Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.4

Submitted by:

New Hampshire Department of Health and Human Services, Division of Community Based Care Services, Bureau of Elderly and Adult Services
Submission Date: March 30, 2007
CMS Receipt Date *(CMS Use)*

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
Request for a five-year renewal of the New Hampshire Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI) Program.

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 waiver's 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.

1. Request Information

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. Waiver Title: Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI)

C. Type of Request *(select only one)*:

O	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
O	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
X	**Renewal (5 Years) of Waiver #**	0060.90.R3	
O	**Amendment to Waiver #**		

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

O	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2007

E.2 Approved Effective Date *(CMS Use):*

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 under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	X	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

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

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
X	Not applicable			

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.

Goal:

The goal of the Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI) Program is to enable eligible seniors and adults with disabilities to choose and access covered services in their communities that will allow them to postpone or avoid institutional placements.

Program Objectives:

1. Be the major vehicle for long term care systems transformation in New Hampshire.
   For the past 10 years, NH has been gradually rebalancing its long term care system to increase reliance upon community based services and decrease the use of institutional services. This has resulted in increased responsiveness to needs and preferences by the Program, and the development of strategies that support community based care, including acquiring grants for overall system transformation and quality assurance, and the statewide ServiceLink Resource Center (SLRC) network, which is the New Hampshire Aging and Disability Resource Center model.
2. Meet the federal and state cost effectiveness requirements.
   Over the past two years, NH has increased the use of technology in the management of the Program. Information gathered for the clinical assessment instrument is entered into a database to generate a list of participant needs, providing the clinical basis for Program support plans. Scheduled development will result in an automated link between the support plans and MMIS payment authorization.
3. Assess applicants, and reassess participants, in a clinically consistent and reliable manner.
   In 2006, NH implemented a clinical assessment instrument that is now used for every assessment and reassessment of clinical eligibility for long term care services, ensuring thorough and consistent assessments. Scheduled IT updates include an automated link between the instrument and payment through the MMIS
4. Support individual choice and preference of services through person-centered planning:
   The RN uses the assessment instrument to identify each individual's needs. Person-centered planning is subsequently facilitated by the case manager working with the individual. BEAS is including training about person-centered planning for staff and providers associated with the Program, including RNs, case managers, providers, and partners to ensure full and consistent understanding of this important concept.
5. Respond to demographic, participant preference and need, service availability and budgetary changes:
   NH is experiencing an unprecedented growth in the aging population as a percentage of the overall state population. The availability of trained staff has not kept pace with this change in demographics and we are looking for new ways to ensure service delivery for participants.

The New Hampshire Office of Energy and Planning updated its projections in November, 2006, that are based on the 2000 U.S. Census. In its most recent report, this Office stated: "In 2000, 12% of NH's population was 65 or older. The projections show this proportion may be about 14% in 2010 and about 28% in 2030."

Providers have reported to BEAS that it is difficult to hire an adequate supply of staff who have caregiving training and experience. This makes it more important to develop new supports, such as personal care workers who are not licensed, to serve the ECI population.

6. Ensure that covered services are consistently of a high quality and are provided by qualified providers
   The Quality Management Strategy (Appendix H) describes our plans to evaluate providers that participate in the HCBC-ECI Program.
7. Increase the ability of individuals to direct their care:
   BEAS anticipates that an increasing percentage of Program participants will want to direct their own care and services during this waiver cycle, and is working with stakeholders to further develop opportunities to self-direct.

Organizational Structure and Roles:

The Program is directed and managed by the Bureau of Elderly and Adult Services (BEAS). This Bureau is part of the Division of Community Based Care Services (DCBCS), which includes the Bureaus of Behavioral Health and Developmental Services, and is part of the single state agency. Registered nurses employed or contracted by BEAS conduct every participant clinical assessment. BEAS executes contracts with individual RNs who meet the qualifications of the RNs employed by the Bureau. These nurses are trained by and report to BEAS. Enrolled case management agencies use the information from the assessment as they work with participants to develop the Program support plan that authorizes Program services. Providers enrolled in accordance with He-E 801 serve participants in their homes or other community settings. SLRCs provide counseling to individuals and families requesting services, through either DHHS-funded or locally funded programs. If the individual chooses to apply for Medicaid, the SLRC assists with the application process.

Financial responsibility for the non-federal share of all long-term care expenses is shared equally by DHHS and County Governments. This includes institutional and community based services and results in the Counties having an equal incentive to support community based care. The County role does not extend to administration of the ECI Program, rather it is limited to a financial relationship that includes the agreement to exchange general Program information as requested.

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)*:

○	The waiver provides for participant direction of services. *Appendix E is required.*
X	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

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 Management Strategy. **Appendix H** contains the Quality Management 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)*:

X	Yes
○	No
○	Not applicable

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

○	**Yes** *(complete remainder of item)*
X	**No**

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 Improvement Act of 2004 (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) under age 21 when 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 amount, frequency and duration 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/MR.

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 §431.51, 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 Management. 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 Management Strategy specified in **Appendix H**.

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

1. Administrative rules: Operation of the Program requires DHHS to maintain an administrative rule that defines all eligibility, service and provider requirements. The administrative rulemaking process includes a public hearing before a rule goes before the Rules Committee, and the Committee meeting itself is public.
2. Budget authorization by the Legislature: The process through which DHHS explains its proposed budget for the Program includes testimony to the Legislature, which is open to the public.
3. ServiceLink Resource Centers (SLRCs): There are SLRC offices in every county of the state. Individuals, family members and caregivers can stop in or call with any questions or concerns about community based care, including care provided through the Program.
4. Case Managers: Case managers are enrolled providers that are responsible for periodically communicating with each participant to assess his/her satisfaction with the services being provided, and the adequacy of those services. Case managers report any problems identified to BEAS.
5. Provider Meetings: BEAS is in regular contact with providers of several services at which time providers may share Program improvement ideas.
6. System Transformation Grant (STG): Several members of the general public have been engaged in discussions through STG work groups. This provides opportunities to hear from people not directly involved in the Program.
7. Real Choices Quality Assurance and Improvement Grant: Grant activities are overseen by a Quality Council that includes consumers, providers and staff.
8. DHHS Commissioner's Quality of Life Council: This Council, which includes elected officials, nursing facility providers, service consumers and staff, meets regularly. One stated goal is to identify ways that providers can include residents in program discussions.
9. SCOA: The State Committee on Aging is committed to enhancing community based services and meets with DHHS every month.

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 as 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:

First Name:	Susan J.L.
Last Name	Lombard
Title:	Bureau of Elderly and Adult Services, Director of Operations
Agency:	New Hampshire Department of Health and Human Services, Division of Community Based Care Services, Bureau of Elderly and Adult Services
Address 1:	129 Pleasant Street
City	Concord
State	New Hampshire
Zip Code	03301
Telephone:	603-271-3452

E-mail	slombard@dhhs.state.nh.us
Fax Number	603-271-4643

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
City	

8. Authorizing Signature

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

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature State Medicaid Director or Designee **Date**

First Name:	John A.
Last Name	Stephen
Title:	Commissioner
Agency:	Department of Health and Human Services
Address 1:	129 Pleasant Street
City	Concord
State	New Hampshire
Zip Code	03301
Telephone:	603-271-4331
E-mail	jstephen@dhhs.state.nh.us
Fax Number	603-271-4912

Appendix A: Waiver Administration and Operation

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

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

X	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; do not complete Item A-2*):		
	○	The Medical Assistance Unit *(name of unit)*:	
	X	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	Division of Community Based Care Services (DCBCS), Bureau of Elderly and Adult Services (BEAS)
○	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. 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.*		

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, 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:

N/A

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

X	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the 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.*
	BEAS contracts with ServiceLink Resource Centers (SLRCs), non-profit agencies located in each county, to provide information, outreach, resource development and education to Participants, providers and the general public. SLRCs were established under RSA 151-E: 5. The contracted Medicaid fiscal agent, ElectronicData Systems Federal (EDS) performs provider recruitment.
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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 *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *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*:
X	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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:

BEAS is responsible for directly monitoring the performance of the SLRCs.

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:

BEAS manages the annual planning cycle, publishes monthly management reports, organizes and conducts regularly scheduled program review, planning, quality assurance, and leadership meetings, monitors and measures program effectiveness on a quarterly basis, publishes an annual report on program effectiveness and operations performance, prepares annual budgets and monitors program expenditures and establishes annual goals and objectives.

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.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	X	☐	X SLRCs	☐
Assist individuals in waiver enrollment	X	☐	X SLRCs	☐
Manage waiver enrollment against approved limits	X	☐	☐	☐
Monitor waiver expenditures against approved levels	X	☐	☐	☐
Conduct level of care evaluation activities	X	☐	☐	☐
Review participant service plans to ensure that waiver requirements are met	X	☐	☐	☐
Perform prior authorization of waiver services	X	☐	☐	☐
Conduct utilization management functions	X	☐	☐	☐
Recruit providers	X	☐	X SLRCs & EDS	☐
Execute the Medicaid provider agreement	X	☐	X EDS	☐
Determine waiver payment amounts or rates	X	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	X	☐	X EDS & SLRCs train providers	☐

Appendix B: Participant Access and Eligibility

Appendix 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 a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup			Minimum Age	Maximum Age	
					Maximum Age Limit: Through age –	No Maximum Age Limit
X	**Aged or Disabled, or Both** *(select one)*					
	X	**Aged or Disabled or Both – General** *(check each that applies)*				
		X	Aged (age 65 and older)			X
		X	Disabled (Physical) (under age 65)	18 years	64 years	
		X	Disabled (Other) (under age 65)	18 years	64 years	
	O	**Specific Recognized Subgroups** *(check each that applies)*				
		☐	Brain Injury			☐
		☐	HIV/AIDS			☐
		☐	Medically Fragile			☐
		☐	Technology Dependent			☐
O	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*					
	☐	Autism				☐
	☐	Developmental Disability				☐
	☐	Mental Retardation				☐
O	**Mental Illness** *(check each that applies)*					
	☐	Mental Illness (age 18 and older)				☐
	☐	Serious Emotional Disturbance (under age 18)				

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

Individuals must require assistance due to a chronic medical diagnosis and/or frailty associated with aging, including Alzheimer's Disease or other types of dementia, and meet clinical eligibility requirements established in RSA 151-E:3 I. Individuals who would otherwise require the services of an IMD, and are of the age of 21 through 64 (per 1905 (a) 28 (B) of the Act), or who would otherwise require the services of a psychiatric residential treatment facility as defined in 42 CFR 483.352, are not eligible.

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)*:

X	Not applicable – There is no maximum age limit
C	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

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)*:

○	**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
	○ Other *(specify)*: _____
X	**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: $ _____
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following 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: _____ %
	○ Other – *Specify:*

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:

Each prospective participant is clinically evaluated by an RN employed by the State, using a standardized assessment instrument, to determine if s/he is clinically eligible and to identify the individual's needs. A determination is made whether the individual's needs can be met through the Program within the institutional cost limit based on this medical assessment.

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.
X	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:
	If a Participant's condition or circumstances change after being accepted to the Program, an RN employed or supervised by the State conducts a clinical reassessment of his/her functional needs. The Case Manager and/or RN talks with the Participant about how his/her needs can be met, including what informal or community supports may be available. Additional Program services may be authorized if they are required to maintain health and safety. Through the risk assessment process and Elder-Wrap meetings, BEAS engages community partners and the Participant in the planning and delivery of appropriate services. The Elder-Wrap process brings together professionals from various community service organizations and provider agencies and case managers to discuss specific challenges they have in common, with the purpose of developing solutions they can effect as a team.
X	Other safeguard(s) *(specify)*:
	If the Participant requires services than are greater than what can be allowed, the case manager and Participant discuss how his/her needs can be met. If the Participant lives in his/her own home or apartment, receiving services through alternative settings, such as Residential Care and Adult Family Care, is considered. Placement in a nursing facility is offered if none of the other alternatives meet the Participant's needs or preferences.

Appendix B-3: Number of Individuals Served

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	3,294
Year 2	3,589
Year 3	3,906
Year 4 (renewal only)	4,254
Year 5 (renewal only)	4,632

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)*:

X	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 (renewal only)	
Year 5 (renewal only)	

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)*:

X	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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):*

X	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:*

X	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 applicants is done through the eligibility process identified in He-E 801. The waiver provides for the entrance of all eligible persons. Enrollment is completed as soon as the eligibility process is completed and the applicant is found eligible. There is no waiting list for this Program.

