APPENDIX II-C

RULEMAKING NOTICE FORM

Notice Number _____ Rule Number **He-M 504**

1. Agency Name & Address: **Department of Health & Human Services** **Bureau of Developmental Services** **105 Pleasant Street, Main Building** **Concord, NH 03301**	2. RSA Authority: **RSA 171-A:3, :18, I, IV** 3. Federal Authority: **42 CFR 455.410; 42 CFR 447.10** 4. Type of Action: Adoption _____ Repeal _____ Readoption _____ Readoption w/amendment **X**

5. Short Title: **Provider and Provider Agency Operations**

6. (a) Summary of what the rule says and of any proposed amendments:

He-M 504 defines the process of enrollment for providers of services to individuals with developmental disabilities and acquired brain disorders, as well as the roles and responsibilities of said providers. He-M 504 is currently an emergency rule, effective June 28, 2023 and scheduled to expire on December 25, 2023.

The Department of Health and Human Services (Department) is proposing to readopt with amendment He-M 504. The proposed amendments include:

- **Updating He-M 504.02 on definition by making minor revisions to the term "area agency", and "service", "service coordinator";**
- **Updating He-M 504.03 on roles and responsibilities of providers and provider agencies to require that checks completed of the state registries pursuant to RSA 169-C:35 and RSA 161-F:49 be completed every other year, to include a volunteer as a mandated reporter, and making minor editorial revisions throughout;**
- **Updating He-M 504.04 on provider and provider agency participation by clarifying that the department screening shall be done within 90 days for both enrollment and reenrollment, to require that no unsatisfactory findings be determined during the Department screening upon enrollment or re-enrollment to become a Medicaid provider, by adding that documentation of services provided between the date of notice and the last date of service shall be transferred to the respective service coordination entity no more than 2 business days after the end of service provision; and by making clarification revisions throughout;**
- **Updating He-M 504.08 on monitoring and determination of cost effectiveness to clarify the requirements relative to the submission of cost reporting information;**
- **Updating He-M 504.11 on provider and provider agency staff requirements to add additional training requirements;**

- **Updating He-M 504.12 on suspension and revocation of provider enrollment by clarifying the contents of the notice of suspension or revocation from the Department and updating the appeals provision;**

- **Updating He-M 504.13 on discontinuation of services by provider or provider agency to require that a provider agency that is not delivering services in conjunction with a residency agreement shall provide a 90-day notice when discontinuing services to an individual; and**

- **Updating He-M 504.14 on waivers to include that waivers shall be granted for the minimum period of time necessary to accommodate the waiver request, not to exceed 5 years unless specific provisions are met.**

6. (b) Brief description of the groups affected:

He-M 504 affects all providers and provider agencies seeking payment from the Department for the provision of authorized services to eligible individuals with developmental disabilities and acquired brain disorders.

6. (c) Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:

RULE	SPECIFIC STATE STATUTES WHICH THE RULE IMPLEMENTS
He-M 504.01 – 504.03	RSA 171-A:3; 18, IV
He-M 504.04	RSA 171-A:3; 18, IV; 42 CFR § 455.410; 42 CFR § 447.10
He-M 504.05	RSA 171-A:3; 18, IV
He-M 504.06	RSA 171-A:3, 18, IV; 42 CFR § 447.10
He-M 504.07	RSA 171-A:3; 42 CFR § 433.139
He-M 504.08	RSA 171-A:3; 18, IV
He-M 504.09	RSA 171-A:3; 42 CFR § 455; 42 CFR § 456
He-M 504.10	RSA 171-A:3; 42 CFR § 455.14
He-M 504.11-504.14	RSA 171-A:3; 18, IV

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name: **Allyson Raadmae**

Address: **Dept. of Health and Human Services**
Administrative Rules Unit
129 Pleasant Street, 2nd Floor
Concord, NH 03301

Title: **Administrator- Administrative Rules Unit**

Phone #: **(603) 271-9604**

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E-mail: **Allyson.E.Raadmae@dhhs.nh.gov**

TTY/TDD Access: Relay NH 1-800-735-2964
or dial 711 (in NH)

The proposed rules may be viewed and downloaded at:
https://www.dhhs.nh.gov/doing-business-dhhs/legal-services/administrative-rules/nh-administrative-rules-public-comment

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Monday, October 2, 2023**

☒ Fax ☒ E-mail ☐ Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Monday, September 25, 2023 at 2:00pm**

Place: **DHHS Brown Bldg., Auditorium, 129 Pleasant St., Concord, NH**

10. Fiscal Impact Statement (Prepared by Legislative Budget Assistant)

FIS # **23:174** , dated **August 14, 2023**

1. Comparison of the costs of the proposed rule(s) to the existing rule(s):
When compared to the existing rule, the proposed rule may benefit state citizens and increase costs to independently-owned businesses by an indeterminable amount. The state general fund benefits to the extent that the rule prevents federal funds from being revoked for certain services.

2. Cite the Federal mandate. Identify the impact on state funds:
The Department of Health and Human Services is currently under a corrective action plan with the Centers for Medicare and Medicaid Services ("CMS") to come into compliance with the requirements of 42 CFR 447.10 relative to providers having the ability to directly bill Medicaid. The Department states that the changes to these rules are needed to come into compliance with the corrective action plan, and do not increase any state general fund expenditures. However, failure to come into compliance with these requirements could mean that the state would lose the 50% matching federal funds for these services, which would be a significant cost to the state general fund. The state general fund benefits from the proposed changes by allowing the state to maintain the 50% federal matching funds.

