Granite Case Management LLC
288 Baptist Hill Road
Canterbury, NH 03224

Senator John Reagan, Chair
Representative Carol McGuire, Vice Chair
Joint Legislative Committee on Administrative Rules
Office of Legislative Services
Administrative Rules
Via Email

In Re: Final Proposal 2021-55, He-M 524, Choices for Independence Program
Amended Conditional Approval Request of April 7, 2022

Dear Senator Reagan and Representative McGuire:

I submit the following in response to the above identified amended conditional approval request and in relation to the remaining unresolved issues raised during my participation in the Medical Care Advisory Committee review of the rule, **on behalf of myself**.

- The rule does not adequately define the services provided to the recipients of the waiver.
- The rule impacts the State's cost for long-term care, as well as the State's reliance on a 50% federal funding match. The match is jeopardized when services are not provided in accordance with federal guidance.
- The rule needs to be in compliance with the federal regulations for the 1915 (c) In Home Supports (IHS) waiver as the rule is intended to form the operational structure for the waiver.
- The department should not rely on an alternate document or process for the operational structure of the IHS Waiver, such as the PDMS Manual, which is being drafted outside of the JLCAR process. At a minimum, applicable definitions should included in this rule.

The rule should be amended to reduce the negative impact to the waiver participants or providers, as much as possible. Addressing the concerns identified in the attachments will further the goal of compliance with applicable regulations.

Respectfully,

Carolyn A Virtue

Attachments: Attachment A – Issues of Overarching Concern
Attachment B - IHS Manual Definitions - Received March 18, 2022
Attachment C - Email Communications of 2/22/2022
Attachment D - Email Communications of 3/9/2022
Attachment E - CMS Corrective Action Plan Letter of 10/28/20
Attachment F - CMS HCBS (1915 c) Waiver Application Instructions Excerpt
Attachment G - Email Communications 4/6-8/2022

CC: Senator James Gray; Senator Suzanne Prentiss; Senator Ruth Ward; Senator Rebecca Whitley; Representative Alan Bershtein; Representative Bill Hatch; Representative Timothy Lang; Representative Peter Schmidt; Michael Morrell; Christina Muniz

1. Clarification of the role and definition of Service Coordination Inconsistent with the federal regulations

Amended Conditional Approval Request

In its amended conditional approval request, the Department does not respond to the request for reference or inclusion of the federal definition for the above referenced service.

Of note, although many services are not adequately defined in this rule, the department is working simultaneously on a "manual" for the IHS Waiver. The department has left the IHS Rule intentionally vague to give them latitude to craft the manual. I am opposed to the crafting of these definitions outside of the legislative rule making process. Consumers and providers should not be denied access to the public process of rule making. I am concerned abut what, if any, authority can be derived from the manual. While the applicability of rule is widely understood, the same cannot be cannot be said of a ***manual.***

As an example, service coordination as contained in the "***manual***" as "Service Coordination: Service Coordination: Services which will assist eligible individuals in gaining access to needed waiver and or State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source. This service may be provided remotely through Telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements. This service may be provided in an acute setting, only when the parent or guardian is not available and under the following conditions: (A) Identified in an individual's person-centered service plan; (B) Provided to meet needs of the individual that are not met through the provision of hospital services; (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and (D) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities."[1]

Of note, what is decided here today goes well beyond this rule, it will impact other waivers. The department states "Once the tools are developed for the IHS waiver they will be adopted and edited as needed for the DD and ABD waivers" [2]

Prior/Current Testimony

On multiple occasions throughout the MCAC subcommittee process it was requested department should utilize a recognized definition for case management, Case management (service coordination) services provider means any entity or organization which is engaged in arranging services furnished to assist individuals, who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.[3]

Utilizing an alternate definition as is done in this rule for the service coordination, which is contrary to federal regulations, puts the program at risk for recoupment of federal dollars associated with the services. Additionally, access to the service provided as intended is out of reach of the waiver population.

The department has stated the rationale for NOT utilizing the proper definition in the He-M 524 rule is due to CMS having the department under a Corrective Action Plan.[4] The department has until July 1, 2023 to come into compliance with the federal regulations, 15 months from now.

The He-M 524 will be in effect for 10 years from now. Where the department already has the authority to ignore federal law for only a short time longer, it makes sense to include the federal reference here as it still applies today although excused and for the duration of the rule.

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[1] See Attachment B, pg. 8

[2] See Attachment C, pg. 2

[3] See Attachment D, pg. 2

[4] See Attachment E

Applicable objections:

In accordance with JLCAR 403.01, the Committee may object to a proposed rule as contrary to the public interest if the Committee determines that the rule is not responsive to a public need. A proposed rule shall be considered not responsive to a public need if the Committee determines that the agency has used broad language when a more specific requirement is needed. The departments plan to rely on a manual for definitions is not proper. The rule itself is the proper place to make such definitions.

In accordance with JLCAR 403.02, the Committee may object to a proposed rule as contrary to the public interest if the Committee determines that the proposed rule cannot be uniformly applied once it is adopted. The rule cannot be uniformly enforced by the agency. Where the department has stated it will rely on the "manual" for definitions and operational structure, it is unclear if any authority at all exists.

