboratory invoices should be made part of the individual's treatment record with the PAHP and be made available upon request to support any treatment provided.

Out-of-state Removable Prosthodontic Services provision is limited to individuals who are participating in Bureau of Developmental Services-approved out-of-state residential services, as outlined in the Residential Services definition in Appendix C, or if the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning.

Removable Prosthodontic Services may be provided in an acute care hospital if the service is alternatively not available and with prior approval from the PAHP if the service is:
-Identified in the individual's person-centered service agreement;
-Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
-Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
-Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

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

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

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

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dentist
Agency	Dentist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Removable Prosthodontic Services

Provider Category:

Individual

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

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

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Removable Prosthodontic Services

Provider Category:

Agency

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

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

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialty Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Intended for recipients whose needs in the areas of medical, behavioral, therapeutic, health and personal well-being require services which are specialized pertaining to unique conditions and aspects of acquired brain disorder. Specialty Services are utilized to provide assessments and consultations and are used to contribute to the design, development and provision of services, training support staff to provide appropriate supports as well as the evaluation of service outcomes and transportation if applicable.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Specialty Services in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Specialty Services in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the
previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical
needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Specialty Services may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

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

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

☒ **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	Psychiatrist, psychologist, forensic specialist, or other consulting health care or disability professional with specialized knowledge.
Individual	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: Specialty Services

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 of disability professional requiring licensure under state law to practice, the provider is required to have the appropriate licensure or certification as outline in state law.

Certificate *(specify):*

None

Other Standard *(specify):*

Other consulting healthcare or disability professionals with specialized knowledge will not need state licensure or certification, but will require meeting the requirements for their specialized field. Forensic specialist are masters level clinicians with the expertise and experience to provide supports to individuals with acquired brain disorder who are at risk for unsafe sexual behaviors or arson.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Specialty Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Specialty Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Specialty Services service definition and provider qualification criteria.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialty Services

Provider Category:

Individual

Provider Type:

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 or certification as outline in state law.

Certificate *(specify):*

None

Other Standard *(specify):*

Other consulting healthcare or disability professionals with specialized knowledge will not need state licensure or certification, but will require meeting the requirements for their specialized field. Forensic specialist are masters level clinicians with the expertise and experience to provide supports to individuals with acquired brain disorder who are at risk for unsafe sexual behaviors or arson.

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Specialty Services, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Specialty Services service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Specialty Services service definition and provider qualification criteria.

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:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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, explain to them corrective measures necessary to improve their skills, and transportation if applicable. Collaborate with the individual, his or her guardian (if applicable) and other caregivers and with other health and wellness professionals as needed. The Services must not otherwise be covered by NH State Plan.

If the only safe and accessible setting for a participant is outside of New Hampshire, the participant may receive Wellness Coaching in another state, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, until a safe and accessible setting is available in New Hampshire. This determination shall be documented in the service agreement. If the individual resides in a New Hampshire town that is close to another state (border adjacent or not more than a 30 minute drive), and the out-of-state provider is identified to be within the individual's community during person-centered planning, the participant may receive Wellness Coaching in an out-of-state setting, in a Medicaid approved setting in accordance with New Hampshire's State Transition Plan, if they so choose, without the BDS Out-of-State Review, as outlined below. This determination shall be documented in the service agreement. In such case, the provider qualifications must still be met.

All settings must demonstrate that the provider meets expectations for the home and community based setting in which the services are provided and complies with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), and any amendments thereto.

BDS Out-of-State Review
All out-of-state service provision must be reviewed and approved by BDS prior to the out of state service provision, with the exception of out-of-state services selected due to border proximity, as outlined above. Requests for out-of-state service provision shall include supporting documentation within the person-centered service agreement of:
• A transition plan that will be articulated in the service agreement, with a timeframe for return to New Hampshire.
• Provider qualification criteria, as outlined for the Waiver service(s).
• The licensing/certification reports from the previous 5 years, or the maximum number available for providers established within the
previous 5 years, from any in-state or out-of-state entity, including deficiency reports and compliance records.
• A plan that will be articulated in the service agreement to demonstrate how an individual will access acute care as well as ongoing medical and clinical
needs that are not covered by the Waiver.
• A plan that will be articulated in the service agreement for oversight and monitoring of the service plan.

As outlined in, "Brief Waiver Description, Main B. Optional", Wellness Coaching may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements and identified in the individual's person-centered plan. BDS will create and implement a Remote Services Checklist. The checklist will act as a safeguard to ensure that a review of community integration is conducted throughout the person-centered planning process and that the individual is not isolated. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a remote method of service delivery. If the individual requires hands-on assistance, remote service delivery shall not be an option. The Remote Services Checklist will include consideration of the percentage of time that remote service provision will be utilized. The amount of time chosen shall be determined during the person-centered planning process and outlined in the individual service agreement. The Service Coordinator will complete the checklist during the person-centered planning process in order to aid in the development of the annual individual service agreement, as well as during the quarterly monitoring activities required by He-M 522.11(m) (3) – (4). Remote service provision is currently available through allowances from the Appendix K. Implementation of the checklist will commence when the appendix K expires.

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

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

and to preserve the individual's functional abilities.

Rendering providers of this service may enter into an agreement with an OHCDS to be the qualified provider and bill on their behalf. This agreement must be voluntary and does not alter the provider qualifications outlined in this section.

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

Service limit: Wellness coaching services has an annual cap of $5,000.

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	Personal Trainer, Certified Instructor or Physical Therapist
Individual	Personal Trainer, Certified Instructor or Physical Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Coaching

Provider Category:

Agency

Provider Type:

Personal Trainer, Certified Instructor or Physical Therapist

Provider Qualifications

License *(specify):*

Licensed physical therapist

Certificate *(specify):*

Certified personal trainer, certified occupational therapist or other relevant certifications.

Other Standard *(specify):*

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Wellness Coaching, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Wellness Coaching service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Wellness Coaching service definition and provider qualification criteria.

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:

Personal Trainer, Certified Instructor or Physical Therapist

Provider Qualifications

License *(specify):*

Licensed physical therapist

Certificate *(specify):*

Certified personal trainer, certified occupational therapist or other relevant certifications.

Other Standard *(specify):*

Individuals providing services for participants self-directing their services must meet the standards noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency or the OHCDS. FMS or OHCDS must ensure the individual or entity performing the service meets the qualifications.

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system.

In instances of out-of-state service provision that has been approved by the Bureau of Developmental Services in accordance with the standard in the service definition for Wellness Coaching, the following documentation must be provided.

• The home-state license and/or certification for the applicable setting, service provided and/or providers.
• If applicable, accreditations for home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

All providers must be enrolled NH Medicaid Providers except in circumstances where an entity contracts with an organized health care delivery system. In such case, verification of provider qualifications is done by the OHCDS.

The FMS is responsible for verification of provider qualifications for participants who self-direct their services.

For out-of-state service providers, the Area Agency is responsible to gather necessary provider qualification information and documentation. The Area Agency will provide this information to BDS, as outlined in the Wellness Coaching service definition and provider qualification criteria.

Frequency of Verification:

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

For out-of-state service providers, the Area Agency shall gather all necessary provider qualification information and documentation annually. The Area Agency will provide this information to BDS annually, as outlined in the Wellness Coaching service definition and provider qualification criteria.

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):

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 for non-licensed and non-certified providers during Acquired Brain Disorder Waiver service record audits. The State ensures that criminal background checks and state registry screenings were completed for licensed and certified providers during inspections by the Health Facilities Administration.

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 were completed for non-licensed and non-certified providers during Acquired Brain Disorder Waiver service record audits. The State ensures that criminal background checks and state registry screenings were completed for licensed and certified providers during inspections by the Health Facilities Administration.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Residence

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Wellness Coaching	☒
Removable Prosthodontic Services	☐
Respite	☒
Community Support Services	☒
Community Integration Services	☒
Residential Habilitation	☒
Crisis Response Services	☒
Specialty Services	☒
Assistive Technology	☒
Non-Medical Transportation	☒
Community Participation Services	☒
Individual Goods and Services	☒
Personal Emergency Response Services	☒
Supported Employment	☒
Service Coordination	☒
Environmental and Vehicle Modification Services	☒

Facility Capacity Limit:

16

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒

Standard	Topic Addressed
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

Appendix C: Participant Services

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

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

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

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

Individual/guardian must be given a choice of providers. If the individual/ guardian choses the individual's spouse to provide personal care services, payment shall be available to the spouse, so long as it is determined that this is in the best interest of the individual and when at least one of the following applies:
1. The individual's level of dependency in performing activities of daily living, including the need for assistance with toileting, eating or mobility, exceeds that of his or her peers with an acquired brain disorder ;
2. The individual requires support for a complex medical condition, including airway management, enteral feeding, catheterization or other similar procedures; or
3. The individual's need for behavioral management or cognitive supports exceeds that of his or her peers with an acquired brain disorder
The legally responsible person or spouse must meet all applicable provider qualifications, including the required criminal records check.

Additionally, in those instances where the spouse is providing personal care services, the spouse cannot provide more than 40 hours per week of personal care services.
The case manager shall review on a monthly basis the hours billed by the spouse for the provision of personal care.
The case manager shall conduct monthly monitoring and quarterly visits in accordance with NH Administrative Rule He-M 522.

☒ **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 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.

Waiver participants/guardians may select any willing and qualified provider without regard to whether or not that provider is currently a provider in the NH 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:
 # and % of new providers demonstrating that they initially met required certification and/or licensing standards and adhered to other standards prior to providing waiver services. N: Number of new providers demonstrating that they initially met required certification and/or licensing standards and adhered to other standards prior to providing waiver services. D: Number of new providers.

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 =
☒ **Other** Specify: New Hampshire Department of Health and Human Services, Bureau of Health Facilities Administration, Office of Legal and Regulatory Services	☒ **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: NH DHHS Bureau of Health Facilities Administration	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of existing providers demonstrating that they continually met required certification and/or licensing standards and adhered to other standards.
Numerator: Number of existing providers demonstrating that they continually met required certification and/or licensing standards and adhered to other standards.
Denominator: Number of existing providers.

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 =
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

New Hampshire Department of Health and Human Services, Bureau of Health Facilities Administration, Office of Legal and Regulatory Services		
	☐ **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: NH DHHS Bureau of Health Facilities Administration	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** 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:
Number and percent of non-licensed/non-certified providers demonstrating that waiver requirements were initially met. Numerator: Number of non-licensed/non-certified providers demonstrating that waiver requirements were initially met. Denominator: Number of new non-licensed/non-certified providers reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of non-licensed/non-certified providers demonstrating that waiver requirements were continually met. Numerator: Number of non-licensed/non-certified providers demonstrating that waiver requirements were continually met. Denominator: Number of existing non-licensed/non-certified providers reviewed.