3. Cost and benefits of the proposed rule(s):

A. To State general or State special funds:
See response to (2) above.

B. To State citizens and political subdivisions:
The Department states that State citizens will benefit from the changes because it brings the rule into alignment with federal requirements, thus preserving access to federal matching funds for services. There will be no cost or cost or benefit to political subdivisions.

C. To independently owned businesses:
The proposed rule includes requirements for all providers of services to individuals with developmental disabilities or acquired brain disorders to enroll as Medicaid providers, provide certain cost reporting information to the department, and ensure specific training is provided. These requirements may have costs associated with them, as they are new requirements for the providers. The reporting and record keeping requirements do not differ by the size of the business.

11. Statement Relative to Part I, Article 28-a of the N.H. Constitution:

The proposed rule modifies an existing program or responsibility, but does not mandate any fees, duties or expenditures on the political subdivisions of the state, and therefore does not violate Part I, Article 28-a of the N.H. Constitution.

Readopt with amendment He-M 504, effective 6-28-23 (Document # 13679, Emergency), to read as follows:

PART He-M 504 PROVIDER AND PROVIDER AGENCY OPERATIONS

Statutory Authority: RSA 171-A:3, 18, IV

He-M 504.01 Purpose. The purpose of these rules is to define the expectations for all providers and provider agencies seeking payment from the department for the provision of authorized services to eligible individuals with developmental disabilities and acquired brain disorders.

He-M 504.02 Definitions. The words and phrases used in these rules shall mean the following, except where a different meaning is clearly intended from the context:

(a) "Acquired brain disorder" means a disruption in brain functioning that:

(1) Is not congenital or caused by birth trauma;

(2) Presents a severe and life-long disabling condition which significantly impairs a person's ability to function in society;

(3) Occurs prior to age 60;

(4) Is attributable to one or more of the following reasons:

a. External trauma to the brain as a result of:

1. A motor vehicle incident;

2. A fall;

3. An assault; or

4. Another related traumatic incident or occurrence;

b. Anoxic or hypoxic injury to the brain such as from:

1. Cardiopulmonary arrest;

2. Carbon monoxide poisoning;

3. Airway obstruction;

4. Hemorrhage; or

5. Near drowning;

c. Infectious diseases such as encephalitis and meningitis;

d. Brain tumor;

e. Intracranial surgery;

f. Cerebrovascular disruption such as a stroke;

g. Toxic exposure; or

h. Other neurological disorders such as Huntington's disease or multiple sclerosis which predominantly affect the central nervous system; and

(5) Is manifested by one or more of the following:

a. Significant decline in cognitive functioning and ability; or

b. Deterioration in:

1. Personality;

2. Impulse control;

3. Judgment;

4. Modulation of mood; or

5. Awareness of deficits;

(b) "Area agency" means "area agency" as defined in RSA 171-A:2, I-b.~~, namely "an entity established as an nonprofit corporation in the state of New Hampshire which is established by rules adopted by the director to provide services to developmentally disabled persons in the area.";~~

(c) "Bureau" means the bureau of developmental services of the department of health and human services;

(d) "Commissioner" means the commissioner of the department of health and human services or their designee;

(e) "Cost of care" means the amount of income that eligible individuals receiving home and community based waiver services are liable to contribute toward the cost of their services in accordance with He-M 517;

(f) "Critical incident" means an alleged, suspected, or actual occurrence of:

(1) Abuse including physical, sexual, verbal, and psychological abuse;

(2) Neglect;

(3) Exploitation;

(4) Serious injury;

(5) Death other than by natural causes;

(6) Other events that cause harm to an individual; and

(7) Events that serve as indicators of risk to individuals' health and welfare such as hospitalizations, medication errors, use of restraints, or behavioral interventions;

(g) "Days" means calendar days unless otherwise specified;

(h) "Department" means the New Hampshire department of health and human services;

(i) "Developmental disability" means "developmental disability" as defined in RSA 171-A:2, V, namely, "a disability:

(1) Which is attributable to an intellectual disability, cerebral palsy, epilepsy, autism, or a specific learning disability, or any other condition of an individual found to be closely related to an intellectual disability as it refers to general intellectual functioning or impairment in adaptive behavior or requires treatment similar to that required for persons with an intellectual disability; and

(2) Which originates before such individual attains age 22, has continued or can be expected to continue indefinitely, and constitutes a severe disability to such individual's ability to function normally in society.";

(j) "Enrolled provider" means a provider agency or independent provider that the department has determined is eligible to provide Home and Community Based 1915 (c) waiver services and receive payment therefore;

(k) "Guardian" means a person appointed pursuant to RSA 463 or RSA 464-A or the parent of an individual under the age of 18 whose parental rights have not been terminated or limited by law;

(l) "Home and Community Based waiver services" means the services defined and funded pursuant to New Hampshire's agreement with the federal government, known as the Developmental Disabilities Waiver, In-Home Supports Waiver, and the Acquired Brain Disorder Waiver, pursuant to the authority section of 1915(c) of the Social Security Act which allows the federal funding of long-term care services in non-institutional settings for persons who are developmentally disabled or who have an acquired brain disorder;

(m) "Individual" means a person who has a developmental disability or acquired brain disorder;

(n) "Medicaid" means the Title XIX and Title XXI programs administered by the department, which makes medical assistance and services available to eligible individuals;