2. The rule does not provide for conflict free case management by any willing and qualified providers required 42 CFR 441.301(c)(1)(vi)

Amended Conditional Approval Request

The issue here is relative to the federal requirements for case management (service coordination) provided under a 1915(c) waiver. The rule is not consistent with the requirements.[5]

In the amended conditional approval request, the Department does not address this.

Prior/Current Testimony

Case management (service coordination) services provider means any entity or organization which is engaged in arranging services furnished to assist individuals, who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. Individuals shall be allowed the free choice of any qualified case management (service coordination) provider when obtaining case management (service coordination) services. Case management (service coordination) services shall not be used to restrict an individual's access to other services. Case management (service coordination) service providers shall be free from conflict of interest and shall not provide case management (service coordination) activities and other services to the same individual. Case management (service coordination) activities shall not include activities which constitute the direct delivery of other services.

In accordance with the comments made in regard to some families providing their own coordination of care actives, I recommend including:

A participant or their representative may coordinate their services in lieu of receiving case management (service coordination).

Please also see attached the waiver instructions with highlights regarding the above which clearly defines 42 CFR 441.301(c)(1)(vi) (vi) as applicable to the waiver. Additionally, I'd comment that if utilized to determine the spirit and intent of CMS, I do not see how we are reaching the bar on service coordination with what is included in the rule presently.[6]

42 CFR 441.301(c)(1)(vi)
(vi) Providers of HCBS for the individual,

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[5] See Attachment G

[6] See Attachment F

or those who have an interest
in or are employed by a provider of
HCBS for the individual must not provide
case management or develop the
person-centered service plan, except
when the State demonstrates that the
only willing and qualified entity to
provide case management and/or develop
person-centered service plans in
a geographic area also provides HCBS.
In these cases, the State must devise
conflict of interest protections including
separation of entity and provider
functions within provider entities,
which must be approved by CMS. Individuals
must be provided with a clear
and accessible alternative dispute resolution
process.

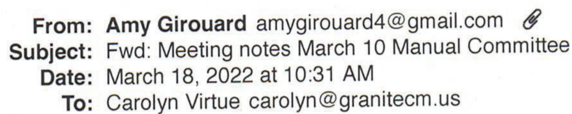
Applicable objection:
In accordance with JLCAR 403.01, the Committee may object to a proposed rule as contrary to the public interest if the Committee determines that the rule is not responsive to a public need. A proposed rule shall be considered not responsive to a public need if the Committee determines that: The rule is not drafted in clear and understandable language and the rule is designed to benefit the administrative convenience of the agency to the detriment of the public.

Attachment B

Email Communications of 3/17 & 18/2022

IHS Manual Definitions

26 PAGES



From: **Amy Girouard** amygirouard4@gmail.com
Subject: Fwd: Meeting notes March 10 Manual Committee
Date: March 18, 2022 at 10:31 AM
To: Carolyn Virtue carolyn@granitecm.us

Thought this might be of interest.
Amy

---------- Forwarded message ---------
From: **Terri Warren** <twarren29@comcast.net>
Date: Thu, Mar 17, 2022, 7:03 PM
Subject: Meeting notes March 10 Manual Committee
To: Jessica.D.Gorton@dhhs.nh.gov <Jessica.D.Gorton@dhhs.nh.gov>, Abigail.P.Conger@dhhs.nh.gov <Abigail.P.Conger@dhhs.nh.gov>, missionmaxwell@gmail.com <missionmaxwell@gmail.com>, cfitzgibbons@gatewayscs.org <cfitzgibbons@gatewayscs.org>, klarocque@pathwaysnh.org <klarocque@pathwaysnh.org>, amalouin@communitypartnersnh.org <amalouin@communitypartnersnh.org>, amyv@mds-nh.org <amyv@mds-nh.org>, Erin Hudson <ehudson@gatewayscs.org>, c.Gonzales@oneskyservices.org <c.Gonzales@oneskyservices.org>, amygirouard4@gmail.com <amygirouard4@gmail.com>

Hello,

Here are the minutes and the document we discussed at our meeting.

Our work for the next meeting is to:

add the definitions for those items listed in the minutes below

Add regions to the area agency definition

Ensure that supported-decision making reflects the same language used on the court website

I have attached the document for your use. Please work on what you can prior to the next meeting.

Notes for consideration from 3/10/22 committee meeting

Be sure all of the definitions are related to In Home Supports

Add definitions for redetermination; quarterly satisfaction; Katie Beckett; community mental health centers; home visit with health care levels; Bureau family centered services; family council; budget; Family as employer of record

Also add regions to the area agency definition; make sure supported decision-making definition is the same as the court website if it is defined there

Remember to add references for the place you would find the support/service in the manual to each definition

Be sure to have it created in Adobe for printing

Have a placeholder for required trainings section

Terri Warren

NH JO Commissioner

Definitions_Ter
ms upd...].docx

Definitions/Terms for Glossary/Appendix

- **Medicaid**

New Hampshire Medicaid is a federal and state funded health care program that serves a wide range of needy individuals and families who meet certain eligibility requirements. The program works to ensure that eligible adults and children have access to needed health care services by enrolling and paying providers to deliver covered services to eligible recipients.