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

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

		Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
Number and percent of provider records reviewed that included evidence that the provider met training requirements per He-M 506 and the approved waiver.
Numerator: Number of provider records reviewed that included evidence that the provider met training requirements per He-M 506 and the approved waiver.
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 = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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 (BDS) will communicate any area found to be out of compliance to the area agency via written reports. 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 Residential Habilitation, Respite, Assistive Technology, Community Integration Services, Community Support Services, Crisis Response, Environmental and Vehicle Modification Services, Individual Goods and Services, Non-Medical Transportation, Personal Emergency Response Services, Specialty Services and Wellness Coaching.

The service caps manage and preserve the primary use of the Acquired Brain Disorder Waiver for services which assist the individual to develop skills that promote greater independence, community participation, and the ability to remain living in the community.

Service limits are as follows:

Residential Habilitation: This waiver service is not available to individuals who are eligible to receive such service through the Medicaid State Plan. Payment is not made for the cost of room and board, building maintenance, upkeep, nor improvement.

Respite: When respite is provided as a service in a Participant Directed and Managed Service (PDMS), the total respite shall not exceed 20% of the overall PDMS budget. In a PDMS budget, the cost of training family managed employees will be outside of the total funds available for respite. The cost of training will not count toward the 20% respite service limitation. The BDS Bureau Chief has the ability to determine limits on a case by case basis due to capacity issues.

Assistive Technology: 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.

Community Integration Services: 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.

Community Support Services: Community Support Services are capped at 30 hours per week. Services may begin and continue for up to 24 consecutive months (two years) while the individual is still residing with his/her family. This services does not include costs related to room and board. The BDS Administrator reserves the right to exceed time limitations placed on this service on a case by case basis.

Crisis Response: This waiver service is not available to individuals who are eligible to receive such service through the Medicaid State Plan. Limited to six month approval.

Environmental and Vehicle Modification Services: For individuals with unsafe wandering and running behaviors, outdoor fencing may be provided under this waiver. Waiver funds allocated toward the cost of such a fence shall not exceed $2,500 which can provide approximately 3,500 square feet of a safe area. Exceptions to this service limitation may be made on a case by case basis.

Individual Goods and Services: 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.

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.

Non-Medical Transportation: Non-Medical Transportation is capped at $5,000 annually. Up to $10,000 annual is allowable for individuals that require specialized transportation including wheelchair van/lift and/or a van that allows the individual being transported to “not” be within arm’s reach of the driver for safety reasons. Verification of an individual's need for specialized transportation will be required upon request to the Bureau of Developmental Services. The Bureau of Developmental Services Administrator reserves the right to approve requests on a case by case basis. Proof of this need to exceed the cap will be required upon request to the Bureau of Developmental Services. When the provider is transporting the individual, the individual is with the caretaker and the only transportation that may be covered is when the transportation that occurs is directly related to the individual's disability or specific to a caretaker providing the transportation to activities determined in the individual service agreement that are not otherwise covered by NH State Plan or other state authorities. Caretakers 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.

Personal Emergency Response Services: 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. Any device that might be considered restrictive will be part of a modification plan (behavior plan) and will be approved by the individual, guardian and the local Human Rights Committee.

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

Wellness Coaching: 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.

Removable Prosthodontic Services: There is a $1500 annual service limit for the New Hampshire Medicaid State Plan Adult Dental Benefit, including Removable Prosthodontic Services. Dentures may be provided no more than once in a five-year period. This service limit may be exceeded with prior approval from DHHS.

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Note instructions at Module 1, Attachment #2, 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.

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

The first is the Waiver Transition Team which includes the Bureau Chiefs for the Bureau of Developmental Services and the Bureau of Elderly and Adult Services for the Department of Health and Human Services, subject matter experts from the Department of Health and Human Services and Long Term Supports and Services, a Project Director, and an HCBS Project Coordinator, both from the University of New Hampshire Institute on Disability - University Center for Excellence in Disability (UCED).

The second group is the Advisory Task Force which is made up of 16 members and was established in March 2015 to provide participant and stakeholder feedback on the development and implementation activities for the Statewide Transition Plan. The group is advisory in nature and includes representatives from a broad array of stakeholders, including those potentially most impacted by the new rules. There is representation from the following groups:

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

The Advisory Task Force meets quarterly to oversee the implementation process of the Statewide Transition Plan (STP). Updates are provided and input obtained to support the state’s efforts in completing the goals outlined in the STP.

NH DHHS completed a thorough review of all standards, rules, and regulations to determine their current level of compliance with the settings requirements. NH received initial approval on their STP on July 3, 2017. NH continues its effort to obtain final approval.

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

NH has identified and begun implementation of goals related to each of the settings’ requirements. Training on the final rule and its expectations occurs on an annual basis for both participants and providers.

Ongoing monitoring of settings is completed by NH DHHS Health Facilities Administration, Office of Legal and Regulatory Services (OLRS). For any setting identified as out of compliance, a plan of corrective action is written, and once approved by OLRS, is implemented to meet the expectations. Data regarding the HCBS expectations is shared with the Advisory Task Force every six months. Additionally, Service Coordinators monitor choice and satisfaction of participants on a quarterly basis. Individual issues are addresses as needed.

NH continues its Heightened Scrutiny review process. The onset of the COVID-19 pandemic has required a shift in the process from in-person to virtual.

More detailed information about NH's Statewide Transition Plan can be found at:

https://www.dhhs.nh.gov/dcbcs/bds/transition.htm

NH-DDHS, BDS, allows the option of service provision outside of the state for the following waiver services: Community Participation Services, Residential Habilitation, Supported Employment, Assistive Technology, Community Integration Services, Community Support Services, Crisis Response Services, Environmental and Vehicle Modifications, Individual Goods and Services, Non-Medical Transportation, Personal Emergency Response Services, Specialty Services and Wellness Coaching. The corresponding process and provider qualifications are listed under each waiver service.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

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:*

The waiver is implemented by the State in collaboration with New Hampshire's ten Area Agencies, designated in accordance with New Hampshire administrative Rule He-M 505, to plan, establish and maintain a comprehensive service delivery system. Area Agencies determine initial eligibility for developmental services, in accordance with NH RSA 171-A. Following this determination, area agencies assist individuals to apply for the Acquired Brain Disorder Waiver and will provide information and resources to assist them in selecting a Service Coordination entity. Person-centered service planning and the individualized service agreement (ISA) are completed by a service coordinator. Many area agencies provide Service Coordination Services as well as other direct waiver services, which is permissible so long as they do not provide both to the same participant.

In limited circumstances, as outlined in the Bureau of Developmental Services' (BDS) Only Willing and Qualified Provider (OWQP) policy, the State may approve an entity to provide both Service Coordination Services and other direct waiver services to the same individual. Agencies that are approved to provide both services must have a firewall in place to mitigate conflict in accordance with the OWQP. Additionally, during the person-centered service planning process, individuals/guardians will be educated on conflict of interest requirements in cases where a conflict is present.

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

1. The ISA is housed within the IntellectAbility platform, which offers a statewide template that all Service Coordinators must utilize for ISA development. The template for the ISA requires that individual choice of service providers is offered as an option during the person-centered planning process.
2. Annually during the person-centered service planning process, the individual and his/her legal guardian is informed of their "client rights" which include choice of services and providers.
3. BDS staff will review to ensure 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.

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.

Service planning and development should prioritize opportunities for the waiver participant to lead service planning, even if he/she has a legal guardian.

He-M 522 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.

As part of the person-centered service planning process, the individual/guardian is provided the opportunity to fully participate and have the lead voice in the decision-making 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 522, 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):

According to New Hampshire Administrative Rule He-M 522 “Eligibility Determination and Service Planning for Individuals with an Acquired Brain Disorder”, service coordinators are required to develop service agreements within the following requirements:

Within 21 days of a completed application for eligibility, the area agency shall have conducted sufficient preliminary planning with the individual and guardian (if applicable) or representative to identify and document the specific services needed. At this time, the Area Agency must discuss with the individual whether they wish to access the Acquired Brain Disorder Waiver and if so, shall submit a Functional Screen to the Bureau of Developmental Services (BDS) in order for the State to determine if the individual meets the level of care to access the waiver. Following determination of level of care, the Area Agency will provide information and resources to the individual in order to make an informed choice in the selection of any qualified Service Coordination entity.

Within 15 business days of the selection of, and acceptance by a service coordination entity, the service coordinator shall hold an initial person-centered service planning meeting with the individual, guardian or representative, and any other persons identified by the individual. The service coordinator shall develop the service agreement within 14 days of the initial service planning meeting. The service coordinator, or area agency, shall provide the completed and signed service agreement with the individual and guardian or representative within 5 days of completion.

The service coordinator is responsible for monitoring services identified in the service agreement and assessing individual, guardian, or representative satisfaction quarterly. Service agreement meetings can be requested when the individual/guardian 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. Service agreements are reviewed and updated annually, at minimum.

All service planning occurs through a person-centered planning process that:
-Maximizes the decision-making of the individual,
-Is directed by the individual and/or guardian,
-Facilities personal choice by providing information and support to assist the individual and/or guardian 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/or guardian,
-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/or guardian,
-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 the process for the individual and/or guardian to request amendments to the service agreement,
-Records the alternative home and community based settings that were considered by the individual, guardian 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,
-Includes strategies for solving disagreements,
-Uses a strengths based approach to identify the positive attributes of the individual,
-Includes the provision of auxiliary services as applicable,
-Provides the individual with information regarding the services and service providers available to enable the individual to make informed decisions as to whom they would like to provide services,
-Considers historical information about the individual's experiences,
-Includes a discussion of the need for assistive technology that could be utilized to support all services and activities identified in the proposed service agreement without regard to the individual's current use of assistive technology,
-Addresses the individual's concerns about current or contemplated guardianship or other legal assignment of rights.

The individual, guardian 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 are developed using a person-centered approach, focusing on the life trajectory of the individual and how to best support their vision of a good life.

Service agreements shall describe the reporting mechanisms under He-M 522.12 Service Agreements and include:

-The specific waiver services to be provided including the amount, scope, frequency, and duration,
-The results of the SIS and the HRST,
-Service documentation requirements sufficient to describe progress on goals and the services received,
-If applicable, reporting mechanisms under self-directed services regarding budget updates and individual and guardian satisfaction with services,
-For individuals who reside in a provider owned or controlled residential setting, the service agreement shall document any modifications of the individual's rights in said setting to:

(1) Privacy in their sleeping or living unit, including doors lockable by the individual with only appropriate staff having keys to doors as needed;
(2) Freedom and support to control their own schedule and activities;
(3) Access to food at any time;
(4) Having visitors of their choosing at any time; and
(5) Freedom to furnish and decorate sleeping or living units.