(o) "Medicaid management information system (MMIS)" means the general system for mechanized claims processing and information retrieval recommended by the Centers for Medicare and Medicaid Services (CMS) for the implementation of the requirements of state fiscal administration pursuant to 42 CFR 433, Subpart C;

(p) "Organized health care delivery system (OHCDS)" means an area agency, designated pursuant to He-M 505, that directly provides at least one home and community based waiver service;

(q) "Pass-through billing" means an arrangement, pursuant to 42 CFR 447.10(g)(3), whereby the OHCDS is the enrolled provider of home and community based waiver services for the purposes of billing and subcontracting for the service provision and has authorization from the department to do so;

(r) "Person-centered service planning" is an individual-directed, positive approach to the planning and coordination of a person's services and other supports based on the individuals aspirations, needs, preferences, and goals;

(s) "Provider" means a person receiving any form of remuneration for the provision of services to an individual;

(t) "Provider agency" means an agency or an independent provider that is established to provide services to individuals;

(u) "Provider applicant" means a provider agency who is undergoing the enrollment or re-enrollment process to become a New Hampshire Medicaid provider;

(v) "Provider enrollment ID" means a unique identification number assigned to provider agencies who are enrolled in the state's Medicaid program and authorized to provide services to Medicaid beneficiaries;

(w) "Room and board" means shelter type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services, and three meals a day or any other full nutritional regimen;

(x) "Sentinel event" means an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. Categories of reportable sentinel events are individual-centered events, in which the individual is either a victim and/or perpetrator, including, but are not limited to:

(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. A medication error;

b. An unauthorized departure or abduction from a facility providing care; or

c. 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;

(8) Serious psychological injury that jeopardizes the person's health that is associated with the planning and delivery of care; or

(9) Injuries due to physical or mechanical restraints;

(10) High profile/high risk event, such as:

a. Media coverage; or

b. Police involvement leading to an arrest;

(y) "Service" means any paid assistance to the individual in meeting ~~his or her~~their own needs provided through the developmental services system;

(z) "Service coordinator" means a provider who meets the criteria in He-M 503 or He-M 522 and is chosen by an individual and ~~his or her~~their guardian or representative to organize, facilitate, and document service planning and to negotiate and monitor the provision of the individual's services;

(aa) "Service coordination agency" means a provider agency providing service coordination services to individuals;

(ab) "Staff" means a person employed by a provider agency, subcontract agency, or other employer; and

(ac) "Utilization review and control" means the monitoring of medicaid program services pursuant to 42 CFR 455 and 42 CFR 456.

He-M 504.03 Roles and Responsibilities of Providers and Provider Agencies.

(a) All provider agencies shall obtain and maintain certifications for community residences, enhanced family care shared living residential habilitation services, and adult day community participation services in accordance with He-M 507 or He-M 1001, as applicable.

(b) All providers and provider agencies shall be responsible for the following:

(1) Participating in person-centered service planning in accordance with He-M 503, He-M 522, and He-M 524;

(2) Ensuring service delivery is led by the individual and family, if chosen by the individual, and promotes community involvement, relationship development, independence, societal contribution, enhancement of individual communications, and aligns with an individual's service agreement and in accordance with RSA 171-A;

(3) Reviewing the service agreement as follows:

a. All provider agencies shall review and sign the service agreement to indicate that they agree to provide services in the amount, scope, frequency and duration, as outlined; and

b. All providers shall review the service agreement relative to the service that they will be providing prior to service provision;

(4) Ensuring that all services are provided in accordance with He-M 310, He-M 503, He-M 522, He-M 524 and He-M 517, as applicable;

(5) Creating and maintaining documentation in accordance with He-M 503, He-M 522 and He-M 524, as applicable;

(6) Providing documentation of service planning, monitoring, and billing related to the service being provided, within 30 days of the request from the following entities, unless otherwise stated in rule, as follows:

a. To the department;

b. To area agencies, regarding information that is necessary for area agencies to complete their responsibilities pursuant to He-M 505; and

c. To service coordinators, regarding information that is necessary for the service coordination provider agency and service coordinator to complete their responsibilities pursuant to Chapter He-M 500;

(7) Participating in crisis mitigation and management which includes, but is not limited to, identifying alternative placement options, sharing information with other provider agencies and providers, and participating in crisis management meetings;

(8) Documenting and submitting to service coordination agencies incident reports regarding critical incidents; and

(9) Managing responses to areas of risk, in accordance with He-M 503, He-M 522 and He-M 524 and by:

a. Reviewing and analyzing incidents related to violent aggression, problematic sexual behaviors, or fire-setting behaviors as they pertain to service planning and provision;

b. Notifying service coordinators of the presentation of incidents in accordance with (a) above;

c. Presenting to committees and other groups related to risk management, when invited by the service coordinator, including, but not limited to, local human rights committees, statewide and local risk management committees, and community of practice to determine application of assessment recommendations received, when the provider agency participated in the plan development;

d. Ensuring documentation of activities and progress in treatment relative to management of risk for an individual to help inform the person-centered development of plans;

e. Ensuring that agency personnel and contractors receive clinically specialized trainings, based on assessed needs of the individuals supported, that enable these personnel to successfully complete risk management activities;

f. Ensuring participation in risk management training activities; and

g. Ensuring that plans are reviewed regularly with individuals and their treatment team to consider ongoing appropriateness and, in the event that potential changes are indicated, seeking additional consultation with providers qualified to conduct and author assessments, whether they created the initial plans or are new, to discuss opportunities for modification of restrictions by sharing data regarding the individual's updated progress in treatment.