  - **APTD**
    - Aid to the Permanently and Totally Disabled (APTD) is cash assistance for individuals who are between the ages of 18 and 64 and who are physically or mentally disabled.
    - To be eligible for APTD cash assistance, you must meet certain requirements. If you are eligible for cash assistance, you are also eligible for medical assistance. Check on the definition of this

  - **MEAD**
    - Medicaid for Employed Adults with Disabilities (MEAD) provides Medicaid coverage to adults with disabilities who are working and who would not otherwise be financially eligible for Medicaid. MEAD was designed to allow individuals with disabilities to increase their working income and have higher resource limits.

  - **Long Term Care**
    - Individuals seeking Long Term Care services covered by the Medicaid Program, which include both nursing home care and Choices for Independence home and community based services, must meet specified medical and financial eligibility requirements. Medical eligibility is determined through an application and assessment process administered by the Bureau of Elderly and Adult Services (BEAS) in accordance with medical criteria established by law. Financial eligibility is determined by the Bureau of Family Assistance (BFA) in accordance with defined criteria for income and resources specific to the Medicaid Long Term Care Program. The Bureau of Elderly and Adult Services and the Bureau of Family Assistance work together to determine ultimate eligibility decisions. Review this for In Home Supports

  - **State Plan**
    - All state Medicaid agencies are required to have an approved Title XIX/Medicaid State Plan. The state plan describes the nature and scope of its program and gives assurance that the state's Medicaid program will operate in compliance with federal Medicaid regulations and other official federal issuances. Having an approved state plan ensures that the state will receive matching federal funds for its Medicaid program.
    - Amendments to the state plan are necessary for many types of changes to the Medicaid program, such as changes to eligibility requirements or groups, changes in the scope of services provided, the addition of new provider types,

adding or eliminating prior authorization requirements, adding or removing service limits, and changing reimbursement amounts or methodologies. Details about state plan requirements, including the timing of submittals, can be found at 42 CFR 430, Subpart B. Proposed state plan amendments are submitted to the Centers for Medicare and Medicaid Services (CMS) for review and approval.

- Need to add info RE: state plan for those in IHS that is NOT an MCO

- **Medicare**

Medicare is the federal health insurance program for: People who are 65 or older, certain younger people with disabilities, people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). The different parts of Medicare help cover specific services:

  - **Medicare Part A (Hospital Insurance) :** Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

  - **Medicare Part B (Medical Insurance):** Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

  - **Medicare Part D (Prescription Drug Coverage):** Part D helps cover the cost of prescription drugs (including many recommended shots or vaccines).

- **HCBC**
  - The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

- **Department of Health & Human Services (DHHS)**
  - The New Hampshire Department of Health and Human Services (DHHS) is the largest agency in New Hampshire state government, responsible for the health, safety and well-being of the citizens of New Hampshire. DHHS provides services for individuals, children, families and seniors, and administers programs and services such as mental health, developmental disability, substance abuse, and public health. This is accomplished through partnerships with families, community groups, private providers, other state

and local government entities, and many citizens throughout the State who help make New Hampshire a special place in which to live.
    - Many programs and services are under the auspices of DHHS because the New Hampshire Legislative and Executive branches have recognized over the years that the majority of people who access Department services have multiple needs that require coordinated assistance from more than one program area. The Department is also charged with administering at the State level many federally enacted health and social service programs.
    - It was more than a century ago when the State first recognized its obligation to support and protect the health and welfare of its citizens. Since then, the New Hampshire Legislature and Governors have been working with the Department in its efforts to improve the effectiveness, coordination and delivery of the many programs and services that help people across the State meet their needs each and every day.

- **Managed Care Organization (MCO)**
    - Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangement between state Medicaid agencies and managed care organizations (MCOs) that accept a set per month (capitation) payment for these services.
    - By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. Add the names here

- **Bureau of Developmental Services (BDS)**
    - The Bureau of Developmental Services (BDS) is committed to joining communities and families in providing opportunities for citizens to achieve health and independence. ... All direct services and supports to individuals and families are provided in accordance with contractual agreements between BDS and the Area Agencies.
    - Bureau Liaison
        - Each region has a Bureau Liaison that they work with directly, to review and address questions regarding the use of funds, and review of the program budget and annual service agreement.
- **Area Agency**
    - Area agencies are private non-profit corporations, funded in large part through, and supervised by, the NH Department of Health and Human Services' Bureau of Developmental Services. Area agencies provide programs and services for people with developmental disabilities and their families. Add regions here

- **Developmental Disability**
    - Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during

the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime.