Attachment #1 to Appendix B-3
Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. Waiver Years Subject to Phase-In/Phase-Out Schedule *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

O	§1634 State
O	SSI Criteria State
X	209(b) State

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		
X	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
X	Optional State supplement recipients		
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	O	100% of the Federal poverty level (FPL)	
	O	%	of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
X	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act): Limited to those aged 18 through 64 years of age		
☐	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)		
X	Medically needy		
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
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*			
O	**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.		
X	**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.*		
	O	All individuals in the special home and community-based waiver group under 42 CFR §435.217	
	X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:	
		X	A special income level equal to (select one):
		O	300% of the SSI Federal Benefit Rate (FBR)

		○	%	of FBR, which is lower than 300% (42 CFR §435.236)
		X	$1250/mo	which is lower than 300%
	X	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
	X	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%
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		

Appendix B-5: Post-Eligibility Treatment of Income

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(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 ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
X	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-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		C	300% of the SSI Federal Benefit Rate (FBR)	
		C	%	of the FBR, which is less than 300%

		C	$	which is less than 300%.
	O		%	of the Federal poverty level
	O	Other (specify):		
O	The following dollar amount:		$	If this amount changes, this item will be revised.
O	The following formula is used to determine the needs allowance:			

ii. Allowance for the spouse only (*select one*):	
O	SSI standard
O	Optional State supplement standard
O	Medically needy income standard
O	The following dollar amount: $200 If this amount changes, this item will be revised.
O	The amount is determined using the following formula:
O	Not applicable *(see instructions)*
iii. Allowance for the family *(select one)*:	
O	AFDC need standard
O	Medically needy income standard
O	The following dollar amount: $200 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.
O	The amount is determined using the following formula:
O	Other (specify):
O	Not applicable *(see instructions)*
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:*	
O	Not applicable *(see instructions)*
O	The State does not establish reasonable limits.
O	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 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*):		
C	The following standard included under the State plan *(select one)*	
	O	The following standard under 42 CFR §435.121:
	O	Optional State supplement standard
	O	Medically needy income standard
	O	The special income level for institutionalized persons *(select one)*

	■	○	300% of the SSI Federal Benefit Rate (FBR)	
	■	○	%	of the FBR, which is less than 300%
	■	○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
X	The following formula is used to determine the needs allowance:			
	$1600/month is allowed for living expenses for participants living in their own homes. $1000/month is allowed for living expenses for participants who live in the homes of their caregivers. Up to $300 is allowed for court-ordered guardianship services. $56 plus the cost of room and board is allowed for the monthly personal needs of participants living in residential care facilities or adult family care homes. This amount is established by law as the minimum personal needs allowance (RSA 167:27-a), and is periodically adjusted by the Department.			

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

○	The following standard under 42 CFR §435.121		
○	Optional State supplement standard		
○	Medically needy income standard		
X	The following dollar amount:	$200	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

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

○	AFDC need standard		
○	Medically needy income standard		
X	The following dollar amount:	$200	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:		
○	Other (specify):		
○	Not applicable *(see instructions)*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

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)*
X	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances 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)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - C 300% of the SSI Federal Benefit Rate (FBR)
    - C % of the FBR, which is less than 300%
    - C $ which is less than 300%.
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

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

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ○ Not applicable *(see instructions)*

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

- ○ AFDC need standard
- ○ Medically needy income standard
- ○ The following 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:
- ○ Other *(specify)*:
- ○ Not applicable *(see instructions)*

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)*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. 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:			
	○	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)		
		○	%	of the FBR, which is less than 300%	
		○	$	which is less than 300% of the FBR	
	○	%	of the Federal poverty level		
	○	Other (specify):			
○	The following dollar amount:	$	If this amount changes, this item will be revised.		
○	The following formula is used to determine the needs allowance:				

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

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*			

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

○	AFDC need standard		
○	Medically needy income standard		
○	The following 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:		
○	Other (specify):		

○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

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)*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

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, a family allowance, and an amount for incurred expenses for medical or remedial care.

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		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*)**:**		

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

○	Allowance is the same
○	Allowance is different. Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:

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)*
○	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-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 waiver 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 *(insert number):*	
	1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	X	The provision of waiver services at least monthly
	O	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*):

X	Directly by the Medicaid agency
O	By the operating agency specified in Appendix A
O	By an entity under contract with the Medicaid agency. *Specify the entity*:
O	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:

Registered nurse holding a NH license who is employed or contracted by the Department to perform clinical assessments.

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

Individuals must require assistance due to a chronic medical diagnosis and/or frailty, such as Alzheimer's Disease or other types of dementia, and meet clinical, level of care, eligibility requirements established in RSA 151-E:3 I, which are: To be clinically eligible for Medicaid coverage of long term care, a person must require 24-hour care for one or more of the following purposes: medical monitoring and nursing care; restorative nursing or rehabilitative care; medication administration requiring medical or nursing intervention; or assistance with two or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence. (RSA 151-E:3) The Medical Eligibility Determination (MED) instrument is used for every applicant to long term care, including institutional and community based services. Individuals who would otherwise require the services of an IMD, and are of the age of 21 through 64, are not eligible, (per 1905 (a) 28 (B) of the Act), or who would otherwise require the services of a psychiatric residential treatment facility as defined in 42 CFR 483.352, are not eligible.

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)*:

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
O	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The registered nurse visits the applicant/participant in his/her home (or hospital if the applicant is receiving acute care) and completes the MED.

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)*:

O	Every three months
O	Every six months
X	Every twelve months
O	Other schedule (*specify*):

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

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
O	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

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)*:

Current status information is constantly available to all RNs electronically through the BEAS-developed and maintained electronic case tracking system. This system displays information that clearly indicates the person's status in the application or renewal process.

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 §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Medical records are retained by BEAS and case management agencies.

Appendix 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).

Long term support counselors at the SLRCs receive comprehensive training and supervision by BEAS concerning the importance of each applicant being accurately informed about his/her ability to choose community based care. They explain the range of available long term care services to every applicant. The appeal process is explained, and written information is provided, upon application. During the clinical assessment visit, the RN gives the individual a brochure that describes the appeal process and explains that HCBC-ECI services are available as an alternative to institutional care. This explanation has been improved through the addition of several questions, developed by a geropsychiatrist that confirm individual preference and understanding with respect to choice and decision making. Each applicant must sign a consent form that states that s/he is choosing community based services instead of institutional services. This is reviewed at each reassessment.

b. Maintenance of Forms. Per 45 CFR §74.53, 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.

Forms are retained by BEAS and case management agencies.

Appendix B-8: Access to Services by Limited English Proficient 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, Aug 8, 2003):

DHHS reaches individuals with limited English Proficiency (LEP) by hiring interpreters and by providing a variety of communication access devices throughout the application process as needed.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	X	
Home Health Aide	X	
Personal Care	X	
Adult Day Health	X	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	X	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Adult Family Care (previously Adult Foster Care)
b.	Adult in-home services
c.	Assistive technology services
d.	Chore
e.	Community transition services
f.	Consolidated services
g.	Environmental accessibility services
h.	Home delivered meals

i.	Personal emergency response systems
j.	Residential care services
k.	Shared housing
l.	Skilled Nursing services
m.	Specialized Medical Equipment Services
n.	Supportive Housing

Extended State Plan Services *(select one)*

X	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:

Supports for Participant Direction *(select one)*

○	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
X	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	
Other Supports for Participant Direction *(list each support by service title)*:		

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

X	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.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not 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:

NH enrolls private agencies that are licensed as case management providers to provide targeted case management services in accordance with the approved State Plan and NH administrative rules and the participant's comprehensive care plan.

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)*:

X	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	Criminal background checks at the State level are required as part of the licensing and certification process for personal care service workers, adult family care providers, residential care providers, adult day providers, home health providers, shared housing providers, and the home delivered meals providers, and is ensured by the Bureau of Licensing and Certification.
○	**No**. Criminal history and/or background investigations are not required.

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)*:

○	**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):
X	**No**. The State does not conduct abuse registry screening. **NH recently adopted a law to expand the functionality of the abuse registry, which will support screening in the future. This waiver will be amended when abuse registry screenings are implemented.**

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

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
X	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Residential Care Facilities	Residential Care Services	Established by license

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Larger residential care facilities maintain a home-like atmosphere through their use of activity and socialization areas and through regular trips to community locations, such as libraries, to the extent that resident health allows. Many residential care facilities were private homes before becoming licensed, and all are designed to appear home-like from the outside. Shared bedrooms do not accommodate more than two people. Licensing requirements include activities to promote intellectual, social and spiritual well-being.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type Residential Care Facilities
Admission policies	X
Physical environment	X
Sanitation	X
Safety	X
Staff : resident ratios	X
Staff training and qualifications	X
Staff supervision	X
Resident rights	X
Medication administration	X
Use of restrictive interventions	X
Incident reporting	X
Provision of or arrangement for necessary health services	X

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:

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:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
O	**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-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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.
X	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered.
	The State will pay relatives who are not legally responsible for the Participant and who do not have power of attorney, and who are employed by an enrolled provider. The State does not pay legal guardians. Allowable relatives may be employed by an enrolled provider to perform authorized waiver services for which they are qualified. Payment is made through enrolled providers and not directly to family members. The enrolled provider ensures that employees are qualified and that payment is made only for services rendered. Services that may be rendered by a relative who is not legally responsible, when the relative is employed by an enrolled provider, are: Adult In Home Care, Adult Medical Day, Chore, Community Transition, Home Health Aide, Homemaker, Personal Care, Respite, Skilled Nursing, Shared Housing, and Supportive Housing.
○	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:

Provider requirements for all services are specified in He-E 801. The Medicaid fiscal agent refers to that rule whenever a new provider requests enrollment. All applicant providers that meet the specified criteria are enrolled. All providers must be registered and bonded to do business in NH

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification					
Service Title:	Adult Family Care (formerly titled Adult Foster Care)				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Personal care and services, homemaker, chore, attendant care and companion services, and medication oversight (to the extent permitted by State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult Family Care (AFC) services are provided to participants who receive them in conjunction with residing in the home. There shall be no more than 2 unrelated individuals living in the home, including participants in the Program. Separate payment shall not be made for homemaker or chore services to participants receiving AFC, as those services are integral to and inherent in the provision of AFC.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications					
Provider Category(s) *(check one or both)*:	X	Individual. List types:	☐	Agency. List the types of agencies:	
	Private homes that are licensed or certified when applicable				
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate	Other Standard *(specify)*
Adult family care	RSA 151:2	RSA 151:2	These private homes are licensed or certified, depending on their size, when applicable.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult family care	Bureau of Licensing and Certification or BEAS	Annual

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Adult In-Home Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope):	
Non-medical care, supervision and socialization provided to isolated individuals to prevent institutionalization. When specified in the comprehensive care plan, this may include meal preparation, light housekeeping, laundry and shopping which are essential to the health and welfare of the participant. In-home services do not include hands-on care. Home health agencies that provide this service are not required to be certified to provide Medicare services.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Agency licensed by the State under RSA 151:2, for home care services
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home care or Homemaker Agencies	Home Health or Homemaker RSA 151:2-b		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home care or Homemaker Agencies	Bureau of Licensing and Certification	Annual

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Adult Medical Day Services				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Adult medical day programs provide a protective environment for impaired or isolated Participants who are at risk of institutionalization. Services include an array of social and health care services and provides day-time respite for primary caregivers. Services are furnished on a regularly scheduled basis, for one or more days per week. Meals provided as part of this service shall not constitute a "full nutritional regimen." Transportation services are not included in this service and are not included in the reimbursement for this service.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Provider Specifications					
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:	
				Adult Medical Day	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative	
Provider Qualifications (*provide the following information for each type of provider)*:					

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Medical Day	Adult Medical Day, RSA 151:2		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Medical Day	Bureau of Licensing and Certification	Annual

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Assistive Technology

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope):

Assistive technology support services are intended to help Participants in the selection, acquisition and use of assistive technology devices. This service provides consultation, evaluation, coordination, training and technical assistance as well as designing, fitting and customizing devices. This service does not cover the actual purchase of the devices.