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 522, service agreements for participants are completed at least annually, or as changes warrant. The service agreement addresses all aspects of the individual's service needs.

He-M 522.10 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 522.10 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 service planning 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, 522.11 requires that service agreements include, if applicable, risk factors and the measures required to be in place to minimize them, including backup plans and strategies.

The service agreement 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, provider agencies are required to be available 24 hours a day.

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 individual is afforded choice of service provider(s) and may choose any qualified provider.

Individuals and/or guardians meet with their selected service coordinator to identify what services are appropriate to meet their needs 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 2 reference checks;
-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 individual/guardian 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 is reviewed by the Bureau of Developmental Services (BDS) 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:

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, 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 the individual and/or persons responsible for implementing a service agreement.

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/guardian's satisfaction;
c. Meet the terms of the service agreement.

He-M 522 indicates that the service coordinator shall be responsible for monitoring services identified in the service agreement and for assessing individual/guardian satisfaction at least quarterly.

An area agency, service coordinator, provider, individual, guardian, or representative shall have the authority to request a service planning meeting at any time.

Service agreement amendments may be proposed at any time.

If the individual, guardian, or provider disapproves of the service agreement or service agreement amendment, the dispute shall be resolved:

(1) Through informal discussions between the individual, guardian, or representative and service coordinator;
(2) By reconvening a service planning meeting; or
(3) By the individual, guardian, or representative filing an appeal to the bureau pursuant to He-C 200.

In addition, the BDS Liaison to the area agency is a mechanism for receiving and following up on areas of individual or systemic concern. Participants and/or guardians 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:*

In limited circumstances, as outlined in the Bureau of Developmental Services' (BDS) Only Willing and Qualified Provider (OWQP) policy, the State may approve an entity to provide both Service Coordination Services and other direct waiver services to the same individual. Agencies that are approved to provide both services must have a firewall in place to mitigate conflict in accordance with the OWQP. Additionally, during the person-centered service 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

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of 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 collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
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 = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of participants with a Health Care Level (HCL) of 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 HCL of 3 or over who have received a clinical review by a nurse trainer within 60 days of the score. Denominator: Total number of participants with a HCL of 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**
☐ **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 that were 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 = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service agreements that had been updated at least annually or had an approved amendment on file which extended the annual review. Numerator: Number of service agreements that had 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 = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose services were delivered in accordance with the service agreement including the type, scope, amount, duration and frequency. Numerator: Number of participants whose services were delivered in accordance with the service agreement 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 =

		95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
The number and percent of participants whose 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 = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 with 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 two methods of service delivery within the PDMS model for Acquired Brain Disorder Waiver services.

They include the following:

1.) Fiscal/Employer Agent (F/EA). Under this PDMS model, the participant (or a representative of their choosing) is the employer of the support workers they hire. The F/EA or Financial Management Services (FMS) entity is the agent to the employer (not the employer of support workers) and operates under Section 3504 of the IRS code and Revenue Procedure 2013-39. The participant can select a F/EA FMS entity to receive and disburse their individual budget funds, manage their support worker's payroll and related taxes, and perform some employer-related tasks (i.e., processing employment-related paperwork, conducting background and registry checks, processing and paying invoices for approved goods and services related to the participant's care needs and facilitating the receipt and payment of worker's compensation insurance). The F/EA FMS entity ensures the participant is compliant with any applicable Internal Revenue Services (IRS) and Department of Labor rules. Under this PDMS model, the participant may hire and manage support workers and purchase approved goods and services related to the participant's care needs.

2.) Agency of Choice Model (AoC). Under this PDMS model, the employment relationship is shared with the AoC FMS entity (Agency) and the participant or representative of their choosing as joint employers of participant's support workers. The Agency performs the employer tasks 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.

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 525 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 Acquired Brain Disorder Waiver are allowed to be delivered through the participant

directed and managed service delivery model. Participants are defined as: (a) the individual acting independently on their own behalf; (b) the legal guardian(s) of the individual accessing the waiver and acting on behalf of the individual; and, (c) a non-legal, chosen representative to act on behalf of the waiver recipient.

Services provided through the waiver are specifically tailored to the competencies, interests, preferences, and needs of the participant and/or his/her guardian and are respectful of the personal values and lifestyle of the participant.

In extending the participant choice and control over their service agreements, the service coordinator provides information and assistance to facilitate and optimize participation, direction, and management of services.

Responsiveness to participant preferences and requests occur within the context of state and federal laws and regulations and policies of the provider agencies, service coordination agencies and area agencies.

Beginning with the initial discussion and education about Acquired Brain Disorder Waiver services, area agency staff share information with the participant regarding such expectations, requirements, and limitations.

The Division of Long Term Supports and Services (DLTSS), PDMS committee, will be making recommendations relative to the following:

-Adoption of a PDMS self-assessment screening tool;
-Development of a PDMS handbook;
-Development and implementation of Orientation, Remediation and Transition policies;
-Expectations relative to delegating direct services to another entity; and
-Clarification regarding opportunities to purchase additional assistance relative to documentation, recruitment, or supervision, if applicable.

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 acquired brain disorders in order to improve and maintain opportunities and experiences in living, working, socializing, personal growth, safety and health.

The participant, guardian, area agency, service coordinator, 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 or guardian may decide what services are needed based on assessments/evaluations such as the Supports 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 a Nurse Trainer.

Area agencies and service coordinators will be responsible to educate and hold individuals that utilize PMDS accountable on fraud, waste, and abuse. In cases where criteria for PDMS is not met, a transition policy will be implemented to assist individuals in accessing services outlined in the service agreement.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Participant directed and managed services are available to all individuals with the exception of those in congregate service arrangements or programs where individuals, families, or guardians do not have the opportunity to direct and manage the services [as defined in State Administrative rule He-M 525] and the approved funding.

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery**

methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Individuals and/or their guardians interested in the Acquired Brain Disorder (ABD) Waiver are provided information regarding Participant Directed and Managed Services (PDMS) method of service delivery upon initial eligibility for the ABD waiver and annually thereafter. Information provided to individuals/guardians by the area agency (when new to service, prior to service planning) or the service coordinator (if already participating in services) include:

- The services that can be participated in through a PDMS;
- Requirements and expectations for service planning and monitoring;
- Provider qualification requirements and roles in parties responsible to complete background checks and other requirements;
- The responsibilities of the area agency, service coordinator, providers and individuals/guardians in the participation in and provision of services and
supports;
- The flexibility available to individuals/guardians to have budget and employer authority.
- Expectations and protections when having providers come into the home environment.
- Expectations and requirements if the individual is taking medication as well as the supports available to administer the medication safely.

A PDMS long term supports and services committee has been developed with broad stakeholder participation.

The goal(s) of the committee include the:

1.) Identification of a self-assessment tool to assist individuals/guardians to determine if PDMS is an option for them.
2.) Development a PDMS Participant Handbook

The handbook will include all relevant information for an individual/guardian to understand the use of Medicaid funds. The handbook will include the rights and responsibilities associated with the management of Medicaid funds, 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
Wellness Coaching	☒	☒
Respite	☒	☒
Community Support Services	☒	☒
Community Integration Services	☒	☒
Residential Habilitation	☒	☒
Crisis Response Services	☒	☒
Specialty Services	☒	☒
Assistive Technology	☒	☒
Non-Medical Transportation	☒	☒
Community Participation Services	☒	☒
Individual Goods and Services	☒	☒
Personal Emergency Response Services	☒	☒
Supported Employment	☒	☒
Service Coordination	☒	☒
Environmental and Vehicle Modification 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 PDMS 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 ABD Waiver allowable expenses;

-review of utilization within the service authorization to confirm that individuals/guardians 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
Wellness Coaching	☐
Removable Prosthodontic Services	☐
Respite	☐
Community Support Services	☐
Community Integration Services	☐
Residential Habilitation	☐
Crisis Response Services	☐
Specialty Services	☐
Assistive Technology	☐
Non-Medical Transportation	☐
Community Participation Services	☐
Individual Goods and Services	☐
Personal Emergency Response Services	☐
Supported Employment	☐
Service Coordination	☒
Environmental and Vehicle Modification 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".

New Hampshire’s system allows individuals to hire an independent service coordinator; the individual/guardian 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 522, 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 Acquired Brain Disorder (ABD) Waiver.

The ABD Waiver is designed to support individuals to be involved with Participant Directed and Managed Services to the extent they wish, and this may be altered at any time. This waiver allows individuals to direct and manage their services along a continuum; if they no longer have any interest in directing and managing their services, they would be supported to transition to traditional services available through the Acquired Brain Disorder Waiver.

Specific attention to the individual's health and welfare is provided through ongoing contacts with the individual by the service coordinator.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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

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

A formal risk assessment conducted within the past year by a N.H. licensed psychologist or psychiatrist that finds the individual to pose a moderate or high risk to community safety and includes recommendations on the level of security, services, and treatment necessary for the individual; and

Recommendation from the area agency's human rights committee, established pursuant to RSA 171-A:17, I, that services under He-M 525 would not provide the degree of security, services, or treatment needed by the individual.

In the cases identified above, the individual may obtain a second opinion from a New Hampshire licensed psychologist or psychiatrist.

The human rights committee shall consider the findings of the assessment conducted as noted above;

If a human rights committee convenes, the committee shall meet, if requested, with the individual and the individual's representative to explain its decision.

Individuals who are not permitted to direct or manage their services are assisted to access traditional ABD Waiver services. During the transition, services shall continue unchanged until an individual can fully transition to traditional services. During the transition, the service coordinator will continue to monitor services, as defined in He-M 522. If there is a health and safety concern, as identified in He-M 310, the complaint process will be followed, as outlined in He-M 202 – Rights Protection Procedures for Developmental Services.

Individuals and their guardians have the right to appeal a decision to disallow or terminate participant direction and management.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		36
Year 2		38
Year 3		40
Year 4		42
Year 5		44

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/guardian 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/guardian 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.

The method for establishing the amount of the Participant Directed and Managed Services budget is as follows:

The Service Coordinator conducts person-centered service planning with the individual to identify the assessed needs of the individual and the services needed. Service needs are determined with consideration of the individual's goals and aspirations as well as information and evaluations shared by the individual and/or guardian that may have been previously conducted through the participant's school or from a 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. Selected services are outlined in the individual service agreement and an individualized budget for services is developed. Individual budget proposals are submitted to the Bureau of Developmental Services (BDS), which makes all final budget determinations based on the cost effectiveness of proposed services.

The method that BDS uses to consistently apply budget development to each participant is based on the average cost for services within this waiver. Budgets are adjusted either up or down to match the individual's needs.