- **Acquired Brain Disorder**
  - An acquired brain disorder (ABD) is defined as a disruption in brain functioning that, is not congenital or caused by birth trauma; presents a severe and life-long disabling condition which significantly impairs a person's ability to function in society; occurs prior to age 60; is attributable to external trauma to the brain such as a motor vehicle incident or fall; anoxic or hypoxic injury to the brain such as cardiopulmonary arrest or carbon monoxide poisoning; infectious diseases such as encephalitis or meningitis; brain tumor; intra cranial surgery or cerebrovascular disruption such as a stroke; toxic exposure; and other neurological disorders such as Huntington's disease or multiple sclerosis that predominantly affect the central nervous system; and is manifested by significant decline in cognitive functioning and ability or deterioration in personality, impulse control, judgment; modulation of mood or awareness of deficits.

- **Developmental Services (DS)**
  - The NH developmental services system offers individuals with developmental disabilities and acquired brain disorders a wide range of supports and services within their own communities. These supports include:
    - Service coordination,
    - Day and vocational services,
    - Personal care services,
    - Community support services,
    - Early Supports and Services and Early Intervention,
    - Assistive technology services; and
    - Specialty services and flexible family supports including respite services and environmental modifications.

- **Developmental Disability (DD) Waiver:** Provides community participation services, residential habilitation/personal care services, respite, service coordination, supported employment, assistive technology support services, community support services (CSS), crisis response services, environmental and vehicle modification services, participant directed and managed services (PDMS) formerly consolidated developmental services, specialty services, wellness coaching for individuals w/autism, DD and ID from 0 - no max age

- **In Home Supports (IHS) Waiver:** Provides in home residential habilitation, service coordination, assistive technology, community integration services, consultations, environmental and vehicle modification services, individual goods and services, non-medical transportation, personal emergency response services (PERS), respite care services, and wellness coaching for individuals with autism, ID, DD ages 0-21.

- **Acquired Brain Disorder (ABD) Waiver:** Provides community participation services, respite, service coordination, supported employment services, assistive technology support services, community support services (CSS), crisis response services, environmental and vehicle modification services, participant directed and managed services - PDMS (formerly consolidated

acquired brain disorder services), residential habilitation/personal care services, specialty services, wellness coaching for individuals w/brain injury ages 22 - no max age

- **Health Risk Screening Tool (HRST)**

The HRST is a web-based system, used by both state and private agencies that provide or facilitate care to vulnerable populations, such as individuals with intellectual and developmental disabilities, traumatic brain injuries, elderly populations as well as many other at risk groups.

  - **Service Agreement:** The annual Service Agreement is completed within the HRST system, which allows for a uniform process, and accuracy with reporting on specific support needs, areas of strength, personal goals, hopes and dreams for the future, and historical background.

  - **Annual Rating/Re-rating:** Part of the HRST process is the annual rating/re-rating, which uses the HRST system to review and answer a wide panel of questions, designed to detect health risks. When fully answered the HRST assigns a numeric degree of health risk to the person called a Health Care Level (HCL).

  - **Quarterly Satisfaction Survey (QSS):** Tool used to survey client and family satisfaction with services on a quarterly basis.

  - **Amendment:** A change to the individual service agreement prior to the annual renewal.

- Goals/Setting Goals: Specific areas client/ individual will work on over the service agreement year. Goals follow the SMART Goal format. Specific, Measurable, Achievable, Relevant, Time Based.
- Budget: Do we need to define, or will there be a section in the manual on the individual budget?
- Monthly Contact/Billable Notes: Monthly documentation completed by the service coordinator, case manager, account manager, etc… to support Medicaid billing. To include type of contact, progress on goals, etc.
- Monthly Progress Notes: Monthly documentation completed by individual, family or provider reporting on services received/provided and progress on goals.
- Timesheets: (Area agency specific) – also need information regarding OT and how that is addressed
- Reimbursement Vouchers/ Invoices (Area agency specific)
- Wage Justification: (Area agency specific? Does every agency have their own process for this?)
- NH BDS Functional Screen for Waivered Services/CCW: Tool used to determine if recipient of service meets level of care for waivered services.

Definitions/Terms for Glossary/Appendix

- Service Categories
  - Residential: Services provided out of the individual's home.
  - Community: Services provided in the individual's community focusing on assistance and training provided to individuals to maintain and improve their skills in personal care, vocational activities and community integration to enhance their social and personal development.
  - Community Support Services: Services intended for individuals who have developed or are trying to develop skills to live independently within the community. Services consist of assistance and training provided to maintain and improve skills in daily living and community integration and to enhance social and personal development.
  - SEP/Employment: Services focusing on assistance and training provided to individuals to maintain and improve their skills in vocational activities and enhance their social, personal development and well-being within the context of vocational goals.
  - Community Integration Services: Community integration services utilize activity based interventions to address the assessed needs of an individual as a means to health and well being as outlined in the service agreement. Community integration services are designed to support and enhance a person's level of functioning, independence and life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by a disability. A pass or membership for admission to community based activities is covered only when needed to address assessed needs. Community based activity passes shall be purchased as day passes or monthly passes, whichever is the most cost effective. Community integration services include activities that promote and individual's health and well being. Fees for water safety training are allowable. Community based camperships are allowable.
  - Assistive Technology: Assistive technology means an item, piece of equipment, certification and training of service animal, or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve functional capabilities of participants. Assistive technology services means a service that directs/assists a participant in the selection, acquisition or use of an assistive technology device. Assistive technology includes: (A) The evaluation of the assistive technology needs of a participant including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; (B) Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology/devices for participants. (C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices such as therapies, interventions, or services associated with other services in the service plan.