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

Services must be prior authorized by BEAS, and are limited to a one-time $15,000/participant. This limitation is applied to this service independently of the $15,000/participant limits on other services.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Durable medical equipment company with a licensed occupational or physical therapist.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Durable medical equipment company			Company must be registered with the State to provide occupational and/or physical therapy.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Durable medical equipment organization	Bureau of Elderly and Adult Services	Prior to service delivery

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Chore Services				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Services necessary to maintain a clean, safe and sanitary environment. This service includes heavy household chores, such as washing floors, windows and walls, repositioning furniture, cleaning gutters or repairing screens, and tacking down loose rugs or tiles in order to provide safe access and egress. These services will be provided only in cases where neither the Participant nor anyone else in the household is capable of performing the tasks or financially able to pay for the service. These services will not be covered when a relative, caregiver, landlord, community agency, or other third party is responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined before any services are authorized.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications					
Provider Category(s) *(check one or both)*:	**X**	Individual List types:	X	Agency List the types of agencies:	
	All qualified businesses		All qualified businesses		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative	
Provider Qualifications (*provide the following information for each type of provider)*:					

Provider Type:	License	Certificate	Other Standard *(specify)*
Businesses established to provide the identified service(s)			Providers must enroll and hire employees who are over 16 years of age.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Chore Provider	BEAS	Prior to service delivery

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Community Transition Services				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
One-time set-up expenses for an individual who transitions from an institution to his/her own home or apartment in the community. Expenses must be reasonable and necessary for an individual to establish his or her basic living arrangement. Expenses may include security deposits required to obtain a lease, essential furnishings, including but not limited to bedding, pots and pans, dishes, cutlery, deposits to ensure utility access, or one-time cleaning costs prior to occupancy.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Services must be prior authorized by BEAS and are limited to $1000/person per transition. This limit is independent of other service limits. This service does not include payment for rent.					
Provider Specifications					
Provider Category(s) *(check one or both)*:	X	Individual. List types:		Agency. List the types of agencies:	
	All qualified providers, including providers enrolled to provide Chore, Consolidated or Personal Care services.				
Specify whether the service may be provided by *(check each that applies):*		Legally Responsible Person	X	Relative	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*		
OQA		OQA: RSA 161:I	Potential providers must submit a bid, be approved by BEAS, and be an enrolled provider.		
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:		Frequency of Verification		
	BEAS		Prior to service delivery		
Service Delivery Method					
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed	

Service Specification					
Service Title:	Consolidated Services				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Services that are linked to provide supportive care to participants in community and residential care settings to help the individual achieve and maintain independence and well being. Services may include transportation to non-medical appointments, personal care services, housekeeping, general supervision, and social programs to promote health and well-being. Services provided by an Other Qualified Agency (OQA) may be participant-directed.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications					
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:	
			Residential Care, Home care or OQA Agencies		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Other Qualified Agency		OQA: RSA 161-I	
Home Health Agency	Home Health RSA 151:2		
Residential care	Residential care RSA 151:2		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Other Qualified Agency	BEAS	Annual
Residential care	Bureau of Licensing and Certification	Annual
Home care agency	Bureau of Licensing and Certification	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Environmental Accessibility Services (formerly titled "home modifications")				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications. * New Name				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Physical adaptations to the Participant's home, required by the comprehensive care plan, which are necessary to ensure the health, welfare and safety of the Participant or which will enable the Participant to function with greater independence and, without which, the Participant would require institutionalization. Services may include the installation of grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric equipment or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the health and welfare of the Participant. Adaptations or improvements that are of general utility, add to the square footage of the home, or are not of direct medical or remedial benefit to the Participant, such as carpeting, roof repair, or air conditioning, are not included in this service.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Services must be prior authorized by BEAS, and are limited to a one-time $15,000/Participant. This limitation is applied to this service independently of specified limits on other services (e.g.: Assistive Technology).					
Provider Specifications					
Provider Category(s) *(check one or both)*:	X	Individual. List types:	☐	Agency. List the types of agencies:	
	Potential providers must submit a bid, be registered and bonded, and be enrolled in the Medicaid Program.				
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type:	License	Certificate	Other Standard *(specify)*		
DME Providers Accessibility Contractors			Potential providers must submit a bid, be registered and bonded to do business in New Hampshire, be approved by BEAS, and be an enrolled Medicaid provider.		
Verification of Provider Qualifications					
Provider Type:		Entity Responsible for Verification:		Frequency of Verification	
Environmental Accessibility Services		BEAS		Prior to service delivery	
Service Delivery Method					
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed	

Service Specification	
Service Title:	Home-Delivered Meals

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

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

Service Definition (Scope):

This service provides the delivery of a nutritionally balanced meal to the Participant's home, that provides at least one-third of the recommended dietary allowances established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, as well as the Dietary Guidelines for Americans issued by the Secretary of the US Department of Health and Human Services and Agriculture. Further, emergencies or potentially harmful situations encountered during the delivery are reported to the appropriate manager.

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				All qualified nutrition providers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Nutrition	Nutrition		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Nutrition	Bureau of Food Protection or, in towns that self-inspect, by the Health Inspector	Annual

Service Delivery Method

Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Home Health Aide				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Services defined in 42 CFR 440.70, that are provided in addition to home health aide services furnished under the approved State Plan. Home health aide services under the waiver differ in provider type (including provider training and qualifications) from home health aide services in the State Plan. The difference from the State Plan is that the employing agency is licensed by the State to direct or provide therapeutic services in accordance with administrative rule He-P 809.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Provider Specifications					
Provider Category(s)	☐	Individual. List types:	X	Agency. List the types of agencies:	
			Agency licensed by the State under RSA 151:2, for home care services		
Specify whether the service may be provided by *(check each that applies):*		Legally Responsible Person	X	Relative	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*		
Home care	RSA 151:2-b		Home Health Aides are individually licensed.		
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:		Frequency of Verification		
Home care	Bureau of Licensing and Certification		Annual		
Service Delivery Method					
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed	

Service Specification					
Service Title:	Homemaker				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Non hands-on general household services, such as light cleaning or meal preparation, provided by homemakers who are employed, trained and supervised by licensed home health agencies.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Provider Specifications					
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:	
				Home Health Agency	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*		
Home Health	Home Health, RSA 151:2-b				
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:	Frequency of Verification			
Home health	Bureau of Licensing and Certification	Annual			
Service Delivery Method					
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed	

Service Specification					
Service Title:	Personal Care				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Services may include light housekeeping chores if specified in the comprehensive care plan. A range of services to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance, such as with activities of daily living, including eating, bathing, dressing, and personal hygiene, or cuing to prompt a participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services including skilled or nursing care and medication administration are allowed to the extent permitted by law.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications					
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:	
				Other Qualified Agency (OQA) and	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative	

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home care	RSA 151:2		
OQA		OQA: RSA 161:I	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home care	Bureau of Licensing and Certification	Annual
OQA	Bureau of Elderly and Adult Services	Annual

Service Delivery Method				
Service Delivery Method		Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Personal Emergency Response Systems				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
An electronic device that enables participants at high risk of institutionalization and who are alone for periods of time to summon help in an emergency. The Participant may also wear a portable "help" button to allow for mobility. The system is connected to the Participant's telephone and programmed to signal a response center when activated. The response center is staffed by trained professionals 24 hours/day, seven days/week.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Services are limited to participants who live alone or who are alone for significant parts of the day who would otherwise require extensive supervision.					
Provider Specifications					
Provider Category(s) *(Check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:	
				Emergency response system providers	
Specify whether the service may be provided by *(check each that applies):*	⊏	Legally Responsible Person	⊏	Relative/Legal Guardian	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*		
Emergency response			Must be established emergency response business.		
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:		Frequency of Verification		
Emergency Response	BEAS		Upon enrollment		
Service Delivery Method					
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed	

Service Specification					
Service Title:	Residential Care Facility Services				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Supportive services provided in a licensed facility, including: Assistance with activities of daily living and incidental activities of daily living; Personal care; 24 hour supervision; Incontinence management; Dietary planning; Non-emergency transportation to/from medical and non-medical services and activities; and any other activities that promote and support health and wellness, dignity and autonomy within a community setting. Residential care facility residents do not have their own, lockable living units. When a participant chooses residential care services, the selection of service provider is guided by the amenities offered at the different locations. Some providers have more single rooms and others have more shared rooms, so the participant's choice of provider may involve whether s/he wants his/her own room or would like a shared bedroom and bathroom. Shared bedrooms do not accommodate more than two people. Personal care, transportation and other services listed above as part of this service are included in the rate paid to the provider and are not separately billed.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Residential Care Facility
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Residential care	Residential Care, RSA 151:2		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Care	Bureau of Licensing and Certification	Annual

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Respite Care				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
O	Service is included in approved waiver. The service specifications have been modified.				
O	Service is not included in the approved waiver.				
Service Definition (Scope):					
Direct and indirect care provided to participants unable to care for themselves, furnished on a short term basis because of the absence of, or need for relief of, the usual caregiver(s). Services may be provided in the Participant's home, in a licensed residential care facility or in a nursing facility.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Services are limited to the equivalent of 20, 24 hour days of care per state fiscal year/participant. Services are provided in units of time that are determined appropriate by the caregiver and case manager.					
Provider Specifications					
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:	
			Home care, Residential Care Facility, Other Qualified Agency, Nursing Facility		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*		
Home Health	Home Health, RSA 151:2-b				
Residential care	Residential care, RSA 151:2				
OQA		OQA, RSA 161:I			
Nursing facility	Nursing Facility, RSA 151:2				
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:	Frequency of Verification			
Home health	Bureau of Licensing and Certification	Annual			
Residential care	Bureau of Licensing and Certification	Annual			
OQA	BEAS	Annual			
Nursing facility	Bureau of Licensing and Certification	Annual			
Service Delivery Method					
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed	

Service Specification					
Service Title:	Shared Housing Services				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
O	Service is included in approved waiver. The service specifications have been modified.				
O	Service is not included in the approved waiver.				
Service Definition (Scope):					
Personal care and services, homemaking, chore, attendant care and companion services, and medication oversight (to the extent permitted by State law) provided in a Participant's private home by a principal care provider who also lives in the home. The caregiver may be a relative but may not be a child, an adult child or spouse, and must be employed by a licensed agency. Separate payment shall not be made for personal care, homemaker or chore services to participants receiving Shared Housing Services, as those services are integral to and inherent in the provision of Shared Housing Services.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home care or Other Qualified Agency
Specify whether the service may be provided by:	☐	Legally Responsible Person	X	Relative

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate	Other Standard *(specify)*
Home care	151:2-b		
OQA		OQA: RSA 161:I	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home care	Bureau of Licensing and Certification	Annual
OQA	Bureau of Elderly and Adult Services	Annual

Service Delivery Method				
Service Delivery Method		Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Skilled Nursing				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
O	Service is included in approved waiver. There is no change in service specifications.				
X	Service is included in approved waiver. The service specifications have been modified.				
O	Service is not included in the approved waiver.				
Service Definition (Scope):					
Services listed in the comprehensive plan of care that are within the scope of the state's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. This service provides intermittent skilled nursing services on a long term basis.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Agency licensed by the State under RSA 151:2, for home care services
Specify whether the service may be provided by:		Legally Responsible Person	X	Relative

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
State licensed Home care agencies	RSA 151:2		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home care	Bureau of Licensing and Certification	Annual

Service Delivery Method				
Service Delivery Method:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification					
Service Title:	Specialized Medical Equipment Services				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
X	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope):					
Specialized Medical Equipment and Supplies include: (a) devices, controls or appliances that are specified in the comprehensive care plan which enable participants to increase their ability to perform activities of daily living; (b) devices, controls or appliances that are specified in the comprehensive care plan to perceive, control or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Purchases must be prior authorized by the Bureau of Elderly and Adult Services, and are limited to $15,000/person/year					

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Durable medical equipment and supply providers enrolled as Title XIX providers.
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Specialized Medical Equipment Services			Enrolled in the NH Medicaid Program to provide medical equipment or supplies.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Medical Equipment Services	Title XIX Fiscal Agent	At enrollment

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Supportive Housing Services (formerly two services: Assisted Living and Congregate Care)

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

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

Service Definition (Scope):

Services provided by a licensed agency in apartments located in publicly funded apartment buildings that include: Personal care services, including assistance with activities of daily living and instrumental activities of daily living; Supervision; Medication reminders; and other supportive activities as specified in the comprehensive care plan or which promote and support health and wellness, dignity and autonomy within a community setting. This service was renamed to avoid conflict with a new state law. Personal care, medication reminders and other services identified as part of this service are included in the rate paid to the provider and can not be separately billed.

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Agency licensed by the State under RSA 151:2, for home care services

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	X	Relative

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home care	RSA 151:2-b		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home care	Bureau of Licensing and Certification	Annual

Service Delivery Method

Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	X	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*
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; and, (f) how participants are notified of the amount of the limit.

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

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Comprehensive Care Plan

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

X	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-3)
X	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Case manager employed by an agency enrolled to provide Targeted Case Management
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

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

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

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.

(a) The long term support counselor at the SLRC explains the full array of long term supports and services that are available to each applicant and/or family or caregiver, participant rights, and learns the applicant's preferences and needs. The BEAS legal office offers participant rights training sessions on a quarterly basis. (b) The applicant/participant is encouraged to identify everyone who s/he would like present at the planning meeting.

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):

(a) In accordance with He-E 801, the comprehensive care plan for each participant is developed by the participant, the case manager, the guardian or representative if there is one, and any family members chosen by the individual to participate. BEAS reviews and approves each plan. (b) The plan development process begins with the clinical assessment interview conducted by the RN at which time the Program is explained and the individual's needs and preferences, life and service goals, and health status are discussed. The fact that the individual has freedom of choice of provider is explained. This freedom of choice includes the selection of the case management agency. The nurse also explains that the individual may choose to change case managers at any point, and that the only service that the case manager provides is comprehensive care plan development and then oversight of plan implementation. Case managers do not provide other direct services. (c) After the individual's need have been identified, and s/he has been found eligible to participate in the Program, a case manager meets with the participant to learn his/her preferences and what informal (unpaid) supports are available. The case manager explains what services are available in the community to meet the participant's needs. (d) As part of participant-centered planning, the case manager first seeks to understand the participant's preferences, support system and lifestyle. To the extent possible and preferred by the participant, ongoing sources of support are encouraged to continue. Services available through the Program are identified when needed to fill needs that are not already being met. Case management Supervisors review a sample of case files to assure the accuracy of the assessment and monitoring processes, and the appropriateness of service plans. (e) The case manager coordinates waiver and State Plan services, and assists the participant in arranging for services and activities outside of the Medicaid Program. The case manager works with the participant to decide how services should be scheduled. (f) The case manager meets with the participant, and others as appropriate, for plan development, implementation and monitoring. The case manager and the participant determine how often the participant and case manager will meet, within guidelines established by BEAS, to monitor service delivery and participant satisfaction. They also discuss how the participant can contact the case manager between meetings if s/he has questions or concerns, and that the comprehensive care plan can be adjusted if the participant finds that the services are not addressing his/her needs and preferences, or if his/her needs change. The comprehensive care plan is not implemented without written

agreement from the participant (or guardian). (g) The plan is reviewed with the nurse at least annually, or more often at the request of the participant, family or guardian, case manager, or when the participant's needs change. A complete clinical assessment is conducted as part of the review.