While residential habilitation services are the primary service within PDMS, individuals 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 individuals/guardians can negotiate different payment levels for staff and providers, based on provider skill set and the individual's needs.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individualized budgeting process starts with identification of the individual's service needs as part of the person-centered service planning process. Information gathered through the eligibility process, the guardian and/or legal representative (which may include existing evaluations through the participant's school or private practitioner), the supports intensity scale (SIS), HRST, and any other relevant evaluations needed to determine appropriate services and support level needed.

The individual service agreement (ISA) is developed jointly using the information outlined in the above paragraph with the individual/guardian and the service coordinator. Service needs identified drive the development of an individualized budget request which is submitted to BDS for review/approval/denial/renegotiation.

Once the individualized budget is approved by BDS, the communication of final budget approval to the individual/guardian is done through the service coordinator.

If an individual's service needs change as demonstrated by assessments, adjustments are made to his/her service agreement via an amendment. If additional service funding is needed, subsequent requests follow the same process as an initial funding request in that the service coordinator develops with the individual/guardian the revised service agreement based on changes in needs and this is costed out in the individualized budget and submitted to BDS for approval.

Individuals/guardians have the right to appeal BDS' decisions.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The service coordinator communicates with the individual/guardian or representative regarding available funds remaining in the individual's budget. Monthly reports of the status of each individual's budget and expenditures are provided to the individual/guardian. Discrepancies relative to planned spending versus actual spending are addressed by the service coordinator and individual/guardian jointly. Utilization is carefully monitored by the service coordinator.

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 Modification).

Flexibility in this regard plays a significant role in the Participant Directed and Managed Services model. If significant changes are desired, for example, ending one service and adding a new service not previously included in the service agreement, a modification of the service agreement would be required. As long as these changes are budget neutral, meet the requirements for the Acquired Brain Disorder Waiver, and do not exceed service limits, there may be no need for BDS to review/approve such changes. All budgets and service arrangements are reviewed on at least an annual basis.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The service coordinator communicates with the individual/guardian relative to available funds. Monthly reports of the status of each individual's budget and expenditures are provided and discussed with the individual. Utilization is carefully monitored.

If a participant/guardian appear to be utilizing the funding at a higher/lower rate than the monthly average, the service coordinator monitors the spending and works with the individual/guardian to understand if the overspending or underspending 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 the Bureau of Developmental Services. All requests for increased funds must be accompanied by appropriate justifications to support the change. This includes information from recent or updated assessments/evaluations/screenings such Supports Intensity Scale, Health Risk Screening Tool, risk assessment, and/or any other relevant evaluation.

Conversely, when funds are projected to be underutilized on a short-term basis, the underutilized funding amount may be reallocated to another waiver eligible individual for one time needs (such as an Environmental Modification).

The service coordinator ensures that the funds budgeted for an individual are appropriately and fully utilized by the individual. Discrepancies relative to planned spending vs. actual spending are addressed by the service coordinator and individual 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.

Pursuant to He-M 517, anyone who has been denied waiver services because the Department determines he/she does not meet the eligibility criteria for waiver services may appeal the decision within 30 working days of receipt of the decision. Such appeal request shall be made by forwarding the request to the bureau administrator, in writing, in care of the department's office of client and legal services, and shall then be forward to the department's administrative appeals unit, which will schedule and conduct the hearing. 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. Copies of the Department's denial would be located in the Medicaid Management Information System (MMIS) system under the applicant's name

Pursuant to administrative rule He-M 522, any determination, action, or inaction by an area agency or provider agency may be appealed by an individual, guardian, or representative, and can be appealed by forwarding an appeal request in writing to the bureau administrator in care of the department's office of client and legal services. Once received, the appeal request will be forwarded to the department's administrative appeals unit, which will schedule and conduct the hearing. The following actions are subject to the notification requirements:

(1) Adverse eligibility actions under He-M 522; (2) A determination to terminate services under He-M 522. The area agency shall provide written and verbal notice to the applicant and representative of the specified actions t, 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, (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. If a hearing is requested, the following 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 if the 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, or
2) In the instance of termination of services, services shall cease one year after the initial decision to terminate services 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.

The Prepaid Ambulatory Health Plan (PAHP) operates a member grievance and appeal process, which are specific to Removable Prosthodontic Services only, as this is the only service in this waiver that is delivered by the PAHP. The PAHP grievance and appeal processes do not supplant the waiver participant's ability to request State a fair hearing.

PAHP Grievance Process

The PAHP shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the PAHP either orally or in writing at any time. [42 CFR 438.402(c)(1)(i-ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]
The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:
-The quality of care or services provided;
-Aspects of interpersonal relationships such as rudeness of a Provider or employee;
-Failure to respect the Member's rights;
-Dispute of an extension of time proposed by the PAHP to make an authorization decision;

The PAHP shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the PAHP receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the PAHP does not have all the information necessary to make the decision. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

The PAHP may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:
-If the Member requests the extension; or
-If the PAHP shows that there is need for additional information and that the delay is in the Member's interest (upon State request). [42 CFR 438.408(c)(1)(i-ii); 438.408(b)(1)]

If the PAHP extends the timeline for a grievance not at the request of the Member, the PAHP shall:
-Make reasonable efforts to give the Member prompt oral notice of the delay; and
-Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with
that decision. [42 CFR 438.408(c)(2)(i-ii); 42 CFR 438.408(b)(1)

The PAHP shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

PAHP Appeal Process

The PAHP shall permit a Member, or the Member's authorized representative, or a Provider acting on behalf of the Member and with the Member's written consent, to request an appeal orally or in writing of any PAHP action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

The PAHP shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's State. [42 CFR 438.406(b)(6)]

The PAHP shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the PAHP's notice of action. [42 CFR 438.402(c)(2)(ii)]

The PAHP shall ensure that oral inquiries seeking to appeal an action are treated as appeals. [42 CFR 438.406(b)(3)]

If the Department receives a request to appeal an action of the PAHP, the Department shall forward relevant information to the PAHP and the PAHP shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

The PAHP shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

The PAHP shall permit the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing [42 CFR 438.406(b)(4)]. The PAHP shall inform the Member of the limited time available for this in the case of expedited resolution.

The PAHP shall provide the Member and the Member's representative an opportunity to receive the Member's case file, including medical records, and any other documents and records considered during the Appeal Process free of charge prior to the resolution. [42 CFR 438.406(b)(5); 438.408(b-c)]

The PAHP may offer peer-to-peer review support, with a like clinician, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should occur in a timely manner.

The PAHP shall resolve standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the PAHP. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

The date of filing shall be considered either the date of receipt of an oral request for appeal or a written request for appeal from either the Member or Provider, whichever date is the earliest.

If the PAHP fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the PAHP's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

The PAHP shall permit the appeal of any action taken by the PAHP. Actions shall include, but are not limited to the following:
-Denial or limited authorization of a requested service, including the type or level of service;
-Reduction, suspension, or termination of a previously authorized service;
-Denial, in whole or in part, of payment for a service. [42 CFR 438.400(b)(3)];
-Failure to provide services in a timely manner, as defined by this Agreement;
-Untimely service authorizations;
-Failure of the PAHP to act within the timeframes outlined in the PAHP Agreement; and
-At such times, if any, that the Department has an Agreement with fewer than two (2) PAHPs, for a rural area resident with only one (1) PAHP, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

Expedited Appeal

For appeals when the PAHP determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

The PAHP shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals. [42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)]

The PAHP shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the PAHP receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

The PAHP may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the PAHP justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] The PAHP shall also make reasonable efforts to provide oral notice.

The date of filing of an expedited appeal shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest.

If the PAHP extends the timeframes not at the request of the Member, it shall:
-Make reasonable efforts to give the Member prompt oral notice of the delay by providing a minimum of three (3) oral attempts to contact the Member at various times of the day, on different days within
two (2) calendar days of the PAHP's decision to extend the timeframe as detailed in He-W 506.08(j);
-Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with
that decision;
-Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i-iii); 42 CFR 438.408(b)(2)-(3)]

The PAHP shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

If the PAHP denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

The Member has a right to file a grievance regarding the PAHPs denial of a request for expedited resolution. The PAHP shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

Pursuant to He-M 310 and He-M 202 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 hotline to receive complaints. User friendly brochures are shared with all participants, guardians, 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 complaint 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 522:

Each area agency must annually share information to all programs, participants, families, and stakeholders the procedures and contact information for filing a complaint. Additionally, each area agency must have this information posted internally within their offices and to their website.

At a minimum, the service coordinator must discuss and provide information in writing, to the individual, guardian, and/or 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 Program Quality (BPQ) PO.1003 Sentinel Event Reporting and Review Policy, as part of a comprehensive quality assurance program with BPQ 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 Program Quality (BPQ) 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.

All providers of services through DHHS and the Bureau of Developmental Services (BDS) are required to report sentinel events that involve an individual 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.

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 Program Quality (BPQ) PO.1003 Sentinel Event Reporting and Review Policy:
https://www.dhhs.nh.gov/bqai/documents/sentinel-event.pdf

Upon the discovery of a sentinel event by a community provider or by a DHHS Division or Bureau (whether by direct report by a provider, other mandatory reporting mechanisms, or a more general discovery), that person or entity shall

provide verbal notification to the appropriate DHHS Bureau Administrator or designee within 24 hours. Written notification of the sentinel event shall be provided by the reporting person or designated agency staff to the appropriate DHHS Office within 72 hours of the event.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The rights of all individuals with acquired brain disorder to be free from abuse, neglect, and exploitation are detailed in NH State Administrative Rule He-M 310. In accordance with He-M 310, 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 hotline to receive such complaints. 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.

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 Bureau of Program Quality (BPQ) 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 BPQ 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 certification requirements. 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 Bureau of Program Quality (BPQ) Sentinel Event Reporting and Review Policy. In addition, BPQ 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 and area agencies are working with IntellectAbility (formerly Health Risk Screening (HRS)) to build a module into the existing platform to track sentinel events electronically which will allow for streamlined data collection and reporting. Oversight of sentinel event reporting is conducted annually.

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:

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:17 requires that each area agency have a Human Rights Committee (HRC).

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 a restraint occurred that falls under the definition of the Bureau of Program Quality (BPQ) PO.1003 Sentinel Event Reporting and Review Policy, BDS would be immediately notified. BDS will review the written report and make recommendations or engage in appropriate follow-up, if 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.

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 acquired brain disorder 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 restrictive intervention and unauthorized restrictive intervention broken down by waiver. The report must identify follow-up action if an unauthorized restrictive intervention 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 restrictive intervention 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: Healthcare Coordination and 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 Bureau 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, 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.