(D) Coordination and use of necessary therapies, interventions or services associated with other services in the service plan. (E) Training or technical assistance for the participant or where appropriate, the family members, guardians, advocates or authorized representatives of the participant; and (F) Training or technical assistance for professional or other individuals who provides services to, employ or are otherwise substantially involved in the major life functions of participants. Devices, controls, or appliances, specified in the individual service agreement that enable the individual to increase their ability to perform activities of daily living, and/or perceive, control, or communicate with the environment in which they live will be covered. Adaptive equipment may only include items of durable and non-durable medical equipment necessary to address the individual's functional limitations and specified in the plan of care. Adaptive equipment may be covered so long as the equipment is necessary to address the individual's functional limitations and is not to be used for recreational purposes. May include performance of assessments to identify type of equipment needed by the participant. This service may be provided in an acute setting under the following conditions: (A) Identified in an individual's person-centered service plan; (B) Provided to meet needs of the individual that are not met through the provision of hospital services; (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and (D) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

- Good and Services: Services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the individual service agreement (ISA) (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: The item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; and the participant and their family does not have the funds to purchase the item or service is not available through other sources. Must not be an otherwise covered state plan service. Goods and Services are purchased based on needs identified in the individual service agreement. Experimental or prohibited treatments are excluded. Directed Goods and Services must be documented in the ISA. The coverage of these services permits a state to authorize the purchase of goods and services that are not otherwise offered in the waiver or the state plan. The goods and services purchased under this coverage may not circumvent other restrictions on the claiming for the costs of room and board.

- Non-Medical Transportation: Transportation services are designed specifically to improve the person's and the family caregiver's ability to access community activities within their own community in response to needs identified through the individual's service agreement. Transportation services can include, but are not limited to: 1. Orientation service using other services or supports for safe movement from one place to another; 2. Travel training such as supporting the individual and family in learning

how to access and use informal and public transport for independence and community integration;3. Transportation service provided by different modalities, including; public and community transportation, taxi services, transportation specific to prepaid transportation cards, mileage reimbursement, volunteer transportation, and non-traditional transportation providers, and 4. Prepaid transportation vouchers and cards.

- Consultation and Training: Evaluation, training, mentoring, or special instruction, which maximize the ability of the service provider, family, and/or other caregivers of a specific child/individual to understand and care for that child's/individual's developmental, functional, health and behavioral needs.

- Environmental Modification: Environmental and Vehicle Modification Services: Include those physical adaptations to the private residence of the participant or the participants family, or vehicle that is the waiver participants primary means of transportation, required by the individual's service plan, that are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and community, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All modifications will be provided in accordance with applicable State or local building codes. Relative to vehicle modification, the following are excluded: Those adaptations or improvements to a vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; purchase or lease of a vehicle; and regularly scheduled upkeep and maintenance of a vehicle with the exception of upkeep and maintenance of the modifications. This service may be provided in an acute setting under the following conditions: (A) Identified in an individual's person-centered service plan; (B) Provided to meet needs of the individual that are not met through the provision of hospital services; (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and (D) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.
- Service Coordination: Service Coordination: Services which will assist eligible individuals in gaining access to needed waiver and or State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source. This service may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements. This service may be provided in an acute setting, only when the parent or guardian is not available and under the following conditions: (A) Identified in an individual's person-centered service plan; (B) Provided to meet needs of the individual that are not met through the provision of hospital services; (C) Not a

substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and (D) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and
to preserve the individual's functional abilities.

- Respite Services: Respite Care services consist of the provision of short-term assistance, in or out of an eligible child's/individual's home, for the temporary relief and support of the family with whom the child/individual lives. Respite can be family arranged or agency arranged. Respite services within the In Home Supports waiver are provided in combination with the other In Home Support Services described in this waiver. This service may be provided in an acute setting, only when the parent or guardian is not available and under the following conditions: (A) Identified in an individual's person-centered service plan; (B) Provided to meet needs of the individual that are not met through the provision of hospital services; (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and (D) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.
- In Home Residential Habilitation: In home residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living and community inclusion that assist the participant to reside in the most integrated setting appropriate to his/her needs. In home residential habilitation also includes personal care and protective oversight and supervision. This service may be provided remotely through telehealth as determined necessary by the State to ensure services are delivered while considering individual choice, cost effectiveness and compliance with CMS requirements. This service may be provided in an acute setting, only when the parent or guardian is not available and under the following conditions: (A) Identified in an individual's person-centered service plan; (B) Provided to meet needs of the individual that are not met through the provision of hospital services; (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and (D) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

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Definitions/Terms for Glossary/Appendix

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Definitions/Terms for Glossary/Appendix

- **Medicaid**

New Hampshire Medicaid is a federal and state funded health care program that serves a wide range of needy individuals and families who meet certain eligibility requirements. The program works to ensure that eligible adults and children have access to needed health care services by enrolling and paying providers to deliver covered services to eligible recipients.