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.

Both the RN and the case manager assess potential risks through participant interviews. These assessments include reviewing conditions in the home that may be unsafe, health conditions and the participant's ability to manage them safely, relationships with family, caregivers and significant others, and an evaluation of the potential for the participant to be the victim of abuse, neglect, exploitation, or self neglect. DCBCS is in the process of further developing its risk management plan that will be used by every waiver program. Further, the BEAS Adult Protective Program receives and responds to reports of abuse, neglect, exploitation and self-neglect of incapacitated adults 18 and over, in accordance with RSA 161-F: 42-57, the Adult Protection Law. An important risk assessment and mitigation resource is the Elder-Wrap system. This is a system of workgroups that are organized on a regional basis and include professionals from multiple provider types. These groups are convened regularly and as needed in all areas of the state. By including a wide range of professionals, the groups are able to identify solutions to unusual and complex issues affecting the health and welfare of participants.

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.

Long term support counselors at the SLRCs receive training and supervision by BEAS to ensure they are current on all Program services, service availability and provider qualifications. Participants are informed of all providers available in their geographical areas, are encouraged to choose, and they are informed of how they can change providers after the initial selection.

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 comprehensive care plan is faxed to BEAS for review once it is signed by the participant/guardian.

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:*

O	Every three months or more frequently when necessary
O	Every six months or more frequently when necessary
X	Every twelve months or more frequently when necessary
O	Other schedule (*specify*):

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 §74.53. Service plans are maintained by the following *(check each that applies)*:

X	Medicaid agency
☐	Operating agency
X	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

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

Case managers monitor the implementation of the comprehensive care plan through direct communication with participants. Case managers determine the appropriate frequency of monitoring and contact with each participant, based on an assessment of need and the participant's support system. Frequency plans are subject to BEAS approval.

b. Monitoring Safeguards. *Select one:*

X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

○	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
X	**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-1: Overview

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.

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 :

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect 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*:

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.

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 a representative. 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:

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-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	☐	☐

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.*	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled as specified in Appendix C-3.	
○	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:
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	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):*
		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.

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 waiver service coverage (s) specified in Appendix C-3 entitled:
☐	**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:*

k. Independent Advocacy *(select one).*

○	**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*:
○	**No.** Arrangements have not been made for independent advocacy.

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:

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.

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

Waiver Year	Employer Authority Only Number of Participants	Budget Authority Only or Budget Authority in Combination with Employer Authority Number of Participants
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

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. *Check each that applies:*

☐	**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; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:*
☐	**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. *Check the 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:
☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☐	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable 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)*:

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. *Check all that apply***:**

☐	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 qualifications in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications in Appendix 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):*

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.

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.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	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:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 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.

During the clinical assessment visit, the RN explains the participant's right to appeal any decision made about his/her eligibility or services and gives a brochure to the individual about the appeal process. Case managers also provide this information. Instructions about how to request an appeal are included in all eligibility denial notices.

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*:

O	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
X	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

O	**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 *(complete the remaining items)*.
X	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. 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).

The Division of Community Based Care Services (DCBCS) is responsible for implementing the DHHS Sentinel Event Protocol, which identifies the types of critical events that must be reported by providers to include: an unanticipated death or permanent loss of function, not related to the natural course of an individual's illness or underlying condition; Homicide or suicide of any individual receiving Department funded care, treatment or services, who had been discharged from a Department funded program or facility within 72 hours of the event; Sexual assault or rape of any individual receiving Department funded care, treatment or services by another client or employee of any Department funded program or facility where there is an act that was witnessed or there is sufficient clinical evidence obtained by the provider to support allegation of nonconsensual sexual contact; Unauthorized departure of an individual receiving Department funded services, from a facility providing care, resulting in death or permanent loss of function; Medication error that results in death, paralysis, coma, or other permanent loss of function; Delay or failure to provide Department funded provider services that result in death or permanent loss of function; Abuse as a result of the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one individual by another; Neglect as a result of the failure to provide the goods and services necessary to avoid physical harm, mental anguish or mental illness; Assault of or by a client of the provider that results in the injury of the person or another person of such severity that medical attention is required; Arson resulting in property loss. Written follow up information is forwarded to the DCBCS Bureau Administrator or designee within 72 hours of the event by completing the Sentinel Event reporting form. Further, licensed providers must adhere to licensing requirements, such as reporting to DHHS, within 72 hours, the occurrence of an unusual event or an unexplained absence.

The Adult Protection law, RSA 161-F:42-57, requires that any individual who believes that an incapacitated adult is being abused, neglected, exploited, or is self-neglecting must report this to DHHS. Case management Supervisors review a sample of case files to assure the accuracy of the assessment and monitoring processes, and the appropriateness of service plans.

b. 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.

Every participant is informed about rights during the application process by the RN performing the assessment, and is re-informed by case managers after services are in place. Residents of licensed residential facilities are informed, and the facility posts the information in a public location, concerning their rights and the availability of the Office of Long Term Care Ombudsman if they have any concerns or believe their rights are being violated. Case managers evaluate the participant's circumstances and statements for any sign of abuse, neglect or exploitation during each of their contacts. All participant education includes the distribution of written contact information for the Office of the Long Term Ombudsman for residents of facilities, or the Adult Protection program for people living in independent settings.

c. 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 DHHS Commissioner shall assign responsibility to either the individual DCBCS Bureau or Quality Improvement Administrator or the Bureau of Improvement and Integrity (BII) to conduct an internal review of an event. An interim report regarding the event shall be submitted to the Commissioner's Office within ten business days. A final report shall be submitted to the Commissioner from the designated DCBCS representative in the time frame specified by the Commissioner. It shall contain a full explanation of the actions leading up to and contributing to the event.

d. 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.

Upon receipt of the final report, the BEAS Bureau Chief and Waiver Program Manager will review the findings and implement pertinent action plans as agreed upon to improve operational practices and systems. The action plan shall describe the organization's risk reduction strategies and include a strategy for evaluating the effectiveness of their plan.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion *(select one):*

C	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
X	The use of restraints or seclusion 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 or Seclusion. 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 or 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).

Participants are served in several different types of locations: their own homes, apartments in a congregate or other apartment buildings, in the homes of their family or caregivers, and in licensed facilities. Of these, Licensed Assisted Living Residence/Supported Housing Residential Care facilities, ALR-SHRCs, are the only waiver-covered setting that are allowed to use restraints, and then only in accordance with licensing standards. Licensing restricts the use of restraints in licensed residential care facilities to emergencies, and when ordered by a physician as part of a treatment plan, as defined by the state law governing resident rights, RSA 151:21, IX: "The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records." The licensing rule, He-P 805.14, specifies restrictions on what restraints may be used in an emergency and reporting requirements in the event restraints are used.

(h) Physical or chemical restraints shall only be used in the case of an emergency, pursuant to by RSA 151:21, IX.

(i) Immediately after the use of a physical or chemical restraint, the resident's guardian or agent, if any, and the department shall be notified of the use of restraints.

(j) The ALR-SRHC shall:

(1) Have policies and procedures on:

a. What type of emergency restraints may be used;

b. When restraints may be used; and

c. What professional personnel may authorize the use of restraints; and

(2) Provide personnel with education and training on the limitations and the correct use of

restraints.

(k) The use of mechanical restraints shall be allowed only as defined under He-P 805.03(ai), which states: "Mechanical restraint" means locked, secured or alarmed ALR-SRHC's or units within an ALR-SRHC, or anklets, bracelets or similar devices that cause a door to automatically lock when approached, thereby preventing a resident from freely exiting the ALR-SRHC or unit within.

(l) The following methods of mechanical restraints shall be prohibited:

(1) Full bed rails;

(2) Gates, if they prohibit a resident's free movement throughout the living areas of the ALR-SRHC;

(3) Half doors, if they prohibit a resident's free movement throughout the living areas of the ALR-SRHC;

(4) Geri chairs, when used in a manner that prevents or restricts a resident from getting out of the chair at will;

(5) Wrist or ankle restraints;

(6) Vests or pelvic restraints; or

(7) Other similar devices that prevent a resident's free movement.

State law RSA 161-F:42, includes in the purpose of the Adult Protection Program: "the philosophy that whenever possible an adult's right to self-determination should be preserved, and that each adult should live in safe conditions and should live his own life without interruption…" This law includes mandatory reporting, which obligates anyone who suspects that someone is being abused or neglected, including being restrained or secluded, to report their suspicions to DHHS. This pertains to adults in all settings.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Bureau of Licensing and Certification is responsible for licensing inspections and reinspections of residential care facilities, approving their policies and procedures concerning restraints, receiving the reports of restraint use, and imposing any applicable fines. The information is shared with BEAS. BEAS is responsible for protective investigations and oversight of the Adult Protection law. Further, case managers evaluate the participant's status during every contact.

b. Use of Restrictive Interventions

C	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:
X	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-a-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.

Licensed residential care facilities may only use restraints in the case of an emergency, pursuant to by RSA 151:21, IX, described above. The licensing rule, He-P 805.14, also described above includes restrictions on what restraints may be used in an emergency. The Adult Protective law, described above, requires reporting of suspicions of abuse or neglect.

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:

The Bureau of Licensing and Certification restricts the use of restraints or seclusion in licensed residential care homes, and includes this during inspections and reinspections. BEAS is responsible for oversight of the Adult Protection law. Case managers evaluate the participant's status during every contact.

Appendix G-3: Medication Management and Administration

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:

X	**Yes**. This Appendix applies *(complete the remaining items)*.
O	**No**. This Appendix is not applicable *(do not 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.

The Bureau of Licensing and Certification is responsible for determining if the residential care facility's procedures for medication management are adequate, and that Bureau re-evaluates adequacy annually by a review of the facility's documentation prior to license renewal.

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.

(a) Annual licensing reinspections by the Bureau of Licensing and Certification include whether the documentation in the medical records meets the requirements in He-P 805.17, described below. Case managers also review medical records when they go to the facility to see the participant. Findings, and any subsequent action planned by the Bureau of Licensing and Certification are reported to BEAS. Any irregularities identified by case managers are reported to BEAS and to the Bureau of Licensing and Certification. The provider is instructed on the necessary corrective action. (b) A reinspection by the (c) Bureau of Licensing and Certification after a brief interval determines whether the provider has taken the corrective action. If the provider has not taken the corrective action, the Bureau of Licensing and Certification may impose a fine or revoke the facility's license. The Bureau of Licensing and Certification involves BEAS throughout this process to ensure participant safety and to assist with discharge planning if necessary.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

X	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)*
O	Not applicable (*do not 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).

He-P 805.17 Medication Services.

(a) All medications shall be administered in accordance with the orders of the licensed practitioner or other professional with prescriptive powers.

(b) Medications, treatments and diets ordered by the licensed practitioner or other professional with prescriptive powers shall be available to give to the resident within 24 hours or in accordance with the licensed practitioner's direction.

(c) The licensee shall have a written policy and system in place instructing how to:

(1) Obtain any medication ordered for immediate use at the ALR-SRHC;

(2) Reorder medications for use at the ALR-SRHC; and

(3) Receive and record new medication orders.

(d) For each prescription medication being taken by a resident, the licensee shall maintain one of the following:

(1) The original written order in the resident's record, signed by a licensed practitioner or other professional with prescriptive powers; or

(2) A copy of the original written order in the resident's record, signed by a licensed practitioner or other professional with prescriptive powers.

(e) Each medication order shall legibly display the following information:

(1) The resident's name:

(2) The medication name, strength, prescribed dose and route, if different then by mouth;

(3) The frequency of administration;

(4) The indications for usage for all medications that are used PRN; and

(5) The dated signature of the ordering practitioner.

(f) For PRN medications the ordering practitioner or a pharmacist shall indicate, in writing, the indications for use and any special precautions or limitations to use of the medication, including the maximum allowed dose in a 24-hour period.

(g) Each prescription medication shall legibly display the following information unless it is an emergency medication as allowed by (ar) below:

(1) The resident's name;

(2) The medication name, strength, the prescribed dose and route of administration;

(3) The frequency of administration;

(4) The indications for usage of all pro re nata (PRN) medications;

(5) The date ordered;

(6) The name of the prescribing practitioner; and

(7) The expiration date of the medication(s).