The Statewide Medication Committee is responsible to identify areas of non-compliance and recommend to the Bureau Nurse Administrator and BDS Medical 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:
The number and percent of participants' records reflecting documentation of an annual discussion about rights, including how to report a complaint regarding abuse, neglect and exploitation. N: Number of participants' records reflecting documentation of an annual discussion about rights, including how to report a complaint regarding abuse, neglect and exploitation. D: Number of records reviewed.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **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 abuse, neglect, exploitation and unexplained death complaints that were investigated within the required timelines. Numerator: Number of abuse, neglect, exploitation and unexplained death complaints that were investigated within the required timelines. Denominator: Total number of abuse, neglect, exploitation and unexplained death complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Abuse, neglect, exploitation and unexplained death 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 of 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: Number of sentinel events regarding abuse, neglect, exploitation and unexplained death that were referred to investigative entities. Denominator: Number of sentinel events regarding abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Supplemental information provided with submission of sentinel event forms

Responsible Party for data collection/generation *(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 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 where recommendation of intervention was necessary and provided. Numerator: The number of sentinel event trends where recommendation of intervention was necessary and provided. Denominator: Number of sentinel event trends where recommendation of intervention was necessary.

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**	☒ **Annually**	☐ **Stratified**

Specify:		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 # and % of identified top sentinel event (SE) trends where recommendation of intervention was provided and resulted in improved performance within the identified trend. N: The # of identified top SE trends where recommendation of intervention was provided and resulted in improved performance within the identified trend D: # of top SE trends where recommendation of intervention was provided

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**

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:

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 seclusion. Numerator: The number of area agencies with documentation that policies are in place regarding the use of restraint and 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 the Bureau of Developmental Services 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 agency policies and procedures were followed. N: The number of instances of restrictive interventions (including restraint and seclusion) in which agency policies and procedures were followed. D: Total number of restrictive interventions (including restraint and seclusion).

Data Source (Select one):
Other
If 'Other' is selected, specify:
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 a current Health Risk Screening Tool (HRST) completed. Numerator: The number of participants who have a current Health Risk Screening Tool (HRST) completed. Denominator: Total number of participants reviewed receiving Acquired Brain Disorder waiver 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **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 who have a current Supports Intensity Scale (SIS) completed. Numerator: The number of participants who have a current Supports Intensity Scale (SIS) completed. Denominator: Total number of participants reviewed receiving Acquired Brain Disorder waiver 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 = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of administered medication doses with no medication errors. Numerator: The number of administered medication doses with no medication errors. Denominator: The total number of medication doses that were administered.

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**	☐ **Weekly**	☒ **100% Review**

Agency		
☒ **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**

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

Individual complaint investigation reports contain recommendations for remedial action when appropriate.

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.

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:

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

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.

New Hampshire (NH) was the recipient of a Living Well Grant from the Administration for Community Living (ACL) which was written and managed by the NH University Center for Excellence in Disability (UCED), Institute on Disability (IOD). The intent of the grant is 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 the quality of incident management systems for people with acquired brain disorder.

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 fourth 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 Institute on Disability (IOD) whose mission includes the advancement of policies and practices that improve the quality of life for children and adults with disabilities.

Additionally, the Living Well Quality Frameworks grant has supported BDS to identify data elements that can be obtained electronically to support the trending and analysis of quality monitoring data. Data elements include individual satisfaction, provider choice, CMS final rule monitoring, regulatory compliance and file review auditing. Funding was used to enhance the current data platform, allowing for data to be pulled on a consistent basis to support ongoing quality monitoring efforts.

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 individuals/guardians to 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 individuals/guardians 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 participants is worthy of consideration and should be determined by the PDMS committee. This may aid agencies in better understanding the supports that individuals 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 from PDMS to traditional services shall be available after an examination of the needs of the individual have been identified and a remediation plan has been documented. In the event the areas of concern(s) are not addressed the individual/guardian may be asked to transition services to a third entity. The PDMS committee would review He-M 525 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 serves 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 BDS Liaisons, joint meetings with certification staff from DHHS Licensing and Certification, monthly meetings with AA Executive Directors, Business Managers, Service Coordinator Supervisors, Medical Care Advisory Committee, and with the NH 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.

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-contracting 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, including Final Rule compliance monitoring, 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: Ongoing

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).*

New Hampshire has a layered approach to ensuring the integrity of payments for Medicaid services. This approach includes regulatory governance of provider agencies, contractual and regulatory governance of area agencies, operational oversight of area agencies and provider agencies, post payment audits, and area agency-supported system oversight and monitoring.

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-ABD. Payment for claims without an appropriate Prior Authorization will be denied by MMIS, NH's fiscal intermediary for Medicaid payments. New Hampshire's administrative rule He-M 504, effective July 1, 2023, outlines when suspension and termination may be appropriate due to provider mismanagement of Medicaid funds. This rule operationalizes the oversight authority of BDS to collaborate with Program Integrity and temporarily or permanently revoke a provider's enrollment ID, suspend payment, and initiate processes for recoupment.

There are multiple steps in the approval of a Prior Authorization for HCBS-DD waiver services. BDS utilizes databases that contain budget and service information for every NH HCBS-DD participant. This information is maintained and verified by BDS staff for each request for a Prior Authorization.

In addition to multiple programmatic tasks, BDS staff also have responsibilities including:
-Area Agency contract monitoring;
-Approving requests for Prior Authorizations of HCBS-DD services from the standpoint of available funds and appropriateness of proposed services;
-Ensuring alignment of service agreement and funding requested;
-Approval of proposals for changes in amount, scope, duration, and/or frequency of services for which changes in funding are requested.

So that BDS staff can complete their prior authorization review, as of 7/1/23, service coordinators are responsible for submitting a four part service authorization request to the bureau. The four parts include a service authorization screen in the state's IT system, a copy of the ISA, a copy of the budget which includes rendering provider rate and scope information, and a provider attestation verifying the services to be rendered. These electronic file submissions enable BDS staff to confirm that services have been planned for and will be delivered in a Medicaid compliant way. BDS staff review includes but is not limited to, verification that services have not been requested outside of established service limitations, that appropriate rates for services have been requested, and that no unauthorized services have been requested.

In conjunction with their financial responsibilities, 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 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. 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.

In addition to the area agency reviews, BDS staff collaborate with area agencies to complete service file reviews for enrolled providers. New Hampshire's ten area agencies, as the designated area agency system, will provide quality oversite of provider agencies. The area agencies will review a BDS selected sample of Medicaid HCBS-DD service authorizations as part of the annual service file review. The area agencies will also review and monitor waiver services to ensure compliance with waiver requirements, along with contact notes/progress notes to ensure they are complete and align with attendance/service provision records. A provider may not exceed the authorization on any given Prior Authorization for any given individual. On those occasions where Medicaid payment has been made but service records are not adequate upon review/audit, recoupments are made.

-The State requires each provider of HCBS Waiver services to submit a cost report no less frequently than every 5 years including independently audited financials. The results of this cost report are submitted to the State no later than 3 months after the end of the organization's fiscal year, unless an extension has been granted by the department.

-The State Office of Program Integrity is the lead office for auditing HCBS service providers. This office ensures that annual audits are conducted in accordance with the provisions of the Single Audit required under OMB Circular A-133 for state agencies. Program Integrity (PI) provides oversight and monitoring of Medicaid providers 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 PI finds anomalies, they follow up with the provider to do an audit. In addition, PI audits providers if they get referrals or complaints.

-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.

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.

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-DD 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.

Finally, area agencies are BDS' partners in ensuring Medicaid fidelity. As a part of their Medicaid Administrative responsibilities area agencies must provide guidance to provider in their catchment region about appropriate use of Medicaid funds. Important to this process are area agency business managers who possess Medicaid finance subject matter expertise. BDS disseminates information to business managers about the state's expectations. 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, 2023. Services that are subject to EVV include Personal Care and Respite. An approved EVV system was not implemented by January 1, 2023. The State has been paying the penalty for Personal Care and Respite services since January 1, 2023.

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.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS)

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS)

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

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

Performance Measure:
The number and percent of participants with a financial record review with sufficient documentation that services paid were actually rendered. Numerator: The number of participants with a financial record review with sufficient documentation that services paid were actually rendered. Denominator: Number of records reviewed.

Data Source *(Select one):*
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 =* *95% confidence level with a +/- 5% margin of error.*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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: The number and percent of waiver rates that follow the approved methodology. Denominator: Number of waiver rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS)

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

Performance Measure:
The number and percent of participant records reviewed that document waiver service claims paid correspond to those specified in the service agreement. Numerator: The number of participant records reviewed that document waiver service claims paid correspond to those specified in the service agreement. Denominator: Number of participant 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 =* *95% confidence level with a +/- 5% margin of error.*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

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

Data Aggregation and Analysis:

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

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 conduct 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).*

NH's current rate methodology is based on a common rate schedule which is used by all Medicaid enrolled providers.

BDS is unable to locate detailed information documenting the rate methodology. It is presumed that the fee schedule was derived using standard rate setting methodology that identifies labor and other costs associated with the provision of services. This rate methodology has been continued, in relationship to funds appropriated by the General Assembly, in the development of Individual Budgets. The new service rates were established as follows: Community Integration Services (CIS) is an independently determined rate; Non-Medical Transportation has two procedure codes, one is a rate per trip (equal to the CFI Waiver rate) and the other an independently determined rate per trip; and, Personal Emergency Response Services (PERS) is an independently determined rate per monthly service. The independently determined rates allow for cost estimates to be based on customary expenses for the area and services being planned. This rate methodology has also been applied to the new ABD Waiver services as follows: Community Integration Services (CIS) is an independently determined rate; Non-Medical Transportation has two procedure codes, one is a rate per trip (equal to the CFI Waiver rate) and the other an independently determined rate per trip; and, Personal Emergency Response Services (PERS) is an independently determined rate per monthly service. The independently determined rates allow for cost estimates to be based on customary expenses for the area and services being planned. Individual Goods and Services Rates are independently determined rates or negotiated rates.

In tandem with the work to implement direct bill and comply with BDS' current CAP, BDS has contracted with a rate setting vendor to develop a new rate methodology. The new rate methodology will be a "brick" build that is based upon DSP wage estimates. Other estimates likely to be included in the rates will be program support, productivity, training, employee benefits, and program administration. These rates will be cost-based; in the Fall of 2022, BDS released a detailed cost survey to its provider community. Providers have since returned these cost reports, sharing information about their program costs, labor costs, fees, personnel functions, and more. The contracted rate setting vendor has reviewed these cost reports for accuracy and completeness and is using the information to develop new rates and a new methodology. The state is planning to begin utilizing the new rate methodology by end of 2023. Robust stakeholder engagement is part of the vendor's work, including a rate workgroup with stakeholders.

Current rate schedules can be found at this link:
https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms#b"

NH's current method of using Individualized Budgets to distribute funding, based on needed services as outlined in their individual service agreement, does need to be updated to full rate setting via a new waiver reimbursement rate redesign in order for NH to come into compliance with CMS Direct Bill Pay CAP and to establish and/or build an independent provider pool to sustain the Developmental Services system in NH. This work is planned to occur during CY21-22. However, the State does review its rate schedule on a periodic basis.