  - **APTD**
    - Aid to the Permanently and Totally Disabled (APTD) is cash assistance for individuals who are between the ages of 18 and 64 and who are physically or mentally disabled.
    - To be eligible for APTD cash assistance, you must meet certain requirements. If you are eligible for cash assistance, you are also eligible for medical assistance. Check on the definition of this

  - **MEAD**
    - Medicaid for Employed Adults with Disabilities (MEAD) provides Medicaid coverage to adults with disabilities who are working and who would not otherwise be financially eligible for Medicaid. MEAD was designed to allow individuals with disabilities to increase their working income and have higher resource limits.

  - **Long Term Care**
    - Individuals seeking Long Term Care services covered by the Medicaid Program, which include both nursing home care and Choices for Independence home and community based services, must meet specified medical and financial eligibility requirements. Medical eligibility is determined through an application and assessment process administered by the Bureau of Elderly and Adult Services (BEAS) in accordance with medical criteria established by law. Financial eligibility is determined by the Bureau of Family Assistance (BFA) in accordance with defined criteria for income and resources specific to the Medicaid Long Term Care Program. The Bureau of Elderly and Adult Services and the Bureau of Family Assistance work together to determine ultimate eligibility decisions. Review this for In Home Supports

  - **State Plan**
    - All state Medicaid agencies are required to have an approved Title XIX/Medicaid State Plan. The state plan describes the nature and scope of its program and gives assurance that the state's Medicaid program will operate in compliance with federal Medicaid regulations and other official federal issuances. Having an approved state plan ensures that the state will receive matching federal funds for its Medicaid program.
    - Amendments to the state plan are necessary for many types of changes to the Medicaid program, such as changes to eligibility requirements or groups, changes in the scope of services provided, the addition of new provider types,

adding or eliminating prior authorization requirements, adding or removing service limits, and changing reimbursement amounts or methodologies. Details about state plan requirements, including the timing of submittals, can be found at 42 CFR 430, Subpart B. Proposed state plan amendments are submitted to the Centers for Medicare and Medicaid Services (CMS) for review and approval.

- Need to add info RE: state plan for those in IHS that is NOT an MCO

- **Medicare**

Medicare is the federal health insurance program for: People who are 65 or older, certain younger people with disabilities, people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). The different parts of Medicare help cover specific services:

  - **Medicare Part A (Hospital Insurance) :** Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

  - **Medicare Part B (Medical Insurance):** Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

  - **Medicare Part D (Prescription Drug Coverage):** Part D helps cover the cost of prescription drugs (including many recommended shots or vaccines).

- **HCBC**
  - The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

- **Department of Health & Human Services (DHHS)**
  - The New Hampshire Department of Health and Human Services (DHHS) is the largest agency in New Hampshire state government, responsible for the health, safety and well-being of the citizens of New Hampshire. DHHS provides services for individuals, children, families and seniors, and administers programs and services such as mental health, developmental disability, substance abuse, and public health. This is accomplished through partnerships with families, community groups, private providers, other state

and local government entities, and many citizens throughout the State who help make New Hampshire a special place in which to live.

- Many programs and services are under the auspices of DHHS because the New Hampshire Legislative and Executive branches have recognized over the years that the majority of people who access Department services have multiple needs that require coordinated assistance from more than one program area. The Department is also charged with administering at the State level many federally enacted health and social service programs.
- It was more than a century ago when the State first recognized its obligation to support and protect the health and welfare of its citizens. Since then, the New Hampshire Legislature and Governors have been working with the Department in its efforts to improve the effectiveness, coordination and delivery of the many programs and services that help people across the State meet their needs each and every day.

- **Managed Care Organization (MCO)**
  - Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangement between state Medicaid agencies and managed care organizations (MCOs) that accept a set per month (capitation) payment for these services.
  - By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. Add the names here

- **Bureau of Developmental Services (BDS)**
  - The Bureau of Developmental Services (BDS) is committed to joining communities and families in providing opportunities for citizens to achieve health and independence. ... All direct services and supports to individuals and families are provided in accordance with contractual agreements between BDS and the Area Agencies.
  - Bureau Liaison
    - Each region has a Bureau Liaison that they work with directly, to review and address questions regarding the use of funds, and review of the program budget and annual service agreement.
- **Area Agency**
  - Area agencies are private non-profit corporations, funded in large part through, and supervised by, the NH Department of Health and Human Services' Bureau of Developmental Services. Area agencies provide programs and services for people with developmental disabilities and their families. Add regions here

- **Developmental Disability**
  - Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during

the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime.