(i) The label of all medication containers maintained in the ALR-SRHC shall match the current written orders of the licensed practitioner unless authorized by (l) or (ar) below.

(j) Only a pharmacist shall make changes to prescription medication container labels.

(k) Any change or discontinuation of medications taken at the ALR-SRHC shall be pursuant to a written order from a licensed practitioner or other professional with prescriptive powers.

(l) When the licensed practitioner or other professional with prescriptive powers changes the dose of a medication and personnel of the ALR-SRHC are unable to obtain a new prescription label:

(1) The original container shall be clearly and distinctly marked, for example, with a colored sticker that does not cover the pharmacy label, in a manner consistent with the ALR-SRHC's written procedure, indicating that there has been a change in the medication order;

(2) Personnel shall cross out the previous order on the daily medication record, indicating that the dose has been changed, and write the new order in the next space available on the medication record; and

(3) The change in dosage, without a change in prescription label as described in (1) and (2) above, shall be allowed for a maximum of 90 days from the date of the new medication order or until the medications in the marked container are exhausted or, in the case of PRN medications, until the expiration date on the container, whichever occurs first.

(m) The licensee shall require that all telephone orders for medications, treatments, and diets are immediately transcribed and signed by the individual receiving the order.

(n) The transcribed order referenced in (m) above shall be counter-signed by the authorized prescriber within 30 days of receipt.

(o) Over-the-counter medications shall be handled in the following manner:

(1) The licensee shall obtain written approval from the resident's licensed practitioner annually; and

(2) Over-the-counter medication containers shall be marked with the name of the resident using the medication and taken in accordance with the directions on the medication container or as ordered by a licensed practitioner.

(p) The medication storage area for medications not stored in the resident's room shall be:

(1) Locked and accessible only to authorized personnel;

(2) Clean and organized with adequate lighting to ensure correct identification of each resident's medication(s); and

(3) Equipped to maintain medication at the proper temperature.

(q) All medication at the ALR-SRHC shall be kept in the original containers as dispensed by the pharmacy and properly closed after each use except as authorized by (ad)(5) below.

(r) Topical liquids, ointments, patches, creams, or powder forms of products shall be stored in such a

manner that cross contamination with oral, optic, ophthalmic and parenteral products shall not occur.
(s) If controlled substances, as defined by RSA 318-B, are stored in a central storage area in the ALR-SRHC, they shall be kept in a separately locked compartment within the locked medication storage area accessible only to authorized personnel.
(t) The licensee shall develop and implement written policies and procedures regarding a system for maintaining counts of controlled drugs.
(u) Except as required by (w) below, any contaminated, expired or discontinued medication shall be destroyed within 30 days of the expiration date, the end date of a licensed practitioner's orders or the medication becomes contaminated, whichever occurs first.
(v) Controlled drugs shall be destroyed only in accordance with state law.
(w) Destruction of controlled drugs under (u) above shall:
(1) Be accomplished in the presence of at least 2 people; and
(2) Be documented in the record of the resident for whom the drug was prescribed.
(x) Medication(s) may be returned to pharmacies for credit only as allowed by the law.
(y) When a resident is going to be absent from the ALR-SRHC at the time medication is scheduled to be taken, the medication container shall be given to the resident if the resident is capable of self-administering, as described in (ac) and (ad) below.
(z) If a resident is going to be absent from the ALR-SRHC at the time medication is scheduled to be taken and the resident is not capable of self-administering, the medication container shall be given to the person responsible for the resident while the resident is away from the ALR-SRHC.
(aa) Upon discharge or transfer, the licensee shall make the resident's current medications available to the resident and the guardian or agent, if any.
(ab) A written order from a licensed practitioner shall be required annually for any resident who is authorized to carry emergency medications, including but not limited to nitroglycerine and inhalers.
(ac) Residents shall receive their medications by one of the following methods:
(1) Self-administered medication as allowed by (ad) below;
(2) Self-directed administration of medication as allowed by (ae) below;
(3) Self-administered with supervision as allowed by (af) and (ag) below; or
(4) Administered by individuals authorized by law.
(ad) For residents who self-administer medication as defined in 805.03(bd) the licensee shall:
(1) Obtain a written order from a licensed practitioner on an annual basis:
a. Authorizing the resident to self-administer medications without supervision;
b. Authorizing the resident to store the medications in their room; and
c. Identifying the medications that may be kept in the resident's room;
(2) Evaluate the resident on a six month basis or sooner, based on a significant change in the resident, to ensure they maintain the physical and mental ability to self-administer;
(3) Have the resident store the medication(s) in his or her room by keeping them in a locked drawer or container to safeguard against unauthorized access and making sure that this arrangement will maintain the medications at proper temperatures;
(4) Have a copy of the key to access the locked medication storage area in the resident's room; and
(5) Allow the resident to fill and utilize a medication system that does not require that medication remain in the container as dispensed by the pharmacist.
(ae) The licensee shall allow the resident to self-direct administration of medications as defined in He-P 803.05.03(be) if the resident:
(1) Has a physical limitation due to a diagnosis that prevents them from self-administration;
(2) Receives evaluations every 6 months or sooner, based on a significant change in the resident, to ensure the resident maintains the physical and mental ability to self-direct administration of medications;
(3) Obtains an annual written verification of their physical limitation and self-directing capabilities from their licensed practitioner and requests the ALR-SRHC to file the verification in their resident record; and
(4) Verbally directs personnel to:
a. Assist them with preparing the correct dose of medication by pouring, applying, crushing, mixing or cutting; and
b. Assist the resident to apply, ingest or instill the ordered dose of medication.
(af) If a resident self-administers medication with supervision, as defined in He-P 805.03(bc), personnel may be permitted to:
(1) Remind the resident to take the correct dose of his or her medication at the correct time;
(2) Place the medication container within reach of the resident;

(3) Remain with the resident to observe the resident taking the appropriate amount and type of medication as ordered by the licensed practitioner;

(4) Record on the resident's daily medication record that they have supervised the resident taking his or her medication; and

(5) Document in the resident's record any observed or reported side effects, adverse reactions, and refusal to take medications and or medications not taken.

(ag) If a resident self-administers medication with supervision, personnel shall not physically handle the medication in any manner.

(ah) Medication administered by individuals authorized by law to administer medications shall be:

(1) Prepared immediately prior to administration; and

(2) Prepared, identified, and administered by the same person in compliance with RSA 318-B and RSA 326-B.

(ai) Personnel shall remain with the resident until the resident has taken the medication.

(aj) If a nurse delegates the task of medication administration to an individual not licensed to administer medications, the nurse shall:

(1) Only delegate medications that are administered by mouth;

(2) Document in the individual's personnel file the evaluation method and tools used to determine that the individual receiving the delegation of medication administration has the necessary skills to administer medication;

(3) Document in the individual's personnel file that the individual continues to be delegated the task of administering medication, based on the nurse's ongoing evaluation;

(4) Document in the individual's personnel file any notice that the delegation of medication administration has been rescinded, if applicable; and

(5) Document in the resident's record the:

a. Specific medication to be administered;

b. Dosage, route and specific time that the medication is to be administered;

c. The names of personnel to whom the nurse has delegated responsibility for the administration of medications; and

d. The results of the nurse's assessment, completed no more than 30 days prior to the delegation occurring, that determined that the resident's condition is stable and that the resident is appropriate for receipt of medication administration via nurse delegation.

(ak) A licensed nursing assistant (LNA) who is not licensed as a medication nurse assistant in accordance with RSA 326-B may administer the following when under the direction of the licensed nurse employed by the ALR-SRHC:

(1) Medicinal shampoos and baths;

(2) Glycerin suppositories and enemas; and

(3) Medicinal topical products to intact skin as ordered by the licensed practitioner.

(al) Except for those residents who self-administer medication, the licensee shall maintain a written record for each medication taken by the resident at the ALR-SRHC that contains the following information:

(1) Any allergies or allergic reactions to medications

(2) The medication name, strength, dose, frequency and route of administration;

(3) The date and the time the medication was taken;

(4) The signature, identifiable initials and job title of the person who administers, supervises or assists the resident taking medication;

(5) For PRN medications, the reason the resident required the medication and the effect of the PRN medication; and

(6) Documented reason for any medication refusal or omission;

(am) Personnel who are not otherwise licensed practitioners, nurses or medication nursing assistants and who assist a resident with self administration with supervision, self directed administration or administration of medication via nurse delegation shall complete, at a minimum, a 4-hour medication supervision education program covering both prescription and non-prescription medication.

(an) The medication supervision education program shall be taught by a licensed nurse, licensed practitioner or pharmacist, whether in-person or through other means such as electronic media.

(ao) The medication supervision education program required by (am) above shall include:

(1) Infection control and proper hand washing techniques;

(2) The 5 rights which are:

a. The right resident;

b. The right medication;

c. The right dose;

d. Administered at the right time; and
e. Administered via the right route;
(3) Documentation requirements;
(4) General categories of medications such as antihypertensives or antibiotics;
(5) Desired effects and potential side effects of medications; and
(6) Medication precautions and interactions.

(ap) The administrator may accept documentation of training required by (am) above if it was previously obtained by the applicant for employment at another licensed ALR-SRHC.

(aq) Non-prescription stock medications shall only be accessed and administered by the licensed nurse or medication nurse assistant on duty.

(ar) An ALR-SRHC shall use emergency drug kits only in accordance with board of pharmacy rule Ph 705.03 under circumstances where the ALR-SRHC:
(1) Has a director of nursing who is a RN licensed in accordance with RSA 326-B; and
(2) Has a contractual agreement with a medical director who is licensed in accordance with RSA 329 and a consultant pharmacist who is licensed in accordance with RSA 318.

(as) The licensee shall develop and implement a system for reporting any observed adverse reactions to medication and side effects, or medication errors such as incorrect medications, within 24 hours of the adverse reaction or medication error.

(at) The written documentation of the report in (as) above shall be maintained in the resident's record.

iii. Medication Error Reporting. *Select one of the following:*

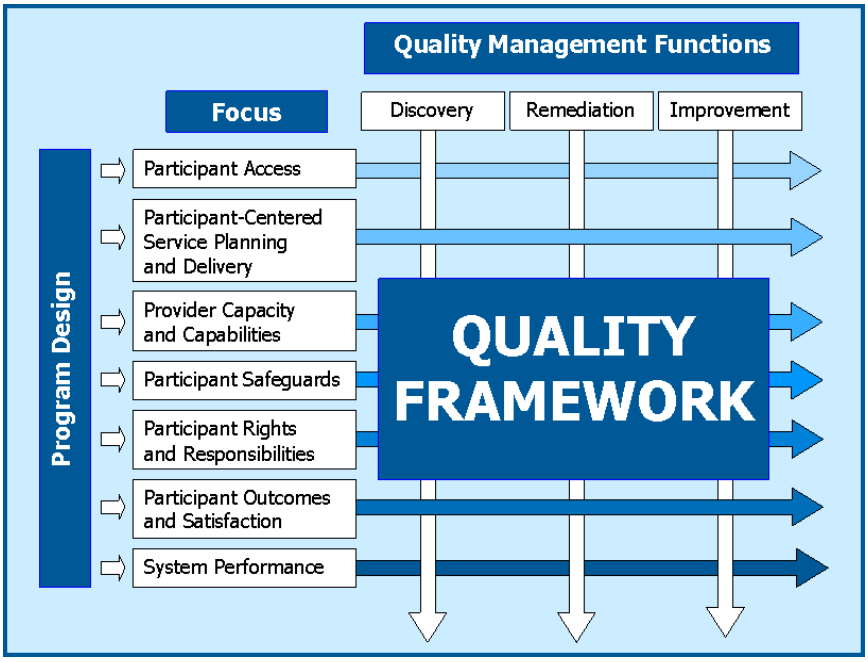
X	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	Bureau of Licensing and Certification
	(b) Specify the types of medication errors that providers are required to *record:*
	Per He-P 805.17, every residential care provider must document any medication errors such as incorrect medications in the resident's record.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Per He-P 805.17, every residential care provider must develop and implement a system for reporting any medication errors such as incorrect medications, within 24 hours of the adverse reaction or medication error.
O	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Compliance by the licensed residential care facility is monitored during annual licensing reinspections. Findings, and any subsequent action planned, are reported by the Bureau of Health Care Facilities to the Bureau of Elderly and Adult Services. Further, case managers review medication management when they see the Participant and report any irregularities to BEAS and to the Bureau of Licensing and Certification.

Appendix H: Quality Management Strategy

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 Management 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 Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate). In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and

The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate. If the State's Quality Management 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 Management Strategy, including the specific tasks that the State plans to undertake during the period that 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 Management 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 identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

The Bureau of Elderly and Adult Services (BEAS) of the New Hampshire Department of Health and Human Services (Medicaid Agency) administers the Home and Community Based Waiver for the Elderly and Chronically Ill (ECI Waiver Program). Registered nurses (RNs) employed by or under contract with BEAS conduct clinical assessments and reassessments for eligibility determinations. Case Managers (CMs) from enrolled case management (CM) agencies develop service plans to address all participant needs. Licensed/certified and enrolled Medicaid providers serve participants in their homes and in the community. The program served 2,594 individuals in 2006. Enrollment is expected to increase as the focus shifts to provide individuals with more choice regarding where they live and how they receive services.