The method of rate determination is the same for participants self-directing services as it is for those who choose not to self-direct their services.

For 7/1/23 direct bill compliance, prior service authorizations must be converted to replace the current area agency rendering provider with the newly enrolled Medicaid providers by service, as is listed in Appendix I-2-b. Residential, Day Habilitation and Supported Employment prior service authorizations will also have to be converted to align units to 365 day billing with 30 leave of absence days, using a newly created revenue code. In order to ensure that residential services are not reduced, and the provider network is maintained, NH is creating a new independently determined residential level 9, day habilitation level 7, and supported employment level 4 procedure codes. This code will be used for the purpose of data conversion and will only be in effect until new rates have been implemented in all individual prior service authorizations. This approach is an administrative change to support provider billing and maintains the use of funding levels aligned with the level of support an individual needs as outlined within the service definitions for Residential, Day Habilitation, and Supported Employment.

The State solicited public comments on rate determination methods as outlined in Main Section 6-I.

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:*

The NH Developmental Services System utilizes in excess of 65 private developmental services agencies who, effective 7/1/23, will be enrolled with Medicaid to bill directly for services rendered or work with a third-party vendor to bill on their behalf. Enrolled providers will have a Medicaid Provider Agreement with the NH State Medicaid Agency and be enrolled in MMIS.

Providers must have a current BDS approved and issued Prior Authorization to bill for any individual receiving HCBS-ABD services.

Billing is done on a fee for services basis in that providers do not bill for HCBS services until rendered and documentation to support each bill must be maintained and available for review by the State Medicaid Agency.

The 10 area agencies will serve as the state's OHCDS in order to provide pass through billing for certain services. Pass through services include Assistive technology, Environmental modifications, Individual Goods and Services, Crisis Services, Non-medical Transportation, PERS, Community Integrated Services, Wellness Coaching, Respite, and Specialty Services. In these cases, the area agency will hold a contract with a provider who is not enrolled with Medicaid to provide a service. The area agency will submit a claim for billing and ensure timely payment to the rendering provider.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial*

participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All HCBS billing is processed through the NH Medicaid Management Information System. All billing for HCBS-ABD services requires a Prior Authorization be open and current in MMIS. Prior Authorizations includes only the services outlined in the individual's service agreement. If an individual's Medicaid status changes, claims are not paid until or unless the individual has open Medicaid status for the time period included on the claim(s).

Providers are not authorized to bill for services without documentation that the services have been provided. 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.

Individual's Prior Authorizations list all waiver services/procedure codes approved for that individual. No payments are made for any HCBS-DD waiver service without a current Prior Authorization. Payment for claims without an appropriate Prior Authorization would be denied by the MMIS.

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(c)(3) providers known as area agencies. He-M 504, effective 7/1/23, authorizes area agencies to act as the states OHCDS. Further, it outlines requirements for completing pass through billing as an OHCDS entity. To be granted OHCDS authority an area agency must be designated pursuant to He-M 505.

The 10 area agencies will be able to provide pass through billing for certain services. In these cases, the area agency will hold a contract with a provider who is not enrolled with Medicaid to provide a service. These contracts must be voluntary and providers will have the opportunity to enroll to bill Medicaid directly at any time. If an individual, guardian, or representative elects to receive a service from a provider who is not currently associated with an area agency, the area agency will assist the provider with establishing a contract. The area agency will submit a claim for billing and ensure timely payment to the rendering provider. The area agency will be responsible for ensuring the provider of the service meets the provider qualifications as outlined in the waiver for the service being provided.

Pursuant to He-M 505 all designated 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 acquired brain disorder and their families within their catchment area; and
-Overseen by the Bureau of Developmental Services: Redesignated every 5 years.

Area agencies are considered successful, operating efficiently and eligible for redesignation when:

-There is a high level of involvement of those who use and depend on services in all aspects of system planning, design, and development;
-The area agency demonstrates through its coordination of services and supports a commitment to a mission which embraces community membership for persons with acquired brain disorder;
-Ongoing inquiry regarding individual/guardian 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/guardians;
-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 acquired brain disorder 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.

iii. Contracts with MCOs, PIHPs or PAHPs.

○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

◉ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s)***

(PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

The Acquired Brain Disorder Waiver utilizes a Prepaid Ambulatory Health Plan (PAHP) for the delivery of Removable Prosthodontic Services only. No other services in this waiver, as outlined in Appendix C, are delivered by the PAHP. The PAHP operates statewide for Removable Prosthodontic Service delivery and payment for this service is included in the PAHP agreement. The PAHP does not perform any waiver operational functions nor administrative functions on behalf of the State Medicaid Agency for this waiver.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Room and board are not allowable budget items and BDS ensures that Medicaid waiver funds are not used for Room and Board by requiring that a budget is submitted for each individual clearly delineating non-Medicaid revenues which are used to pay for Room and Board, typically, Social Security income. The Room and Board amount is clearly reflected in each individual's budget and it is subtracted from the amount total prior to the Medicaid funding amount being expressed.

Room and Board payments are made from individual's income by the individual or guardian directly to the agency or entity providing residential services.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

○ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

◉ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☒ ***Other charge***

Specify:

Per Appendix B-5-c-i, the Standard of Need (SoN), as outlined by the New Hampshire Department of Health and Human Services, plus $148, increased annually by the COLA, or a portion of the COLA, is the limit for individuals who live in homes owned and/or operated by providers unrelated to the individual by ancestry, marriage, or other legal arrangement. The SoN, plus $148, increased annually by the COLA, or a portion of the COLA, for individuals who live independently or with their families, is the special income level for an institutionalized person of 300% of SSI (FBR).

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.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded.

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.

The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	

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.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (select one):

- ○ ***There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.***
- ○ ***There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.***

Specify the cumulative maximum and the time period to which the maximum applies:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	93820.20	9455.10	103275.30	145078.25	14467.48	159545.73	56270.43
2	93901.21	22856.42	116757.63	150881.38	15046.18	165927.56	49169.93
3	94116.18	23249.75	117365.93	156916.64	15648.03	172564.67	55198.74
4	94037.88	23658.82	117696.70	163193.30	16273.95	179467.25	61770.55
5	93938.14	24084.25	118022.39	169721.04	16924.91	186645.95	68623.56

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	287	287
Year 2	292	292
Year 3	297	297
Year 4	302	302
Year 5	307	307

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.*

J-2-d: The projected numbers in this section, for WY1-WY5, were derived by using actual 372 Average Length of Stay for FY14-19. The data for FY14-19 was used to calculate an average trend of 0.44%. This trend was used to project FY20-26 as follows:

ABD Waiver Renewal FY22-26

WY	Fiscal Year	"Projected ALOS J-2-d"
1	FY22	337
2	FY23	339
3	FY24	340
4	FY25	342
5	FY26	343

The average trend, 0.44%, was calculated using the Average Trend formula: = ((FY19/FY14)^(1/5)-1).

The State has no reason to doubt what the average trend percentage is calculating to be and therefore has used it to assist in our projections.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D equals totals in J-2-d divided by total projected participants in each year of the waiver.

The 3.1% rate increase, given to all services that are rate based, is as a result of the State's Biennial budget legislation of 2019.

Five (5) tables were created that were used to populate the WY templates in J-2-d-i. The completion of the J-2-d-i for each WY calculated a projected total expenditure. The total was divided by the projected utilization to calculate Factor D for each WY1 through WY5.

The source of data for the Acquired Brain Disorder (ABD) waiver for State Fiscal Year (SFY) 14-19 was queried in NH's Medicaid Management Information System (MMIS). In addition, NH's Bureau of Elderly and Adult Services (BEAS), Choices for Independence (CFI) waiver for SFY14-19 was queried to assist in projecting new services to the ABD waiver: Assistive Technology, for which CFI Special Medical Equipment service was used for, as they are similar services; and, Personal Emergency Response System (PERS). The additional new ABD services: Individual Goods and Services (items/services otherwise not covered by NH State Plan); Non-Medical Transportation; Community Integration Services (inclusive of thereauptic, recreation and campership); and Wellness Coaching, were projected based on feedback from Bureau experience and public session input. The data calculated in each table is as follows and each WY table in J-2-d-i was entered into WMS:

Table 1: Number of Users – Projected # of Unduplicated Count by service, based on % of Total Waiver Unduplicated count, per submitted 372 reports, multiplied by updated projected utilization in B-3.

a. SFY14-19 unduplicated counts for ABD services, mentioned above, were averaged. The average was divided by the average total projected ABD unduplicated count for SFY14-19 to determine the % of total unduplicated individuals. These percentages were used to project the unduplicated count per services as a percentage of the ABD waiver renewal updated projected utilization in B-3.

b. SFY14-19 unduplicated counts for CFI services, mentioned above, were averaged. The average was divided by the average total CFI unduplicated count for SFY14-19 to determine the % of total unduplicated individuals. These percentages were used to project the unduplicated count per services as a percentage of the ABD waiver renewal updated projected utilization in B-3.

c. For the additional new ABD services, the percentage used was based on Bureau expertise and public session input, to project the unduplicated count per services as a percentage of the ABD waiver renewal projected utilization in B-3.

Table 2: Units per User part 1 - Actual Units Billed in MMIS by year.

a. Actual units billed in MMIS by year, for the current ABD services, was used to calculate an average trend by service. In addition, the average units for FY14-19 was calculated by service. The average trend was applied to the average units for FY14-19 as the base to project units used for FY22 through FY26.

b. Actual units billed in MMIS by year, for the CFI services (listed above), was used to calculate an average trend by service. In addition, the average units for FY14-19 was calculated by service. The average trend was applied to the average units for FY14-19 as the base to project units used for FY22 through FY26.

Table 3: Units per User part 2 - Units Billed per service (Table 2) divided by WY projected Utilization by service (Table 1). The numbers are entered into J-2-d-i.

a. Projected units by service (Table 2), for the current ABD services, was divided by WY projected utilization by service (Table 1) to arrive at a units per user number.

b. Projected units by service (Table 2), for the CFI services (see above), was divided by WY projected utilization by service (Table 1) to arrive at a units per user number.

c. For the additional new ABD services, the unit per user used was based on Bureau expertise and public session input, to project the unit per user per service.

Table 4: Avg. Cost per unit of service - Rates (to include 3.1% rate increase) & CAPS per service, if applicable.

a. The services for current ABD and CFI that have rates are listed. A 3.1% rate increase calculation was done and added to the rate to show the rate that will be in effect 1/1/21.

b. The services that have a CAP are listed.

c. The services that are independently determined, based on an individual's needs using customary costs within their region, was listed. The rate increase, for independently determined services, is not shown as it is calculated when the prior authorization (PA) is approved in MMIS. For these services, the Avg. Cost per unit of service are calculated.