- **Acquired Brain Disorder**
  - An acquired brain disorder (ABD) is defined as a disruption in brain functioning that, is not congenital or caused by birth trauma; presents a severe and life-long disabling condition which significantly impairs a person's ability to function in society; occurs prior to age 60; is attributable to external trauma to the brain such as a motor vehicle incident or fall; anoxic or hypoxic injury to the brain such as cardiopulmonary arrest or carbon monoxide poisoning; infectious diseases such as encephalitis or meningitis; brain tumor; intra cranial surgery or cerebrovascular disruption such as a stroke; toxic exposure; and other neurological disorders such as Huntington's disease or multiple sclerosis that predominantly affect the central nervous system; and is manifested by significant decline in cognitive functioning and ability or deterioration in personality, impulse control, judgment; modulation of mood or awareness of deficits.

- **Developmental Services (DS)**
  - The NH developmental services system offers individuals with developmental disabilities and acquired brain disorders a wide range of supports and services within their own communities. These supports include:
    - Service coordination,
    - Day and vocational services,
    - Personal care services,
    - Community support services,
    - Early Supports and Services and Early Intervention,
    - Assistive technology services; and
    - Specialty services and flexible family supports including respite services and environmental modifications.

- **Developmental Disability (DD) Waiver:** Provides community participation services, residential habilitation/personal care services, respite, service coordination, supported employment, assistive technology support services, community support services (CSS), crisis response services, environmental and vehicle modification services, participant directed and managed services (PDMS) formerly consolidated developmental services, specialty services, wellness coaching for individuals w/autism, DD and ID from 0 - no max age

- **In Home Supports (IHS) Waiver:** Provides in home residential habilitation, service coordination, assistive technology, community integration services, consultations, environmental and vehicle modification services, individual goods and services, non-medical transportation, personal emergency response services (PERS), respite care services, and wellness coaching for individuals with autism, ID, DD ages 0-21.

- **Acquired Brain Disorder (ABD) Waiver:** Provides community participation services, respite, service coordination, supported employment services, assistive technology support services, community support services (CSS), crisis response services, environmental and vehicle modification services, participant directed and managed services - PDMS (formerly consolidated

Definitions/Terms for Glossary/Appendix

acquired brain disorder services), residential habilitation/personal care services, specialty services, wellness coaching for individuals w/brain injury ages 22 - no max age

- **Health Risk Screening Tool (HRST)**

The HRST is a web-based system, used by both state and private agencies that provide or facilitate care to vulnerable populations, such as individuals with intellectual and developmental disabilities, traumatic brain injuries, elderly populations as well as many other at risk groups.

  - **Service Agreement:** The annual Service Agreement is completed within the HRST system, which allows for a uniform process, and accuracy with reporting on specific support needs, areas of strength, personal goals, hopes and dreams for the future, and historical background.

  - **Annual Rating/Re-rating:** Part of the HRST process is the annual rating/re-rating, which uses the HRST system to review and answer a wide panel of questions, designed to detect health risks. When fully answered the HRST assigns a numeric degree of health risk to the person called a Health Care Level (HCL).

  - **Quarterly Satisfaction Survey (QSS):** Tool used to survey client and family satisfaction with services on a quarterly basis.

  - **Amendment:** A change to the individual service agreement prior to the annual renewal.

- Goals/Setting Goals: Specific areas client/ individual will work on over the service agreement year. Goals follow the SMART Goal format. Specific, Measurable, Achievable, Relevant, Time Based.
- Budget: Do we need to define, or will there be a section in the manual on the individual budget?
- Monthly Contact/Billable Notes: Monthly documentation completed by the service coordinator, case manager, account manager, etc... to support Medicaid billing. To include type of contact, progress on goals, etc.
- Monthly Progress Notes: Monthly documentation completed by individual, family or provider reporting on services received/provided and progress on goals.
- Timesheets: (Area agency specific) – also need information regarding OT and how that is addressed
- Reimbursement Vouchers/ Invoices (Area agency specific)
- Wage Justification: (Area agency specific? Does every agency have their own process for this?)
- NH BDS Functional Screen for Waivered Services/CCW: Tool used to determine if recipient of service meets level of care for waivered services.

Definitions/Terms for Glossary/Appendix

- Service Categories
  - Residential: Services provided out of the individual's home.
  - Community: Services provided in the individual's community focusing on assistance and training provided to individuals to maintain and improve their skills in personal care, vocational activities and community integration to enhance their social and personal development.
  - Community Support Services: Services intended for individuals who have developed or are trying to develop skills to live independently within the community. Services consist of assistance and training provided to maintain and improve skills in daily living and community integration and to enhance social and personal development.
  - SEP/Employment: Services focusing on assistance and training provided to individuals to maintain and improve their skills in vocational activities and enhance their social, personal development and well-being within the context of vocational goals.
  - Community Integration Services: Community integration services utilize activity based interventions to address the assessed needs of an individual as a means to health and well being as outlined in the service agreement. Community integration services are designed to support and enhance a person's level of functioning, independence and life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by a disability. A pass or membership for admission to community based activities is covered only when needed to address assessed needs. Community based activity passes shall be purchased as day passes or monthly passes, whichever is the most cost effective. Community integration services include activities that promote and individual's health and well being. Fees for water safety training are allowable. Community based camperships are allowable.
  - Assistive Technology: Assistive technology means an item, piece of equipment, certification and training of service animal, or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve functional capabilities of participants. Assistive technology services means a service that directs/assists a participant in the selection, acquisition or use of an assistive technology device. Assistive technology includes: (A) The evaluation of the assistive technology needs of a participant including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; (B) Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology/devices for participants. (C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices such as therapies, interventions, or services associated with other services in the service plan.