New Hampshire has developed two major initiatives to support the shift from institutional to community care. A new comprehensive assessment instrument will help to improve and standardize Waiver Program operations. BEAS is also in the process of developing modifications to the way that eligibility determinations are carried out and CM services are provided. BEAS is developing clear guidelines that will define the role of RNs (eligibility determinations and redeterminations) and CMs (service plan development and ongoing monitoring). These initiatives will help to streamline procedures and to develop service plans in a more efficient and appropriate manner.

New Hampshire is also continuing to develop regional Aging and Disability Resource Centers, called Service Link Resource Centers (SLRCs). SLRCs play an active role in informing individuals in need of support services about Waiver services and referring individuals to the Waiver Program to determine eligibility for services.

New Hampshire was awarded a Real Choice Systems Change Quality Grant. This has supported efforts to focus on quality as a critical component of the ECI Waiver Program. BEAS recognizes and embraces the importance of an ongoing process to develop and enhance a quality management system that ensures that the program is operated as planned, outcomes are achieved, and opportunities for improvement are identified and implemented.

The Quality Management (QM) Strategy described herein is based on both current practices and plans for improvement. This approach encompasses activities carried out by participants, service providers, case management entities, and state agencies.

I. QM PROCESS and TEAM

A) NH has been in the process of developing a multi-level approach to managing quality in the ECI Waiver Program. This approach includes standard program policies and procedures, discovery methods to identify problems and trends, and remediation and improvement activities to address both individual and systemic issues, respectively. QM activities happen at three levels:

Front line activities focus on access to program services and the goal of ensuring the health and welfare of participants. Activities also focus on ensuring that the service plan is based on an individual's personal goals and addresses all participant needs. Activities include:

- SLRCs are locally based aging and disability resource centers that provide community education and referrals to the ECI Waiver Program.
- BEAS RNs conduct initial and annual level of care (LOC) determinations using a standard assessment instrument.
- Case management is provided by independent CM agencies that contract with the state and are not

affiliated with any service provider. CMs conduct in-home assessments (information from the RN's LOC determination is shared with the CM agency) to develop service plans, monitor services and conduct reassessments to assure that services are adequate, appropriate and cost effective. CMs assess and monitor a participant's conditions, needs and changes in the informal support network or other circumstances to address any unmet needs or risks.

- CM Supervisors review a sample of case files to assure the accuracy of the assessment and monitoring processes, and the appropriateness of service plans.
- BEAS social workers conduct protective investigations to assure the safety of all participants when suspicions of abuse, neglect, exploitation, and self-neglect are reported.
- BEAS arranges for public guardianship services for participants who are unable to make decisions on their own and do not have family representatives.
- The BEAS legal office offers participant rights training sessions on a quarterly basis.
- The NH Bureau of Licensing and Certification carries out licensing and certification of Waiver service providers.
- BEAS conducts activities associated with verifying provider qualifications and certification of other qualified agencies.
- Providers use NH-MMIS to submit claims for Waiver services provided to participants. MMIS requires all providers to provide proof of qualifications required for the ECI Program. BEAS is contacted for direction if enrollment eligibility is not clear.

Mid level activities focus on the compilation, review and analysis of information generated from front line activities. Results of mid level activities are communicated to the appropriate front line source to address specific situations as well as system wide trends. Results may also indicate a need for additional training and or clarification of policies and procedures. Activities include:

- BEAS RN supervisors review a sample***** (at least one case is selected from each RN) of LOC determinations each month to assure accuracy of initial and annual redeterminations. BEAS RN supervisors meet with RNs individually to provide one-on-one supervision. In addition, RN supervisors and RNs meet on a quarterly basis to identify program issues.
- The BEAS-QM coordinator reviews a sample* of case files (from CM agencies) each quarter to assure the accuracy and completeness of assessments, effectiveness of the monitoring processes, appropriateness of service plans, quality, and effectiveness of the service provided.
- The BEAS-QM coordinator reviews CM agency quarterly reports that identify and describe each agency's monitoring activities including issues identified and remediation actions taken to respond to both individual and agency wide areas needing improvement.
- The ECI Waiver Program Manager meets on a quarterly basis with the SLRC Directors, CM Agencies and service providers to share information and reports, and to address programmatic issues.
- The ECI Waiver Program Manager takes appropriate actions based on reports and information regarding provider licensing and certifications from the Bureau of Licensing and Certification and action taken by BEAS.
- Each month, the ECI Waiver Manager compares a sample* of paid claims to service authorizations to identify cases of underutilization and over utilization. Cases of under utilization are addressed on a case-by-case basis. BEAS works with the SURs Unit of the Medicaid Agency to recover overpayments.

***** BEAS is in the process of reviewing current sampling procedures and will be using the principles established in the Sampling Guide ("Sampling: A Practical Guide for Quality Management in Home and Community-Based Waiver Programs") developed by the National Quality Contractor for CMS to determine sample sizes.

Systemic level activities involve the ongoing review of QM activities and reports to identify trends, systemic issues, remediation steps, and improvement goals. The ECI Waiver Program Manager oversees QM activities at all levels. In addition, NH has established an internal Quality Management Leadership Committee to focus on a systemic view of the ECI Waiver Program as well as other Waiver Programs and long term care services. This Committee develops and monitors improvement plans that encompass the ECI Waiver Program. Systemic level activities also include the following components:

- The ECI Waiver Program Manager reviews and analyzes mid level, quarterly reports generated by CM agencies regarding monitoring and status of remediation activities and BEAS Reports regarding LOC decisions.
- The ECI Waiver Program Manager reports system wide and regional results (including reports from CM agencies, RN supervisors, and MMIS) to the QM Leadership Committee to identify issues, analyze trends and develop remediation and improvement strategies.
- The QM Leadership Committee (including the BEAS Bureau Chief) develops quality indicators and improvement goals based on system wide issues discovered during the QM process.
- The QM Leadership Committee conducts an annual review to determine if modifications need to be made to the current QM strategy.
- NH Elder Abuse Advisory Council was established to improve the protection of New Hampshire seniors from abuse, neglect and exploitation by increasing public education and awareness; developing resources, supports and services; improving community relations; and examining and recommending legislation.
- The Quality Council for the ECI Waiver Program was established as a result of and in conjunction with the Real Choice Quality Grant. The Council consists of representation from ECI program agencies, BEAS staff and participants. The Council reviews QM reports, proposes modifications to program policies and procedures, and recommends improvement to the ECI Waiver Program as well as possible improvement projects and strategies
- An annual ECI Waiver Program-QM Report is issued to the Commissioner of the Department of Health and Human Services and the Directors of the Office of Medicaid Business and Policy (Medicaid Agency), and the Division of Community Based Care Services.

B) Plans for Enhancements to the NH-QM Strategy

- **Participant Experience Survey (PES).** NH has determined that the PES process will be used to capture and analyze responses from participants to identify problem areas such as choice and unmet needs, develop remediation strategies, and measure and evaluate the impact of each strategy. This QM activity will provide information from participants to contribute to the evaluation of the program and to establish improvement plans.

  Decisions regarding sample size will be based on the principles established in the Sampling Guide developed by the National Quality Contractor for CMS ("Sampling: A Practical Guide for Quality Management in Home and Community-Based Waiver Programs"). Subsequent to the initial round of surveys, NH will establish a schedule to continue this process. At this time, it is expected that this process will be conducted every two years.

  Target Date: The goal is for PES to be implemented in July 2007 and NH plans to have established measures, data and system-wide reports by July 2008.

- **Sentinel Event Protocol** The NH Sentinel Event Protocol has been developed to collect, respond to, and analyze events that involve an individual enrolled in the ECI Waiver Program. This protocol is also used for other Waiver Programs and DHHS services.

  The Protocol defines the events (unanticipated death, neglect, abuse, etc.) and specific procedures regarding notifications, reporting, agency review and document controls. Each event associated with an ECI Waiver Program participant will be reviewed by the ECI Waiver Program Manager or the QM Coordinator to determine appropriate next steps related to the specific event.

  The Protocol includes a causal analysis process designed to identify systemic issues that may have contributed to the event. The state recognizes that understanding the circumstances surrounding the specific event is critical to identifying potential systemic improvements.

  An annual report will be submitted to top level state agency administration including the ECI Waiver Program Manager, the BEAS- QM Coordinator, QM Leadership Committee, BEAS Bureau Chief and Medicaid Director. In addition, the state will develop plans to share this report in a public forum.

Target Date: The Protocol was issued in January 2006. A revised reporting form was issued in October 2006 and statewide implementation will be completed by July 2007. NH plans to issue the first Annual Report in January 2008.

- **Complaint Investigation System.** NH is in the process of developing a standard method to collect, analyze and respond to complaints from ECI Waiver Program participants. Currently, complaints are received and addressed by BEAS RNs, CMs, CM Supervisors and state agency staff. However, there is no standard method for collecting and analyzing the complaints by program (ECI Program vs. other state services). The plans for this new system will enable the ECI Waiver Program Manager, the BEAS QM Coordinator and the QM Leadership Committee to analyze the type and number of complaints from a systemic level to look for trends by area and provider, to identify statewide issues and to develop plans for improvement.

  Target Date: It is expected that this system will be in place by January 2008

- **Automation of Case Review Tool**. NH is in the process of modifying the current review tool used by CM supervisors, BEAS-RNs and BEAS- RN supervisors to document case monitoring activities. Subsequent to final modifications, BEAS plans to automate this tool in order to generate reports that will help to identify, document, and measure issues identified at all levels. Some examples include percent of instances where evidence of choice was present and percent of participants who were contacted by CMs in a timely way.

  The development of these measures and the automation of the review tool will also support efforts to measure progress in meeting established improvement goals. This part of the strategy will support front line activities to identify issues at the individual level, provider level, and regional level and will also help to identify statewide issues and trends.

  Target Date: It is expected that this system will be in place by July 2008

- **Enhancements to the NH Case Tracking Information System.** NH is in the process of developing upgrades to the case tracking system that will support the state's ability to compare services authorized in the ECI Waiver Program to services delivered by Waiver Program providers. Plans for the upgrade also include automated information and reports regarding LOC annual redetermination due dates in order to measure and report on overdue reassessments. Subsequent to the systems upgrade, reports will be provided in a more timely and accurate manner.

  Target Date: It is expected that this system will be in place by July 2008

- **Monitoring Process for Non-licensed/Non-certified Providers.** The following ECI Waiver Program services are not licensed or certified by the Bureau of Licensing and Certification or BEAS: personal emergency response system, home delivered meals, environmental modifications, assistive technology services, specialized medical equipment, chore services and shared housing. BEAS will develop an improved process to ensure that these providers adhere to Waiver requirements. Currently, there are a variety of mechanisms in place to assure quality services. BEAS has been working with one main and a very few smaller personal emergency response system providers for several years and has observed their through reports from participants. Home Delivered Meals are provided by agencies that are inspected either locally or by the State food protection agency. These providers are the same ones used for meals provided for the recipients of the service through the Social Service Block grant and the Older Americans grant. Chore service providers are also the same providers whose work has been evaluated through performance under the Social Service Block grant and the Older Americans grant. Shared housing providers, once this service is implemented, will be individuals who move into the participant's home to provide care, and these individual workers will be screened and overseen by enrolled agencies, likely Other Qualified Agencies, that are certified.

  Target Date: It is expected that this process will be developed by January 2008 and will be in place by July 2008

II. WAIVER ASSURANCES

1. Level of Care (LOC)

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

Applicants enter the ECI Waiver Program through an SLRC or the state agency network. The ECI Waiver Program does not have a Waiting List for services. Reports are generated by the SLRC that include the number of inquiries and the number of applicants referred for ECI Waiver Program services and nursing facility services. The ECI Waiver Program Manager receives and analyzes these quarterly reports to identify and respond to statewide and regional trends.

Once an individual enters the application process for the ECI Waiver Program, the time elapsed between the application and LOC determination is measured by a standard report from the BEAS case tracking system. This quarterly report is reviewed by the RN supervisors and BEAS QM Coordinator to ensure that applications are processed in a timely manner.

An LOC report is generated annually that includes a standard report of the total number of ECI applications and initial LOC determinations by region along with an analysis (by RN Supervisor) and remediation steps taken. This annual report is reviewed by the ECI Waiver Program Manager.

The LOC of enrolled participants are reevaluated at least annually or as specified in the approved Waiver

A standard report is generated on a quarterly basis to identify the date that an LOC is due and to flag overdue LOC determinations. This information is reviewed by a BEAS- RN Supervisor to follow-up on individual cases and to identify regional trends.

An LOC report is generated annually that includes a standard report of the total number of re-determinations and the number of overdue re-determinations by region along with an analysis (by RN Supervisor) and remediation steps taken. This annual report is reviewed by the ECI Waiver Program Manager.

The process and instruments described in the approved Waiver are applied to determine LOC.