(c) In addition to the requirements in He-M 504.03(b)(9) for response to management of risk, service coordination provider agencies and service coordination providers shall:

(1) Make referrals for individuals exhibiting violent aggression, problematic sexual behaviors or fire-setting behaviors for evaluations or planning activities initially and ongoing; and

(2) Participate in and present to committees and other groups related to risk management including, but not limited to, local human rights committees, statewide and local risk management committees and community of practice to determine application of assessment recommendations received; and

(d) All service coordination agencies shall document sentinel events and submit reports to the applicable area agency for finalization in accordance with RSA 126-A:4.

(e) All provider agencies shall be able to be contacted during their published hours of business, as indicated in the medicaid provider enrollment process.

(f) In addition to (e) above, all home and community based waiver community residence and enhanced family care shared living residential habilitation provider agencies and service coordination provider agencies shall be accessible 24/7 and have an on-call system for emergency access outside of regular business hours to ensure response within 30 minutes by a representative with decision-making authority.

(g) Each provider agency must complete a New Hampshire criminal records check no more than 30 days prior to hire and prior to working with any individual, and every other year thereafter, for all of its providers, staff, contractors, and volunteers who will have direct contact with individuals or families and:

(1) If the applicable provider, staff, contractor or volunteer's primary residence is out of state, a criminal records check for their state of residence shall be completed prior to working with any individual, and every other year thereafter; or

(2) If the applicable provider, staff, contractor or volunteer has resided in New Hampshire for less than one year, a criminal records check for their previous state of residence shall be completed prior to working with any individual.

(h) Each provider agency shall complete a check of the -Division of Children, Youth and Families (DCYF) state registry, pursuant to RSA 169-C:35 for all of its providers, staff, contractors, and volunteers who will have direct contact with individuals or families, prior to working with any individual and every other year thereafter.

(i) Each provider agency shall complete a check of the registry of founded reports of abuse, neglect, and exploitation pursuant to RSA 161-F:49 for all of its providers, staff, contractors, and volunteers who will have direct contact with individuals and families prior to working with any individual and every other year thereafter.

(j) Except as allowed in (k) and (l) below, a provider agency shall not hire a person, or permit them to volunteer:

(1) Who has a:

a. Felony conviction; or

b. Any misdemeanor conviction involving:

1. Physical or sexual assault;

2. Violence;

3. Exploitation;

4. Child pornography;

5. Threatening or reckless conduct;

6. Theft;

7. Driving under the influence of drugs or alcohol; or

8. Any other conduct that represents evidence of behavior that could endanger the well-being of an individual; or

(2) Whose name is on either of the state registries of founded abuse, neglect, and exploitation as established by RSA 161-F:49 and RSA 169-C:35.

(k) A provider agency may hire a person, or permit the person to volunteer, with a criminal record listed in (j)(1) a. or b. above for a single offense that occurred 10 or more years ago in accordance with (l) and (m) below. In such instances, the individual, their ~~his or her~~ guardian if applicable, and the provider agency shall review the person's history prior to approving the person's employment.

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

(1) Is approved by the individual, their ~~his or her~~ guardian, if applicable, and the provider agency;

(2) Does not negatively impact the health or safety of the individual; and

(3) Does not affect the quality of services to the individual.

(m) Upon hiring or permitting a person to volunteer pursuant to (k) and (l) above, the provider agency shall document and retain the following information in the individual's record:

(1) The date(s) of the approvals in (l) above;

(2) The name of the individual for whom the person will provide services;

(3) The name of the person hired or permitted to volunteer;

(4) Description of the person's criminal offense;

(5) The type of service the person is hired or volunteering to provide;

(6) The provider agency's name and address;

(7) A full explanation of why the provider agency is hiring or allowing the person to volunteer despite the person's criminal record;

(8) Signature of the individual, or of the legal guardian(s) if applicable, indicating agreement with the employment and date signed;

(9) Signature of the provider agency staff person who obtained the individual or guardian's signature and date signed;

(10) Signature of the provider agency's executive director or designee approving the employment; and

(11) The signature and phone number of the person being hired or permitted to volunteer.

(n) In instances when obtaining the checks required in (g)-(h) would delay a provider agency's ability to have a provider, staff, contractor, or volunteer begin providing services, the provider agency shall obtain a self-attestation from the prospective provider, staff, contractor, or volunteer to attest that they have not:

(1) Committed a felony or misdemeanor in this or any other state; and

(2) Had a finding by the department or any administrative agency in this or any other state for assault, fraud, abuse, neglect, or exploitation of any person.

(o) Self-attestations obtained in accordance with (n) above shall be accepted while the provider agency is awaiting the results of the checks required in (g)-(h) above, but not be valid for more than 90 days. Individual and guardian approval must be obtained if a provider, staff, contractor or volunteer will work directly with an individual and not under the supervision of a provider, staff, contractor or volunteer with completed checks.

(p) Each provider agency shall check the office of the inspector general exclusion list prior to hire and monthly thereafter with regard to checking names of prospective or current providers, staff, and contractors.

(q) Each provider agency, provider, staff, ~~and~~ contractor, and volunteer is a mandated reporter and shall report to the appropriate department authority any individual who is suspected of being abused, neglected, exploited, or self-neglecting, in accordance with, RSA 161-F:46 and RSA 169-C:35, and pursuant to He-M 202, any individual who is suspected of being abused, neglected, exploited, or having had their service rights violated, in accordance with He-M 310.