Table 5: Projected expenditure per service - Actual 372 Expenditures, for ABD & CFI services, as explained above, by year for FY14-19 were used to calculate an average trend percentage. In addition, the average expenditures for FY14-19 was calculated by service. The average trend was applied to the average expenditures

for FY14-19 as the base to project expenditures used for FY22 through FY26.

The 3.1% rate increase was given on 1/1/20 and 1/1/21 for all Medicaid rates. Those higher rates were used as the base rate, to which the average trend was applied in order to arrive at the projections for WY 1-5.

Factor D's are projected to increase due to additional services added to the ABD Waiver and to increasing staffing costs due to workforce shortages.

The addition of the Removable Prosthodontic Services is effective April 1, 2023.

The addition of Removable Prosthodontic Services will increase Factor D based on the calculations in the attached workbook titled "DRAFT of Projected DD, ABD & CFI Waiver Amendment for Denture Service 10-27-22v2 UPDATED 1-29-23.xlsx" and below:
Acquired Brain Disorder (ABD)

Removable Prosthodontic Services Amendment Factor D	*WY1*	*WY2*	*WY3*	*WY4*	*WY5*
CMS Approved Waiver Unduplicated Individuals (Utilization) - Appendix J-2-a	*287*	*292*	*297*	*302*	*307*
# of individuals per 1,000 utilization	*0.29*	*0.30*	*0.30*	*0.31*	
# of Individuals per 1000 (Exhibit C of Milliman Report)	*8*	*8*	*8*	*8*	
Pent up Demand Adjustment of 1.20 (Page 8 of Milliman Report)	*1.200*	*1.200*	*1.200*	*1.200*	
DCG (Milliman Health Cost Guidelines - Dental(TM) Adjustment of 1.013 (Page 10 of Milliman Report)	*1.013*	*1.013*	*1.013*	*1.013*	
Updated Utilization per 1,000	*9.72*	*9.72*	*9.72*	*9.72*	
Amendment Additional Denture Service					
Utilization (WY2 = 7 months; WY3-5 = 12 months)	*2*	*3*	*3*	*3*	
Avg Units per User	*1*	*1*	*1*	*1*	
Avg Charge (Exhibit C of Milliman Report)	*$414.74*	*$414.74*	*$414.74*	*$414.74*	
Total Cost	*$829.48*	*$1,244.22*	*$1,244.22*	*$1,244.22*	
Current Total Waiver Expenditures	*$26,926,397.47*	*$27,327,199.28*	*$27,678,029.72*	*$28,125,198.54*	*$28,564,919.60*
Amendment Total Waiver Expenditures	*$26,926,397.47*	*$27,328,028.76*	*$27,679,273.94*	*$28,126,442.76*	*$28,566,163.82*
Amendment Factor D (It will calculate once add the new service)	*$93,820.20*	*$93,589.14*	*$93,196.21*	*$93,133.92*	*$93,049.39*

The additional dollars added, as a result of the new Removable Prosthodontic Services, were calculated by WY as follows:

Updated Utilization per 1,000 is a result of multiplying the # of individuals per 1000 (Exhibit C of the Milliman Report); Pent up Demand Adjustment of 1.20 (Page 8 of the Milliman Report); and, DCG (Milliman Health Cost Guidelines – Dental ™ Adjustment of 1.013, Page 10 of the Milliman Report).

Utilization is a result of multiplying the # of individuals per 1,000 utilization (Waiver unduplicated individuals) by the Updated Utilization per 1,000. For WY1 this equals 0 as the new Removable Prosthodontic Service doesn't start until WY2. For WY2 it is based on 7 months of service. For WY3-5 it is calculated based on 12 months of service.

Per Appendix B-5-c-I, for the 7-1-23 waiver amendment, NH added the total projected cost of care or cost share to residential services, that has been applied to individuals receiving ABD services as they are billed each month, as beginning 7-1-23 only residential services will have a cost of care. The cost of care was added to residential WY2 for 4 months only and for full years for WYs 3-5. As a result, WY2-5 Factor D's changed slightly.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The projected numbers in this section, for WY1-WY5, mirror the CMS approved current ABD Waiver due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served.

Factor G' is greater than Factor D' because the acuity of individuals in the NF institution is much higher than the acuity of individuals on the ABD Waiver. In addition, managed care is making a difference in home and community based care, with cost being deferred to the MCO, thus reducing Factor D'.

The addition of Removable Prosthodontic Services services to Medicaid State Plan services will be increased by the attached workbook titled "DRAFT of Projected DD, ABD & CFI Waiver Amendment for Denture Service 10-27-22v2 UPDATED 1-29-23.xlsx" and below:
Acquired Brain Disorder (ABD)

Removable Prosthodontic Services Amendment Factor D' WY1 WY2 WY3 WY4 WY5
Current Factor D' $9,455.10 $9,833.30 $10,226.63 $10,635.70 $11,061.13
Avg Charge for all Dental minus Dentures ($1,500 yrly limit on dental services minus Avg Charge for dentures, page 1 of Milliman Report) $13,023.12 $13,023.12 $13,023.12 $13,023.12
Amendment Factor D' (Current +Avg Charge for Dental minus Dentures) $9,455.10 $22,856.42 $23,249.75 $23,658.82 $24,084.25

The additional dollars added, as a result of the new Removable Prosthodontic Services, were calculated by using the $1,500.00 yearly limit on dental services, per page 1 of the Milliman Report, and subtracting the average charge for dentures of $414.74, per Exhibit C of the Milliman Report.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The projected numbers in this section, for WY1-WY5, mirror the CMS approved current ABD Waiver due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served.

Projected expenditures, for Factor G, are not anticipated to be higher than what is already projected in WYs 2-5, of the current approved waiver, as a result of adding the Removable Prosthodontic Services.

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 projected numbers in this section, for WY1-WY5, mirror the CMS approved current ABD Waiver due to being obligated by the Maintenance of Effort (MOE), of the ARP, to not make a reduction in services or individuals being served.

Factor G' is greater than Factor D' because the acuity of individuals in the NF institution is much higher than the acuity of individuals on the ABD Waiver. In addition, managed care is making a difference in home and community based care, with cost being deferred to the MCO, thus reducing Factor D'.

Projected expenditures, for Factor G', are not anticipated to be higher than what is already projected in WYs 2-5, of the current approved waiver, as a result of adding the Removable Prosthodontic Services.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Community Participation Services	

Waiver Services	
Residential Habilitation	
Respite	
Service Coordination	
Supported Employment	
Assistive Technology	
Community Integration Services	
Community Support Services	
Crisis Response Services	
Environmental and Vehicle Modification Services	
Individual Goods and Services	
Non-Medical Transportation	
Personal Emergency Response Services	
Removable Prosthodontic Services	
Specialty Services	
Wellness Coaching	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Participation Services Total:							**2930718.25**
Community Participation Services	☐	15 Minutes	145	2713.00	7.45	**2930718.25**	
Residential Habilitation Total:							**14024724.80**
Residential Habilitation	☐	Day	236	232.00	256.15	**14024724.80**	
Respite Total:							**6326.08**
Respite	☐	15 Mintues	2	746.00	4.24	**6326.08**	
Service							**656544.00**

GRAND TOTAL:		**26926397.47**
Total: Services included in capitation:		
Total: Services not included in capitation:		26926397.47
Total Estimated Unduplicated Participants:		**287**
Factor D (Divide total by number of participants):		**93820.20**
Services included in capitation:		
Services not included in capitation:		93820.20
Average Length of Stay on the Waiver:	337	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination Total:							
Service Coordination	☐	Month	240	10.00	273.56	**656544.00**	
Supported Employment Total:							**60752.49**
Supported Employment	☐	15 Minutes	4	2003.71	7.58	**60752.49**	
Assistive Technology Total:							**220000.00**
Assistive Technology	☐	Item	22	1.00	10000.00	**220000.00**	
Community Integration Services Total:							**6013120.00**
Community Integration Services	☐	Each	86	8.74	8000.00	**6013120.00**	
Community Support Services Total:							**192271.64**
Community Support Services	☐	15 Minutes	19	1231.09	8.22	**192271.64**	
Crisis Response Services Total:							**103915.24**
Crisis Response Services	☐	15 Minutes	11	1924.00	4.91	**103915.24**	
Environmental and Vehicle Modification Services Total:							**15780.38**
Environmental and Vehicle Modification Services	☐	Each	11	1.00	1434.58	**15780.38**	
Individual Goods and Services Total:							**22500.00**
Individual Goods and Services	☐	Each	15	1.00	1500.00	**22500.00**	
Non-Medical Transportation Total:							**2102700.00**
Non-Medical Transportation	☐	Each	43	9.78	5000.00	**2102700.00**	
Personal Emergency Response Services							**79087.20**

GRAND TOTAL:		**26926397.47**
Total: Services included in capitation:		
Total: Services not included in capitation:		*26926397.47*
Total Estimated Unduplicated Participants:		**287**
Factor D (Divide total by number of participants):		**93820.20**
Services included in capitation:		
Services not included in capitation:		*93820.20*
Average Length of Stay on the Waiver:	*337*	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Emergency Response Services	☐	Month	155	12.00	42.52	**79087.20**	
Removable Prosthodontic Services Total:							**0.00**
Removable Prosthodontic Services	☐	Each	0	1.00	414.74	**0.00**	
Specialty Services Total:							**122957.40**
Specialty Services	☐	Each	202	6.00	101.45	**122957.40**	
Wellness Coaching Total:							**375000.00**
Wellness Coaching	☐	Hour	15	5.00	5000.00	**375000.00**	

GRAND TOTAL:	**26926397.47**
Total: Services included in capitation:	
Total: Services not included in capitation:	26926397.47
Total Estimated Unduplicated Participants:	**287**
Factor D (Divide total by number of participants):	**93820.20**
Services included in capitation:	
Services not included in capitation:	93820.20
Average Length of Stay on the Waiver:	337

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Participation Services Total:							**2948424.57**
Community Participation Services	☐	15 Minutes	147	2449.00	8.19	**2948424.57**	
Residential							**14343768.00**