RN supervisors review 100% of the case files to ensure that policies and procedures are followed including the completion of the assessment instrument and that the decision-making rules were followed. A standard review tool is used to document that the process was followed. Problems identified are addressed with individual staff members. The results of the review are also summarized and analyzed on a quarterly basis by the RN Supervisor and ECI Waiver Program Manager to identify training needs.

The State monitors LOC decisions and takes action to address inappropriate LOC determinations.

RN supervisors review 100% of the case files to determine the appropriateness of LOC decisions including denials. A standard review tool is used to measure the accuracy of completion of the assessment instrument. Problems identified are addressed with individual staff members. The results of the review are also summarized and analyzed on a quarterly basis by the RN Supervisor and ECI Waiver Program Manager to identify training needs.

2. Service Plan

The Service Plan addressed all participant's needs (including health and safety risk factors) and personal goals either by Waiver Services or other means.

CMs develop individualized service plans that seek to address all of the needs and personal goals of ECI Waiver Program participants. All service plans are reviewed by CM supervisors. In addition, BEAS RNs review 100% of the initial service plans and review a sample of cases on a quarterly basis. This review will determine that the service plan addresses the participant's needs and personal goals, and that the participant accepts and agrees with the service plan. Issues identified by CM supervisors and RNs are addressed on a case-by-case basis. Case Review Tools are used to document this process. These tools are summarized and analyzed by the ECI Waiver Program Manager to identify systems issues and/or training needs.

The Participant Experience Survey (PES) process will also be used to determine that the service plan addresses the participant's needs and personal goals and to capture and analyze responses from participants regarding the services provided by the ECI Waiver Program. Decisions regarding sample size will be based on the principles established in the Sampling Guide developed by the National Quality Contractor for CMS ("Sampling: A Practical Guide for Quality Management in Home and Community-Based Waiver Programs"). Subsequent to the initial round of surveys, NH will establish a schedule to continue this process. At this time, it is expected that this process will be conducted every two years. This will support current QM activities to gather and analyze feedback from participants to establish improvement plans.

The state monitors SP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the SP development.

CM Supervisors review a sample of case files on a quarterly basis to determine the accuracy of assessment and monitoring processes, and that the service plan addresses the participant's current needs. The BEAS-QM coordinator reviews CM agencies quarterly reports that identify agency monitoring activities including issues identified and remediation actions taken to respond to both individual and agency wide problems.

In addition, the BEAS-QM coordinator reviews a sample of case files (from each CM agency) to assure accuracy of the assessment and monitoring processes, and that the service plan addresses the participant's current needs. A standard review tool is used and results are addressed with CM Agencies. The results of the review are also summarized and analyzed on a quarterly basis to identify systems issues and/or training needs.

SPs are updated/revised at least annually or when warranted by changes in the Waiver application.

CM Supervisors review a sample of cases on a quarterly basis to confirm that CM contacts occur on a monthly basis to review and modify the service plans as appropriate and to determine that the service plan is updated annually. The BEAS-QM coordinator reviews CM agency quarterly reports to confirm agency-monitoring activities and to document that service plans are updated on an annual basis. The report also includes issues identified and remediation actions taken to respond to both individual and agency wide problems.

Services are delivered in accordance with the SP, including the type, scope, amount, duration and frequency specified in the SP

In addition to the case file review process, NH is in the process of developing a standard report to identify under-utilization and over-utilization of each Waiver service compared to the service plan. (The enhancement to the NH Case Tracking System will be in place by July 2008.) The BEAS QM Coordinator will review these reports on a monthly basis to track under-utilization and over-utilization. Follow up will be carried out by BEAS RNs to determine the cause of all the discrepancies and any remediation steps needed to resolve problems identified.

The BEAS QM Coordinator will compile and report on the results of the follow up to identify systemic issues that need to be resolved. This information will also be shared with the Waiver Program Manager.

Participants are afforded choice between waiver services and institutional care, and between/ among waiver services and providers.

CM supervisors review a sample of case files each month to ensure that participants are offered choice between waiver services and institutional care and between and among waiver services including the service delivery methods. This process includes a review of the participant's signature (standard form) to document freedom of choice. In addition, the BEAS QM Coordinator reviews the CM agency reports (% of instances where evidence of choice was present) on a quarterly basis to confirm this activity and also reviews a sample of cases to determine that choice was offered.

3. Qualified Providers

The State verifies that providers meet and continue to meet required licensing and/or certification standards and adhere to other state standards prior to furnishing waiver services.

The NH Bureau of Licensing and Certification (state agency within the Department of Health and Human Services) conducts activities associated with provider licensing and certification. BEAS is responsible for certification of other qualified providers. The Waiver Program Manager is responsible to ensure that waiver program providers are licensed/certified prior to providing services and that the license/certification remains valid while providing services to Waiver Program participants.

The ECI Waiver Program Manager crosschecks a list of providers that meet state licensing/certification requirements with a report generated from the case tracking system to confirm that the provider is qualified to provide Waiver program services. The Bureau also informs the ECI Waiver Program Manager when a provider no longer meets licensing/certification requirements. This data is reviewed on an ongoing basis to ensure that providers continue to meet licensing/certification requirements.

The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

The following ECI Waiver Program services are not licensed or certified by the Bureau of Licensing and Certification or BEAS: personal emergency response system, home delivered meals, environmental modifications, assistive technology services, specialized medical equipment, chore services and shared housing. BEAS will develop an improved process to ensure that these providers adhere to Waiver requirements. Currently, there are a variety of mechanisms in place to assure quality services. BEAS has been working with one main and a very few smaller personal emergency response system providers for several years and has observed their performance through reports from participants. Home Delivered Meals are provided by agencies that are inspected either locally or by the State food protection agency. These providers are the same ones used for meals provided for the recipients of the service through the Social Service Block grant and the Older Americans grant. Chore service providers are also the same providers whose work has been evaluated through performance under the Social Service Block grant and the Older Americans grant. Shared housing providers, once this service is implemented, will be individuals who move into the participant's home to provide care, and these individual workers will be screened and overseen by enrolled agencies, likely Other Qualified Agencies, that are certified. It is expected that this process will be developed by January 2008 and will be in place by July 2008

The state identifies and remediates situations where providers do not meet requirements:

The ECI Waiver Program Manager works with the NH Bureau of Licensing and Certification to address situations where providers do not meet requirements. Additional information is gathered from the RNs and CMs to determine a course of action on a case-by-case basis. The NH Bureau of Licensing and Certification in collaboration with the Waiver Program Manager will communicate with the provider agency to determine remediation steps.

The state implements its policies and procedures for verifying that provider training has been conducted in accordance with the state requirements and the approved Waiver.

The NH Bureau of Licensing and Certification (BLC) and collects and compiles training reports from each provider on an annual basis to ensure that training requirements are met. The ECI Waiver Program Manager receives and reviews a compilation of these reports from the BLC. The BLC in collaboration with the ECI Waiver Program Manager will communicate with provider agencies that do not meet 100% of the training requirements to determine remediation steps.

4. Health and Welfare

There is continuous monitoring of health and welfare of participants and remediation actions are initiated when appropriate.

The health and welfare of participants of NH's ECI Waiver program is a major focus of the monitoring activities that occur at all three levels of the QM strategy. CM Supervisors, BEAS-RNs and RN Supervisors carry out monitoring activities to ensure that the assessment and monitoring processes address

potential risks and plans are developed to manage the risks. A standard review tool is used and results are addressed with individual staff members. The results of the review are also summarized and analyzed on a quarterly basis by the RN Supervisor and ECI Waiver Program Manager to identify trends and/or training needs.

CM Supervisors review a sample of cases on a quarterly basis to confirm CM contact on a monthly basis to review and to confirm that the service plan was modified as appropriate. The BEAS-QM coordinator reviews CM agency quarterly reports that identify agency monitoring activities including issues identified and remediation actions taken to respond to both individual and agency wide problems.

The NH Sentinel Event Protocol (Protocol) will also support BEAS efforts to respond to unexpected and serious incidents related to participant health and welfare. Each event (ex. event requiring medical attention) is reviewed by the ECI Waiver Program Manager or the BEAS-QM Coordinator to determine appropriate next steps related to the specific event. This process will help to identify systemic issues that may have contributed to certain incidents.

In addition, when the new complaint investigation system has been implemented, the ECI Waiver Program Manager will have access to information related to complaint investigations from Waiver program participants regarding provider services. This will enable the Waiver Program Manager to respond to specific complaints as appropriate and analyze information by region and by provider.

The state on an ongoing basis identifies and address and seeks to prevent instances of abuse, neglect and exploitation.

The NH Elder Abuse Advisory Council was established in 2005 to increase public awareness of the symptoms of abuse, neglect, self-neglect and exploitation. The Council includes representatives from BEAS, law enforcement, the NH Attorney General's office, NH Committee on Aging, Service Link Resource Centers, and the provider community. The Council has developed a resource guide and training curriculum for police officers and the legislature to help to address elder abuse issues.

The Adult Protective Services Program established by state law is within the BEAS. BEAS social workers conduct protective investigations to assure safety of all residents including participants of the ECI Waiver Program. The following activities are carried out to determine that instances of abuse, neglect, self-neglect and exploitation have been referred to the Adult Protective Services Program, as required by law: 100% of new ECI Waiver program cases are reviewed by BEAS RNs, the CM supervisors review a sample of cases on a quarterly basis, and the BEAS-QM coordinator reviews a sample of case files (from CM agencies). A standard review tool is used and results are addressed with individual staff members. The results of this review process are also summarized and analyzed on a quarterly basis by the RN Supervisor and BEAS QM Coordinator to identify trends and/or training needs.

In addition, the ECI Waiver Program Manager is in the process of developing an agreement with the Adult Protective Services Program to ensure that reports regarding program participants are reported to the ECI Waiver Program Manager. It is expected that this agreement will be in place by July 2007.

6. Administrative Authority

The Medicaid Agency retains authority and responsibility for the operation of the Waiver Program.

The New Hampshire Department of Health and Human Services (DHHS) operates as the New Hampshire Medicaid Agency with oversight of the ECI Waiver. Staff of the Bureau of Elderly and Adult Services (within DHHS) act at the state and regional levels to provide ongoing monitoring and oversight of the ECI Waiver Program.

7. Financial Accountability

Claims for FFP for the cost of Waiver services are based on state payments for Waiver services that have been rendered to Waiver participants, authorized in the SP and properly billed by qualified providers in accordance with the approved Waiver

The ECI Waiver Program Manager compares a sample of paid claims to service authorizations on a quarterly basis. Instances of under and over utilization of services are addressed on a case-by case basis. BEAS works with the Surveillance and Utilization Review Unit of the Medicaid Agency to recover overpayments. Targeted audits are conducted by BEAS based on the results of the review conducted by the ECI Program Manager.

NH is in the process of developing upgrades to the NH case tracking system that will support the state's ability to compare services authorized in the ECI Waiver Program to services delivered by Waiver Program providers. A standard report will be generated to inform the ECI Waiver Program Manager of instances of over and under utilization. An analysis will be carried out in response to each instance to identify trends and/or provider training needs.

III. Quality Management Information

In addition to the ongoing QM reports described above, NH is in the process of enhancing the content and format of the annual report to be submitted to top level state agency administration including the Waiver Program Manager, BEAS- QM Coordinator, QM Leadership Committee, QM Council, BEAS Bureau Chief and Medicaid Director. In addition, the state will develop plans to share this report in a public forum that will include the State Council on Aging and the NH Quality of Life Council.

Target Date: It is expected that the format for an annual report and the plans to share this report in a public forum will be established by January 2009.

IV. Evaluation of QM Strategy

The QM Leadership Committee will conduct an annual review to determine if modifications need to be made to the QM strategy. This review will be based on the information from the Annual QM Report and feedback from the Quality Council for the ECI Waiver Program and from BEAS staff. Proposed modifications to the QM strategy will be developed and shared with the Quality Council and BEAS staff prior to implementation.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All claims for HCBC-ECI services are paid through the New Hampshire Medicaid MMIS and edits are applied to ensure that all billed services are covered, provided by properly enrolled providers, and rendered to individuals who were eligible on the dates of service. Scheduled automation will link the individual comprehensive care plans of each participant to the MMIS to create an automated prior authorization of every service. This will prevent payment of any service that is not authorized for the participant who is the claimed service recipient. Further, the SURS unit within the Medicaid Agency and the New Hampshire Attorney General Medicaid Fraud Unit provide the support necessary to pursue recoveries against any provider that bills incorrectly. MMIS claims are audited by the Legislative Budget Assistant (LBA) each year.

Currently, several services are prior authorized on an individual basis: Community transition services, Consolidated services, Environmental Accessibility Services, Assistive Technology, and Specialized Medical Equipment. For these services, each request is evaluated by the nursing supervisor prior to authorizing the service. If a participant needs some minor environmental accessibility service, such as a ramp, the case manager coordinates an evaluation by a licensed occupational or physical therapist, and seeks bids from three different potential service providers. This information is used by the nursing supervisor to support service authorizations.

APPENDIX I-2: Rates, Billing and Claims

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).