(r) Provider agencies shall collect any applicable room and board payments.

(s) Provider agencies shall collect any applicable cost of care payments.

He-M 504.04 Provider and Provider Agency Participation

(a) Each provider agency who seeks to be enrolled to provide and receive reimbursement for home and community based waiver services shall:

(1) Complete an application for enrollment via the MMIS portal at: https://nhmmis.nh.gov/portals/wps/portal/ProviderLogin in order to apply to be and operate as a New Hampshire Medicaid enrolled provider in accordance with 42 CFR 455.410 and He-W 520.06, unless they choose to contract with an OHCDS for pass-through billing, pursuant to He-M 504.06;

(2) Contact the bureau to request a screening in accordance with (b) below following initiation of an application in accordance with (1) above;

(3) Meet the applicable licensing, certification, or other requirements of the specific service they provide, such as but not limited to, criteria required in New Hampshire RSA 151, RSA 171-A, 42 CFR 441.301, or a contract with the bureau or OHCDS; and

(4) Have an executed Medicaid provider participation agreement with the department in order to obtain Medicaid agency identification numbers from the department for the specific services for which the provider agency is enrolling.

(b) Each provider applicant shall participate in a department screening upon enrollment and re-enrollment to review the following:

(1) Mission and vision statements, as applicable;

(2) Training practices, such as but not limited to, requirements per specific position, purchased training platforms, and continuing education hours requirements;

(3) Service-specific competencies, as related to developmental services defined in chapter He-M 500;

(4) Three references that illustrate the provider applicant's ability to meet their service obligations in accordance with their mission and vision statement;

(5) Financial indicators of fiscal integrity, including but not limited to;

a. Financial statements identifying current portion of long-term debt payments (principal and interest); and

b. A measure of total current assets available to cover the cost of current liabilities;

(6) Liability protections;

(7) Policies and practices regarding restraint and seclusion;

(8) Attestation that criminal background and appropriate registry checks were completed pursuant to He-M 504.03 (e)-(g); and

(9) Attestation that office of inspector general checks were completed in accordance with He-M 504.03(n).

(c) The screening in (b) above shall occur within 90 days of application for enrollment or reenrollment.

(d) A provider applicant shall not be enrolled pursuant to (a) (4) above until the department has completed the screening in (b) above and has communicated this to the department's program integrity office.

(e) In addition to the reasons set forth in He-W 520.06, the department shall deny an application for provider agency enrollment or re-enrollment, as applicable, due to any of the following reasons:

(1) An unsatisfactory finding in the screening completed in accordance with (b) above;

(~~1~~2) Any reported abuse, neglect, or exploitation of an individual by an applicant, provider, provider agency, or contractor, if such abuse, neglect, or exploitation is reported on the state registry of abuse, neglect, and exploitation in accordance with RSA 161-F:49 or RSA 169-C:35;

(~~2~~3) A provider agency fails to ensure that its providers, staff, and contractors meet the training requirements in chapter He-M 500, He-M 1001, He-M 1201, or Nur 404;

(~~3~~4) A provider agency, provider, staff, or contractor has an illness or behavior that, as evidenced by documentation obtained or the observations made by the department, would endanger the well-being of the individuals or impair the ability of the provider agency to comply with department rules and the provider agency failed to take appropriate action to address and respond;

(~~4~~5) A provider agency, or any of its providers, staff, contractors, or any representative thereof, knowingly provides materially false or misleading information to the department;

(~~5~~6) A provider agency, or any of its providers, staff, contractors, or any representative thereof, fails to permit or interferes with any inspection or investigation by the department;

(~~6~~7) A provider agency, or any of its providers, staff, contractors, or representatives thereof, fails to provide required documents to the department or entities acting on its behalf;

(~~7~~8) Federal or state laws, regulations, or guidelines are modified or interpreted by the department in such a way that either providing the services under the agreement is prohibited or the department is prohibited from paying for such services from the planned funding source, as the department sees fit; or

(~~8~~9) The provider agency, provider or contractor no longer holds a required license, certification, or other credential to qualify as a provider of services.

(f) Enrollment or re-enrollment shall be denied upon the written notice by the department to the provider agency stating the specific rule(s) with which the provider agency does not comply.

(g) A provider agency may request an appeal, in accordance with He-C 200, regarding a proposed denial of enrollment or re-enrollment within 30 business days of the decision.

(h) The provider agency's enrollment status shall be suspended until the appeal determination is adjudicated.

(i) The denial shall not become final until the period for requesting an appeal has expired, or, if the provider agency requests an appeal, until such time as the administrative appeals unit issues a decision upholding the department's decision.

(j) Appeals shall be submitted in writing, to the bureau administrator in care of the department's office of client and legal services ~~within 30 days following the date of notification of denial or revocation~~.

(k) Each enrolled provider shall:

(1) Submit claims for payment in accordance with He-M 504.05; and

(2) Be subject to monitoring by the department.

(l) An enrolled provider or applicant shall update MMIS and notify the department, in writing to the bureau chief, or designee, of any material change in any status or condition of any element on their application within 30 days of the change occurring for changes such as, but not limited to:

(1) Business affiliation;

(2) Ownership and control information;

(3) Federal tax identification number;

(4) Criminal convictions;

(5) Addition to the BEAS or DCYF state registries; and

(6) The types of services that are offered.