GRAND TOTAL:	**27419151.96**
Total: Services included in capitation:	
Total: Services not included in capitation:	27419151.96
Total Estimated Unduplicated Participants:	**292**
Factor D (Divide total by number of participants):	**93901.21**
Services included in capitation:	
Services not included in capitation:	93901.21
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Total:							
Residential Habilitation	☐	Day	240	226.00	264.45	**14343768.00**	
Respite Total:							**6440.96**
Respite	☐	15 Mintues	2	629.00	5.12	**6440.96**	
Service Coordination Total:							**667486.40**
Service Coordination	☐	Month	244	10.00	273.56	**667486.40**	
Supported Employment Total:							**61755.70**
Supported Employment	☐	15 Minutes	5	2061.96	5.99	**61755.70**	
Assistive Technology Total:							**220000.00**
Assistive Technology	☐	Item	22	1.00	10000.00	**220000.00**	
Community Integration Services Total:							**6110720.00**
Community Integration Services	☐	Each	88	8.68	8000.00	**6110720.00**	
Community Support Services Total:							**194168.45**
Community Support Services	☐	15 Minutes	19	1330.65	7.68	**194168.45**	
Crisis Response Services Total:							**105899.44**
Crisis Response Services	☐	15 Minutes	11	1612.60	5.97	**105899.44**	
Environmental and Vehicle Modification Services Total:							**16080.24**
Environmental and Vehicle Modification Services	☐	Each	11	1.00	1461.84	**16080.24**	
Individual Goods and Services Total:							**22500.00**
Individual Goods and	☐					**22500.00**	

GRAND TOTAL:	**27419151.96**
Total: Services included in capitation:	
Total: Services not included in capitation:	27419151.96
Total Estimated Unduplicated Participants:	**292**
Factor D (Divide total by number of participants):	**93901.21**
Services included in capitation:	
Services not included in capitation:	93901.21
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services		Each	15	1.00	1500.00		
Non-Medical Transportation Total:							**2138400.00**
Non-Medical Transportation	☐	Each	44	9.72	5000.00	**2138400.00**	
Personal Emergency Response Services Total:							**80617.92**
Personal Emergency Response Services	☐	Month	158	12.00	42.52	**80617.92**	
Removable Prosthodontic Services Total:							**829.48**
Removable Prosthodontic Services	☐	Each	2	1.00	414.74	**829.48**	
Specialty Services Total:							**127060.80**
Specialty Services	☐	Each	206	6.00	102.80	**127060.80**	
Wellness Coaching Total:							**375000.00**
Wellness Coaching	☐	Hour	15	5.00	5000.00	**375000.00**	

GRAND TOTAL:	**27419151.96**
Total: Services included in capitation:	
Total: Services not included in capitation:	27419151.96
Total Estimated Unduplicated Participants:	**292**
Factor D (Divide total by number of participants):	**93901.21**
Services included in capitation:	
Services not included in capitation:	93901.21
Average Length of Stay on the Waiver:	339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Participation Services Total:							**2970352.71**
Community Participation Services	☐	15 Minutes	151	2193.00	8.97	**2970352.71**	
Residential Habilitation Total:							**14759316.00**
Residential Habilitation	☐	Day	244	220.00	274.95	**14759316.00**	
Respite Total:							**6561.40**
Respite	☐	15 Mintues	2	530.00	6.19	**6561.40**	
Service Coordination Total:							**610585.92**
Service Coordination	☐	Month	248	9.00	273.56	**610585.92**	
Supported Employment Total:							**62720.76**
Supported Employment	☐	15 Minutes	5	2122.53	5.91	**62720.76**	
Assistive Technology Total:							**230000.00**
Assistive Technology	☐	Item	23	1.00	10000.00	**230000.00**	
Community Integration Services Total:							**6208640.00**
Community Integration Services	☐	Each	89	8.72	8000.00	**6208640.00**	
Community Support Services Total:							**196263.36**
Community Support Services	☐	15 Minutes	19	1438.67	7.18	**196263.36**	
Crisis Response Services Total:							**108007.60**
Crisis Response Services	☐	15 Minutes	12	1339.38	6.72	**108007.60**	
Environmental and Vehicle Modification Services Total:							**16385.76**
Environmental and Vehicle	☐					**16385.76**	

GRAND TOTAL:	**27952505.14**
Total: Services included in capitation:	
Total: Services not included in capitation:	27952505.14
Total Estimated Unduplicated Participants:	**297**
Factor D (Divide total by number of participants):	**94116.18**
Services included in capitation:	
Services not included in capitation:	94116.18
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modification Services		Each	12	1.00	1365.48		
Individual Goods and Services Total:							**22500.00**
Individual Goods and Services	☐	Each	15	1.00	1500.00	**22500.00**	
Non-Medical Transportation Total:							**2173500.00**
Non-Medical Transportation	☐	Each	45	9.66	5000.00	**2173500.00**	
Personal Emergency Response Services Total:							**81638.40**
Personal Emergency Response Services	☐	Month	160	12.00	42.52	**81638.40**	
Removable Prosthodontic Services Total:							**1244.22**
Removable Prosthodontic Services	☐	Each	3	1.00	414.74	**1244.22**	
Specialty Services Total:							**129789.00**
Specialty Services	☐	Each	209	6.00	103.50	**129789.00**	
Wellness Coaching Total:							**375000.00**
Wellness Coaching	☐	Hour	15	5.00	5000.00	**375000.00**	

GRAND TOTAL:	**27952505.14**
Total: Services included in capitation:	
Total: Services not included in capitation:	27952505.14
Total Estimated Unduplicated Participants:	**297**
Factor D (Divide total by number of participants):	**94116.18**
Services included in capitation:	
Services not included in capitation:	94116.18
Average Length of Stay on the Waiver:	340

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Participation Services Total:							**2993047.20**
Community Participation Services	☐	15 Minutes	153	1980.00	9.88	**2993047.20**	
Residential Habilitation Total:							**14998382.80**
Residential Habilitation	☐	Day	248	215.00	281.29	**14998382.80**	
Respite Total:							**6687.12**
Respite	☐	15 Mintues	2	447.00	7.48	**6687.12**	
Service Coordination Total:							**620434.08**
Service Coordination	☐	Month	252	9.00	273.56	**620434.08**	
Supported Employment Total:							**63707.32**
Supported Employment	☐	15 Minutes	5	2185.50	5.83	**63707.32**	
Assistive Technology Total:							**230000.00**
Assistive Technology	☐	Item	23	1.00	10000.00	**230000.00**	
Community Integration Services Total:							**6311760.00**
Community Integration Services	☐	Each	91	8.67	8000.00	**6311760.00**	
Community Support Services Total:							**198534.12**
Community Support Services	☐	15 Minutes	20	1555.91	6.38	**198534.12**	
Crisis Response Services Total:							**110030.70**
Crisis Response Services	☐	15 Minutes	12	1112.77	8.24	**110030.70**	
Environmental and Vehicle Modification Services Total:							**16697.04**
Environmental and Vehicle	☐					**16697.04**	

GRAND TOTAL:	**28399441.16**
Total: Services included in capitation:	
Total: Services not included in capitation:	28399441.16
Total Estimated Unduplicated Participants:	**302**
Factor D (Divide total by number of participants):	**94037.88**
Services included in capitation:	
Services not included in capitation:	94037.88
Average Length of Stay on the Waiver:	342

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modification Services		Each	12	1.00	1391.42		
Individual Goods and Services Total:							**24000.00**
Individual Goods and Services	☐	Each	16	1.00	1500.00	**24000.00**	
Non-Medical Transportation Total:							**2209500.00**
Non-Medical Transportation	☐	Each	45	9.82	5000.00	**2209500.00**	
Personal Emergency Response Services Total:							**83169.12**
Personal Emergency Response Services	☐	Month	163	12.00	42.52	**83169.12**	
Removable Prosthodontic Services Total:							**1244.22**
Removable Prosthodontic Services	☐	Each	3	1.00	414.74	**1244.22**	
Specialty Services Total:							**132247.44**
Specialty Services	☐	Each	213	6.00	103.48	**132247.44**	
Wellness Coaching Total:							**400000.00**
Wellness Coaching	☐	Hour	16	5.00	5000.00	**400000.00**	

GRAND TOTAL:	**28399441.16**
Total: Services included in capitation:	
Total: Services not included in capitation:	28399441.16
Total Estimated Unduplicated Participants:	**302**
Factor D (Divide total by number of participants):	**94037.88**
Services included in capitation:	
Services not included in capitation:	94037.88
Average Length of Stay on the Waiver:	342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Participation Services Total:							**3016969.60**
Community Participation Services	☐	15 Minutes	155	1789.00	10.88	**3016969.60**	
Residential Habilitation Total:							**15242852.79**
Residential Habilitation	☐	Day	253	209.00	288.27	**15242852.79**	
Respite Total:							**6816.16**
Respite	☐	15 Mintues	2	377.00	9.04	**6816.16**	
Service Coordination Total:							**630282.24**
Service Coordination	☐	Month	256	9.00	273.56	**630282.24**	
Supported Employment Total:							**64827.36**
Supported Employment	☐	15 Minutes	5	2250.95	5.76	**64827.36**	
Assistive Technology Total:							**240000.00**
Assistive Technology	☐	Item	24	1.00	10000.00	**240000.00**	
Community Integration Services Total:							**6417920.00**
Community Integration Services	☐	Each	92	8.72	8000.00	**6417920.00**	
Community Support Services Total:							**200633.86**
Community Support Services	☐	15 Minutes	20	1683.17	5.96	**200633.86**	
Crisis Response Services Total:							**112190.67**
Crisis Response Services	☐	15 Minutes	12	924.75	10.11	**112190.67**	
Environmental and Vehicle Modification Services Total:							**17014.32**
Environmental and Vehicle	☐					**17014.32**	

GRAND TOTAL:	**28839009.14**
Total: Services included in capitation:	
Total: Services not included in capitation:	*28839009.14*
Total Estimated Unduplicated Participants:	**307**
Factor D (Divide total by number of participants):	**93938.14**
Services included in capitation:	
Services not included in capitation:	*93938.14*
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modification Services		Each	12	1.00	1417.86		
Individual Goods and Services Total:							**24000.00**
Individual Goods and Services	☐	Each	16	1.00	1500.00	**24000.00**	
Non-Medical Transportation Total:							**2244800.00**
Non-Medical Transportation	☐	Each	46	9.76	5000.00	**2244800.00**	
Personal Emergency Response Services Total:							**84699.84**
Personal Emergency Response Services	☐	Month	166	12.00	42.52	**84699.84**	
Removable Prosthodontic Services Total:							**1244.22**
Removable Prosthodontic Services	☐	Each	3	1.00	414.74	**1244.22**	
Specialty Services Total:							**134758.08**
Specialty Services	☐	Each	216	6.00	103.98	**134758.08**	
Wellness Coaching Total:							**400000.00**
Wellness Coaching	☐	Hour	16	5.00	5000.00	**400000.00**	

GRAND TOTAL:	**28839009.14**
Total: Services included in capitation:	
Total: Services not included in capitation:	28839009.14
Total Estimated Unduplicated Participants:	**307**
Factor D (Divide total by number of participants):	**93938.14**
Services included in capitation:	
Services not included in capitation:	93938.14
Average Length of Stay on the Waiver:	343