DCBCS establishes payment rates for waiver services in a manner to ensure access and to be comparable to the rates set for non-waiver services, as established by the Medicaid Agency. Public comment is accepted in the DCBCS budget process, and DCBCS works with provider associations for DCBCS to be informed of the actual cost of service delivery.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers bill the MMIS directly. Many providers use the supplied electronic software that enables them to bill electronically.

c. Certifying Public Expenditures *(select one)*:

State:	
Effective Date	

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):	
	☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public 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 Non-State Public Agencies**. Specify: (a) the non-State public 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.*)
X	**No**. Public agencies do not certify expenditures for waiver services.	

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All provider billings are processed through the MMIS, which has claim edits and audits in place that limit the procedure codes that can be billed by ECI providers. Edits also ensure that payment is made only for Program-covered services rendered by qualified providers to participants who were Program-eligible on the date(s) of service. Scheduled automation will link the comprehensive care plans to the MMIS so that only services in authorized plans will be paid. Currently, environmental accessibility services, specialized medical services, assistive technology services, community transition, and consolidated services require that a specific prior authorization be entered into the MMIS for claims payment, thus avoiding mis-payment.

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 §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

X	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) 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:

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*):

X	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.

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:*

X	**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 and (b) the types of providers to which such payments are made. 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.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
X	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public 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 public providers differs from the amount paid to private providers of the same service. When a public 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:

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:*

X	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	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.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**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.
X	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**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:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

X	**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 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 public 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 public agencies as CPEs, as indicated in Item I-2- c:

b. Local 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. *Check each that applies:*

X	**Appropriation of Local Revenues.** Specify: (a) the local 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 public agencies as CPEs, as specified in Item I-2- c:
	DHHS submits monthly bills to the county governments for 50% of the non-federal share of Medicaid claims for services provided to Participants.
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the 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 public agencies as CPEs, as specified in Item I-2- c:
☐	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

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) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

X	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.*	
	☐	Provider taxes or fees
	☐	Provider donations
	☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX 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. (*Do not complete Item I-5-b*).
X	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Participants who live in residential settings are responsible for paying room and board from their income. This is paid directly to the residential care provider. The waiver payment is designated for services.

APPENDIX 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:*

○	**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:*
X	**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.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).

○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

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)*:

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

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

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:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**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

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:			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 (Column 7 less Column 4)**
1	$13,557	$9,624	$23,181	$48,610	$3,783	$52,393	$29,212
2	$15,813	$10,512	$26,325	$49,583	$4,131	$53,714	$27,389
3	$16,578	$11,479	$28,057	$50,575	$4,511	$55,086	$27,029
4	$17,096	$12,535	$29,631	$51,586	$4,926	$56,512	$26,881
5	$17,822	$13,688	$31,510	$52,618	$5,379	$57,997	$26,487

Appendix J-2 - Derivation of Estimates

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:	Level of Care:
Year 1	3,294		
Year 2	3,589		
Year 3	3,906		
Year 4 (renewal only)	4,254		
Year 5 (renewal only)	4,632		

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-d.

CMS-372(S) SFY-06 Initial = 289 Days/365 = .79

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 for these estimates is as follows:

The projected FY 2007 values for users, units and cost for each waiver service were estimated by first calculating ratios of first half FY 2006 to year-end FY 2006 actuals. These ratios were then applied to first half FY 2007 actuals to project year-end SFY 2007 values. The service specific costs were each reduced by

1.75% to bring the total in line with the overall projected year-end HCBC expenditure. Values for 'avg units per user' and 'avg cost per unit' were then calculated mathematically. For FY 2008 (Y1) and FY 2009 (Y2), the overall HCBC-ECI state agency requested budget amount was applied as the grand total cost value. The ratio of the service specific cost to the total cost for FY 2007 was applied against these totals to obtain the 2008 and 2009 service specific costs. The 2007 values for service specific users were increased by the ratio of 2008:2007 unduplicated participants. This process was then repeated for each remaining year (Y2-Y5). Specific costs per user values were obtained by inflating 2007 values by a projected 4.2% annually (excl PERS which is held constant). Units and units per user were then calculated mathematically. In 2008, Supported Housing is anticipated to be the focus of a specific budgetary increase and has been adjusted accordingly in cost, units and users.
For 2010-2012 (Y3-Y5), the 2009(Y3) units per user were carried forward for each service. The values of total cost and units were then calculated mathematically from the other values. The sum of the service specific costs result in the grand total costs.

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:

In FY 2006, the overall paid per client expense for all other Medicaid services was $6,320. Based on the CMS 372(S), the D' ratio was thus 13,644/6,320 or 2.15:1. Applying this factor to the budgeted values for FY 08/09 (Y1, Y2) results in values of $9,624 and $10,512 respectively. Applying the resulting 9.2% growth factor for the remaining 3 years results in D' values of $11,479 for Y3, 12,535 for Y4 and $13,688 for Y5. The initial Y1 value is lower than the FY 2006 actual value due to the impact of Medicare Part D.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

In FY 2006, the incurred Factor G value was $44,406 (CMS 372(S)) compared to the actual paid value of $38,134. This results in a ratio of 1.1645. In 2008(Y1) and 2009(Y2), the State budgeted amounts are $41,744 and $42,579 respectively. Inflating by the 2% inflation observed between 08/09 for the years 2010-2012 (Y3-Y5) and applying the 1.1645 ratio to these values results in the following:
Y1=$48,610 Y2=$49,583 Y3=$50,575 Y4=$51,586 Y5=$52,618

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:

In FY 2006, the overall paid per client expense for all other Medicaid services was $6,320. Based on the CMS 372(S), the G' ratio was thus 5,345/6,320 or 0.845:1. Applying this factor to the budgeted values for FY 08/09 (Y1, Y2) results in values of $3,783 and $4,131 respectively. Applying the resulting 9.2% growth factor for the remaining 3 years results in D' values of $4,511 for Y3, $4,926 for Y4 and $5,379 for Y5. The initial Y1 value is lower than the FY 2006 actual value due to the impact of Medicare Part D.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: 1 Year 2008					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. Adult Family Care	day	240	289	72.12	5,002,000
2. Adult In Home Care	15 min	106	1532	3.57	579,845
3. Adult Medical Day	day	410	98	51.39	2,064,810
4. Assistive Technology	occurrence	7	1	324.44	2,271
5. Chore	15 min	105	281	4.53	133, 515
6. Community Transition	transition	3	1	800	2400
7. Consolidated	day	15	300	80.00	360,000
8. Environmental Accessibility	occurrence	68	1	7457.28	507,095
9. Home Delivered Meals	meal	963	153	7.14	1,052,300
10. Home Health Aide	15 min	1,507	695	5.95	6,227,743
11. Homemaker	15 min	1,442	535	4.52	3,486,792
12. Personal Care	15 min	1,344	1827	4.56	11,204,945
13. PERS	month	2,114	9	32.88	625,600
14. Residential Care	day	559	221	57.45	7,096,860
15. Respite	15 min	113	1230	1.66	231,139
16. Shared Housing	day	13	270	25.80	90,544
17. Skilled Nursing	15 min	2,112	75	21.12	3,344,937
18. Specialized Medical Equipment	item	563	12	80	540,000
19. Supportive Housing	day	188	290	$38.60	$2,104,483
GRAND TOTAL:					$44,657,279
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3294
FACTOR D (Divide grand total by number of participants)					$13,557
AVERAGE LENGTH OF STAY ON THE WAIVER					289

Waiver Year: 2 Year 2009					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. Adult Family Care	day	283	310	75.27	6,603,437
2. Adult In Home Care	15 min	116	1600	3.72	690,432
3. Adult Medical Day	day	448	108	53.40	2,583,504
4. Assistive Technology	occurrence	17	1	334.31	5,678
5. Chore	15 min	156	325	5.35	272,056
6. Community Transition	transition	4	1	800	3200
7. Consolidated	day	15	300	80.00	360,000
8. Environmental Accessibility	occurrence	80	1	7985	638,800
9. Home Delivered Meals	meal	1,051	169	7.41	1,316,646
10. Home Health Aide	15 min	1,606	745	6.20	7,418,114
11. Homemaker	15 min	1,625	550	4.76	4,254,250
12. Personal Care	15 min	1,468	1957	4.88	14,019,703
13. PERS	month	2,309	10	33.90	782,755
14. Residential Care	day	700	230	61.15	9,845,150
15. Respite	15 min	123	1300	1.81	289,203
16. Shared Housing	day	38	300	34.75	396,150
17. Skilled Nursing	15 min	2,307	79	22.50	4,100,693
18. Specialized Medical Equipment	item	915	12	82	899,923
19. Supportive Housing	day	194	290	$40.37	$2,271,392
GRAND TOTAL:					$56,751,086
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,589
FACTOR D (Divide grand total by number of participants)					$15,813
AVERAGE LENGTH OF STAY ON THE WAIVER					289

Waiver Year: 3 Year 2010					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. Adult Family Care	day	308	322	78.44	7,774,680
2. Adult In Home Care	15 min	126	1684	3.88	823,931
3. Adult Medical Day	day	488	108	55.67	2,933,990
4. Assistive Technology	occurrence	18	1	336.56	6,058
5. Chore	15 min	192	350	5.40	362,880
6. Community Transition	transition	6	1	850	5100
7. Consolidated	day	18	300	80.00	432,000
8. Environmental Accessibility	occurrence	90	1	8000	720,000
9. Home Delivered Meals	meal	1,146	169	7.72	1,495,266
10. Home Health Aide	15 min	1,774	750	6.46	8,595,030
11. Homemaker	15 min	1,736	557	4.91	4,747,734
12. Personal Care	15 min	1,600	2000	4.96	15,872,000
13. PERS	month	2,516	10	33.91	853,115
14. Residential Care	day	763	230	64.40	11,301,556
15. Respite	15 min	133	1300	1.85	319,865
16. Shared Housing	day	43	300	35.80	461,820
17. Skilled Nursing	15 min	2,374	80	22.85	4,339,672
18. Specialized Medical Equipment	item	1105	12	83	1,100,514
19. Supportive Housing	day	212	290	$42.41	$2,607,315
GRAND TOTAL:					$64,752,526
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,906
FACTOR D (Divide grand total by number of participants)					$16,578
AVERAGE LENGTH OF STAY ON THE WAIVER					289

Waiver Year: 4 Year 2011					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. Adult Family Care	day	336	322	80	8,655,360
2. In Home Care	15 min	136	1684	4	916,096
3. Adult Medical Day	day	530	108	57	3,262,680
4. Assistive Technology	occurrence	18	1	345	6,210
5. Chore	15 min	210	350	5.35	393,225
6. Community Transition	transition	7	1	850	5,950
7. Consolidated	day	19	300	80.00	456,000
8. Environmental Accessibility	occurrence	90	1	8000	720,000
9. Home Delivered Meals	meal	1,199	169	8.00	1,621,048
10. Home Health Aide	15 min	1,916	755	6.70	9,692,086
11. Homemaker	15 min	1,861	557	5.10	5,286,543
12. Personal Care	15 min	1,714	2000	5.15	17,654,200
13. PERS	month	2,700	10	34.00	918,000
14. Residential Care	day	848	230	66.15	12,780,180
15. Respite	15 min	145	1300	1.89	356,265
16. Shared Housing	day	45	300	37	499,500
17. Skilled Nursing	15 min	2,510	81	23.50	4,777,785
18. Specialized Medical Equipment	item	1773	12	84	1,787,500
19. Supportive Housing	day	229	290		$2,938,605
GRAND TOTAL:					$72,727,233
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4,254
FACTOR D (Divide grand total by number of participants)					$17,097
AVERAGE LENGTH OF STAY ON THE WAIVER					289

Waiver Year: 5 Year 2012					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. Adult Family Care	day	350	322	80	9,016,000
2. Adult In Home Care	15 min	146	1684	4.15	1,020,336
3. Adult Medical Day	day	560	108	60	3,628,800
4. Assistive Technology	occurrence	19	1	350	6,650
5. Chore	15 min	225	350	5.45	429,188
6. Community Transition	transition	8	1	850	6,800
7. Consolidated Services	day	20	300	80.00	480,000
8. Environmental Accessibility	occurrence	90	1	8000	720,000
9. Home Delivered Meals	meal	1,310	169	8.15	1,804,329
10. Home Health Aide	15 min	2,030	755	7.00	10,728,550
11. Homemaker	15 min	2,039	557	5.30	6,019,332
12. Personal Care	15 min	1,910	2000	5.35	20,437,000
13. PERS	month	2,900	10	34.25	993,250
14. Residential Care	day	900	250	69.00	15,525,000
15. Respite	15 min	159	1300	1.95	403,065
16. Shared Housing	day	49	300	40	588,000
17.Skilled Nursing	15 min	2,785	82	24.75	5,652,158
18. Specialized Medical Equipment	item	1782	12	84	1,796,663
19. Supportive Housing	day	245	290	$46.37	$3,294,375
GRAND TOTAL:					$82,549,496
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4,632
FACTOR D (Divide grand total by number of participants)					$17,822
AVERAGE LENGTH OF STAY ON THE WAIVER					289