(m) An enrolled provider shall notify any applicable service coordination agency if any change results in a change to the provider agency's ability to deliver services to an individual as outlined in that individual's service agreement within 2 business days.

(n) An enrolled provider or provider applicant shall notify any applicable area agency or service coordination agency if any change impacts their status as a provider agency within 2 business days.

(o) An enrolled provider shall immediately notify, in writing, the department, any applicable area agencies, any applicable service coordination agencies, and any individuals receiving services from the provider agency, in accordance with He-M 504.13 of their decision to terminate their status as an enrolled provider and update the MMIS at least 90 days prior to the termination date.

(p) Enrolled providers terminating in accordance with (o) above shall ensure each individual's full service file and any other pertinent documentation is transferred to their respective service coordination agency within 2 business days of the notification.

(q) Documentation of services provided between the date of notice and the last date of service provision shall be transferred to the respective service coordination entity no more than 2 business days after the end of service provision.

(rq) Claims submitted by, or payments made to, enrolled provider agencies who have not timely furnished the notification of changes or have not submitted any of the items that are required due to a change, in accordance with (m)-(p) above, shall be denied payment or subject to recovery.

He-M 504.05 Payment for Services

(a) Provider agencies shall submit all initial claims to the MMIS, so that the claims are received no later than 90 days after the date of service on the claim.

(b) If a provider agency has submitted a claim that is denied, during the 90-day billing period and the claim is subsequently rejected, the provider agency shall resubmit the claim within 15 months from the earliest date of service if the provider agency still wishes to receive reimbursement.

(c) Submission of claims in accordance with (a) and (b) above shall constitute the provider agency's assurance that:

(1) The service was delivered in compliance with all applicable federal and state rules and requirements in effect on the date the service(s) was provided, including but not limited to, the home and community based waiver services, chapter He-M 500, He-W 520, He-W 521, and CFR 455.410;

(2) The provider agency has created and maintained all records necessary in accordance with He-M 503, He-M 517, He-M 522, and He-M 524;

(3) The provider agency is prepared to share records with the department or the department's designee, including area agencies, within 30 days as requested; and

(4) The information included within the claim is accurate and complete.

(d) Provider agencies shall not bill the individual for medicaid covered services, even if medicaid denies the claim, when the individual is eligible for medicaid and approved for the service provided.

(e) Claims submitted by, or payments made to, provider agencies who have not timely billed shall be subject to denied payment or recovery.

He-M 504.06 Pass-Through Billing.

(a) Pass-through billing shall be permissible for the following home and community based waiver services:

(1) Assistive technology;

(2) Environmental and vehicle modification services;

(3) Individual goods and services;

(4) Crisis response services when providing indirect services;

(5) Non-medical transportation;

(6) Personal emergency response system;

(7) Community integration services;

(8) Respite;

(9) Wellness coaching; and

(10) Specialty services for assessments, consultations and evaluations.

(b) An OHCDS that provides pass-through billing shall:

(1) Establish itself as the enrolled provider for the home and community based waiver service(s) in (a) above for which pass-through billing will be done;

(2) Hold a contract or other agreement with a provider or provider agency for service provision. Provision of goods, other than environmental or vehicle modifications, shall not require a contract or agreement;

(3) Ensure that the providers and provider agencies with whom it contracts, or has agreements with, meet:

a. The service and provider qualification standards under the applicable home and community based services waiver, He-M 504 and He-M 506 to provide the services pursuant to (1) above;

b. Medicaid requirements and are free from sanctions or exclusions or are otherwise not excluded from receiving medicaid reimbursement;

c. Medicaid office of inspector general screening requirements prior to service delivery and monthly thereafter;

d. All federal and state rules and requirements; and

e. All applicable regulatory and industry standards and maintains good standing as a provider agency;

(4) Submit claims to MMIS for rendered services and goods and ensure that records are maintained to verify that such services and goods were provided in the amount, scope, and frequency that was claimed;

(5) Reimburse subcontractors;

(6) Submit to the bureau within 30 days of the close of the state fiscal year, in addition to all other required reports and statements, an aggregate annual summary delineating OHCDS activities, including subcontractor names, amounts paid per subcontractor, nature of services, and number of individuals served by each subcontractor;

(7) Ensure that it maintains detailed records, available for the Department, its designee, or respective individual, at request for review at any time, to verify the purchase of services and goods outlined in (a) above; and

(8) Ensure that policies and practices do not:

a. Restrict any home and community based waiver services provider agency or provider to participate only through an OHCDS and that such arrangements are voluntary; and

b. Restrict individuals into securing services exclusively through an OHCDS.

He-M 504.07 Third Party Liability. All third party obligations shall be exhausted before medicaid may be billed, in accordance with 42 CFR 433.139.

He-M 504.08 Monitoring and Determination of Cost Effectiveness

(a) Each provider agency shall submit to the department annually, cost reporting information, which includes, but is not limited to, the following:

(1) A signed statement certifying that the information provided is true, accurate, and complete and acknowledging that penalties for any false statement or misrepresentation of material fact include fine or imprisonment;

(2) Financial statements and schedules for the reporting period;

(3) Expenses and personnel information; and

(4) Information reflective of the most recent desk audit or field audit adjustments made to the previous cost report, if applicable, with the exception of items still under appeal that have not been resolved.

(b) Complete, cost information shall be submitted:

(1) No later than 120 days after the end of the state fiscal year, unless an extension has been granted by the department, pursuant to (g)-(h) below; or

(2) By the former owner of the organization within 90 days of the sale of the entity when a change in ownership occurs.

(c) The department shall consider annual cost information reported to be incomplete if it is not provided in accordance with (a) above.

(d) The department shall audit the cost information reported not less than every 3 years.

(e) Any provider agency that submits incomplete cost reporting information shall be subject to penalties described in (i) below, unless an extension has been granted pursuant to (g)-(h) below.

(f) The department shall notify the provider agency of incomplete cost reporting information within 30 days of receipt of information. The timeframe for submitting complete cost reporting information as described in (b)(1)-(2) shall not change due to an incomplete report submitted by a provider agency.

(g) Requests for extensions for submitting cost reporting beyond the prescribed deadline shall:

(1) Be in writing;

(2) Be submitted to the department at least 10 business days prior to the due date, unless one of the circumstances identified in (h)(1)-(4) below occurs during the 10 business day prior to the due date, in which case the request shall be made by telephone within 10 business days of the occurrence;

(3) Clearly explain the necessity for the extension; and

(4) Specify the date on which the report shall be submitted.

(h) Approval of extensions shall be made only if it is determined that the delay is caused by circumstances beyond the provider agency's control, such as, but not limited to:

(1) Natural or manmade disasters;

(2) Strikes by employees;

(3) The death of an owner or senior management; or

(4) Any other instances where the agency can demonstrate a critical impact to operations.

(~~h~~i) Failure to submit the required cost information shall result in delayed or reduced payments effective on the first day of the month following the due date for filing of cost information, and for each successive month of delinquency in filing the completed cost information.

He-M 504.09 Utilization Review and Control. The department's program integrity unit shall monitor utilization of home and community based waiver services to identify, prevent, and correct potential occurrences of fraud, waste and abuse in accordance with in accordance with He-W 520, 42 CFR 455, and 42 CFR 456.

He-M 504.10 Fraud Detection and Investigation.

(a) In accordance with 42 CFR 455.14, the department's program integrity unit shall address complaints of medicaid fraud, waste, or abuse from any source or the identification of any questionable practices after analysis of paid claim history by conducting a preliminary investigation.

(b) Cases where potential fraud has been detected as a result of a preliminary investigation pursuant to (a) above, shall be referred for a full investigation to the appropriate agency, in accordance with 42 CFR 455.15.

(c) A full investigation and resolution shall be conducted in accordance with 42 CFR 455.16.

(d) The department shall recoup state and federal medicaid payments as permitted by 42 CFR 455, 42 CFR 447 and 42 CFR 456 for a provider agency's failure to maintain supporting records in accordance He-W 520 and He-M 504.

He-M 504.11 Provider and Provider Agency Staff Requirements.

(a) All providers shall meet the applicable provider training requirements in He-M 506.

(b) All provider agency staff, providers and contractors who have direct contact with individuals and families who are hired on or after August 1, 2023 shall be certified in person-centered thinking within their first year of employment and every 5 years thereafter.

(c) All provider agency staff, providers and contractors who have direct contact with individuals and families who were hired before August 1, 2023 shall be certified in person-centered thinking by March of 2025 and every 5 years thereafter.

(d) All provider agency staff, providers and contractors who have direct contact with individuals and families shall participate in at least one person-centered thinking course per year.

(e) Person-centered trainings and programs for (b)-(d) above shall consist of nationally recognized models and best practices identified by the National Center on Advancing Person-Centered Practices and Systems (NCAPPS).

(f) Providers of the following services are not subject to the requirements in (b)-(e) above:

(1) Assistive technology;

(2) Environmental and vehicle modification services;

(3) Individual goods and services;

(4) Crisis response services when providing indirect services;

(5) Non-medical transportation;

(6) Personal emergency response system;

(7) Community integration services;

(8) Respite;

(9) Wellness coaching; and

(10) Specialty services for assessments, consultations and evaluations.

(g) Providers who are also family members shall be subject to (b)-(c) at the discretion of the individual and guardian.

He-M 504.12 Suspension and Revocation of Provider Enrollment.

(a) If the department finds at any time that an enrolled provider repeatedly fails to meet their information sharing and billing obligations, or that their continued operations endanger the health, safety, or welfare of individuals, or the public, the department shall order the suspension or revocation of the enrolled provider.

(b) Suspension shall include receiving notice from the department of its intent to~~:~~

~~(1) Suspend licensure and certification, as appropriate, in accordance with He-M 507, He-M 1001, and He-P 814; or~~

s~~S~~uspend the claims or the provider enrollment ID for the specific service location associated with the violation or, if the violation is specific to all sites, the provider enrollment ID's for that provider agency.

(c) Revocation shall include receiving notice from the department of its intent to~~:~~

~~(1) Revoke licensure and certification, as appropriate, in accordance with He-M 507, He-M 1001, and He-P 814; or~~

~~(2)~~ r~~R~~evoke the provider enrollment ID for the specific service location associated with the violation or, if the violation is specific to all sites, the provider enrollment ID's for that provider agency.

(d) When a claim or provider enrollment suspension is issued, pursuant to (b) above, a plan of correction shall be issued by the department and will outline the conditions necessary for reinstatement including if the provider agency is permitted to continue to provide services during a claim suspension period.

(e) If the provider agency is permitted to continue providing services during the suspension period, claims shall be suspended until they have met the requirements of the corrective action plan; and

(f) If a provider agency is not permitted to continue providing services during the suspension period, the department shall deny claims for payment or other reimbursement requests for dates of service during the suspension period.

(g) Provider agencies shall remain under suspension until specified conditions for reinstatement as outlined in a corrective action plan issued pursuant to (d) above, are met and approved by the department.

(h) If the provider agency does not meet the conditions for reinstatement, as outlined in a corrective action plan, a recommendation shall be made for enrollment termination to the department's program integrity office.

(i) A provider agency may request an appeal, in accordance with He-C 200, regarding a proposed suspension or revocation of enrollment within 30 business days of the decision.

(j) The provider's enrollment status shall be suspended until the appeal determination is adjudicated.

(k) The revocation shall not become final until the period for requesting an appeal has expired, or, if the provider agency requests an appeal, until such time as the administrative appeals unit issues a decision upholding the department's decision.

(l) Appeals shall be submitted in writing, to the bureau administrator in care of the department's office of client and legal services ~~within 30 days following the date of notification of suspension or revocation~~.

He-M 504.13 Discontinuation of Services by Provider or Provider Agency.

(a) A provider agency that is not delivering services in conjunction with a residency agreement, in accordance with He-M 310.10(c), shall immediately provide the individual, guardian, and service coordinator, with a written ~~30~~90-day notice that clearly describes the basis for the provider agency's

decision to discontinue service provision and all reasonable efforts made by the provider agency to work with the participant and guardian to maintain such service provision.

(b) When written notice is issued in accordance with (a), services shall not end before the ~~30~~90-day notice period except by mutual agreement of the individual, guardian and provider agency.

(c) A provider agency that is delivering services in conjunction with a residency agreement, in accordance with He-M 310.10(c), shall follow the procedures for notification outlined in He-M 310.

(d) If a notice to discontinue services is issued in accordance with (a) above, the following actions shall occur:

(1) The provider agency shall transfer a copy of the individual's full service file to their service coordination agency within 2 business days;

(2) The service coordinator shall conduct service planning for any necessary transitions, in accordance with He-M 503, He-M 522, or He-M 524 within 5 business days; and

(3) The provider and provider agency shall participate in service planning and provision based on developments resulting from (2) above during the notice period outlined in (a) above or the transition period to a new provider agency.

(e) If a notice is issued in accordance with (b) above, the following shall occur:

(1) The provider agency shall transfer a copy of the individual's full service file to their service coordination agency within 2 business days;

(2) The service coordinator shall conduct service planning for any necessary transitions in accordance with He-M 310.10; and

(3) The provider agency shall provide the service coordinator with alternative residential options, if applicable, or demonstrate a good faith effort to provide this information.

(f) An individual or guardian may request an appeal of a notice provided in accordance with (a) above, unless the reason for discontinuation of services is due to the provider agency's cessation of services.

(g) Appeals shall be filed, in writing, to the bureau administrator in care of the department's office of client and legal services within 30 days following the date of notification of service discontinuation, in accordance with (a) above and He-C 200.

(h) If an appeal is requested, the following actions shall occur:

(1) Services and payments shall be continued as a consequence of an appeal for a hearing until a decision has been made; and

(2) If the provider agency's decision is upheld, services shall cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later.

He-M 504.14 Waivers.

(a) A provider applicant, area agency, provider agency, individual, guardian, or provider may request a waiver of specific procedures outlined in He-M 504 by completing and submitting the form titled "NH Bureau of Developmental Services Waiver Request" (July 2019 edition) in accordance with (b) and (c) below.

(b) A completed waiver request form shall be signed by the provider agency's executive director or designee recommending approval of the waiver.

(c) A waiver request shall be submitted to:

Bureau of Developmental Services
Hugh J. Gallen State Office Park
105 Pleasant Street, Main Building
Concord, NH 03301

(d) No provision of procedure prescribed by statue shall be waived.

(e) The request for a waiver shall be granted by the commissioner or his or her designee within 30 days if the alternative proposed by the requesting entity meets the objective or intent of the rule and it:

(1) Does not negatively impact the health or safety of the individual(s); and

(2) Does not affect the quality of services to individuals.

(f) Upon receipt of approval of a waiver request, the requesting entity's subsequent compliance with the alternative provisions or procedures approved in the waiver shall be considered compliance with the rule for which waiver was sought.

(g) Waivers shall be granted in writing for the minimum period necessary to accommodate the waiver request, with a specific duration not to exceed 5 years except as in (h)-(i) below.

(h) Any waiver shall end with the closure, termination, revocation or suspension of the related program or service.

(i) A requesting entity may request a renewal of a waiver from the bureau. Such request shall be made at least 30 days prior to the expiration of a current waiver.

APPENDIX A

RULE	SPECIFIC STATE STATUTES WHICH THE RULE IMPLEMENTS
He-M 504.01 – 504.03	RSA 171-A:3; 18, IV
He-M 504.04	RSA 171-A:3; 18, IV; 42 CFR § 455.410; 42 CFR § 447.10
He-M 504.05	RSA 171-A:3; 18, IV
He-M 504.06	RSA 171-A:3, 18, IV; 42 CFR § 447.10
He-M 504.07	RSA 171-A:3; 42 CFR § 433.139
He-M 504.08	RSA 171-A:3; 18, IV
He-M 504.09	RSA 171-A:3; 42 CFR § 455; 42 CFR § 456
He-M 504.10	RSA 171-A:3; 42 CFR § 455.14
He-M 504.11-504.14	RSA 171-A:3; 18, IV