(D) Coordination and use of necessary therapies, interventions or services associated with other services in the service plan. (E) Training or technical assistance for the participant or where appropriate, the family members, guardians, advocates or authorized representatives of the participant; and (F) Training or technical assistance for professional or other individuals who provides services to, employ or are otherwise substantially involved in the major life functions of participants. Devices, controls, or appliances, specified in the individual service agreement that enable the individual to increase their ability to perform activities of daily living, and/or perceive, control, or communicate with the environment in which they live will be covered. Adaptive equipment may only include items of durable and non-durable medical equipment necessary to address the individual's functional limitations and specified in the plan of care. Adaptive equipment may be covered so long as the equipment is necessary to address the individual's functional limitations and is not to be used for recreational purposes. May include performance of assessments to identify type of equipment needed by the participant. This service may be provided in an acute setting under the following conditions: (A) Identified in an individual's person-centered service plan; (B) Provided to meet needs of the individual that are not met through the provision of hospital services; (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and (D) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

- Good and Services: Services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the individual service agreement (ISA) (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: The item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; and the participant and their family does not have the funds to purchase the item or service is not available through other sources. Must not be an otherwise covered state plan service. Goods and Services are purchased based on needs identified in the individual service agreement. Experimental or prohibited treatments are excluded. Directed Goods and Services must be documented in the ISA. The coverage of these services permits a state to authorize the purchase of goods and services that are not otherwise offered in the waiver or the state plan. The goods and services purchased under this coverage may not circumvent other restrictions on the claiming for the costs of room and board.

- Non-Medical Transportation: Transportation services are designed specifically to improve the person's and the family caregiver's ability to access community activities within their own community in response to needs identified through the individual's service agreement. Transportation services can include, but are not limited to: 1. Orientation service using other services or supports for safe movement from one place to another; 2. Travel training such as supporting the individual and family in learning

how to access and use informal and public transport for independence and community integration;3. Transportation service provided by different modalities, including; public and community transportation, taxi services, transportation specific to prepaid transportation cards, mileage reimbursement, volunteer transportation, and non-traditional transportation providers, and 4. Prepaid transportation vouchers and cards.

- Consultation and Training: Evaluation, training, mentoring, or special instruction, which maximize the ability of the service provider, family, and/or other caregivers of a specific child/individual to understand and care for that child's/individual's developmental, functional, health and behavioral needs.

- Environmental Modification: Environmental and Vehicle Modification Services: Include those physical adaptations to the private residence of the participant or the participants family, or vehicle that is the waiver participants primary means of transportation, required by the individual's service plan, that are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and community, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All modifications will be provided in accordance with applicable State or local building codes. Relative to vehicle modification, the following are excluded: Those adaptations or improvements to a vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; purchase or lease of a vehicle; and regularly scheduled upkeep and maintenance of a vehicle with the exception of upkeep and maintenance of the modifications. This service may be provided in an acute setting under the following conditions: (A) Identified in an individual's person-centered service plan; (B) Provided to meet needs of the individual that are not met through the provision of hospital services; (C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and (D) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.
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Attachment C

Email Communications of 2/2/2022

2 PAGES

From: **Amy Girouard** amygirouard4@gmail.com
Subject: Fwd: MCAC Follow Up - PDMS Subcommittee
Date: February 2, 2022 at 3:12 PM
To: Carolyn Virtue carolyn@granitecm.us

---------- Forwarded message ---------
From: **Hunt, Sandy** <Sandy.L.Hunt@dhhs.nh.gov>
Date: Wed, Feb 2, 2022, 2:52 PM
Subject: MCAC Follow Up - PDMS Subcommittee
To: amygirouard4@gmail.com <amygirouard4@gmail.com>
Cc: Melby, Leslie <Leslie.K.Melby@dhhs.nh.gov>

Amy – I am following up to the request brought forth by the MCAC as follows:

He-M 524, In-Home Supports, Amy Giouard

The He-M 524 subcommittee will meet today to begin its review of the proposed in-home supports rule. Appreciation was noted for the rule's consumer perspective. Areas to focus on are service coordination, and children not graduating or exiting the school system. A request was made to see the PDMS committee's work. The Department will follow up on the request.

BDS Follow up regarding the work of the PDMS Subcommittee:

The Division of Long Term Supports Participant Directed and Managed Services Committee meets monthly from 200-430 on the 3rd Wednesday of every month. While the overall focus for the larger committees is PDMS (to include all 3 waivers) the smaller subcommittees are focusing on development of tools relative to the I H S waiver. The agenda usually follows:

2:00-2:30 Area Agencies meet independently

2:30-4:00 BDS and Stakeholders join to discuss updates from the individual subcommittees and updates regarding the waivers

4:00-4:30 Area Agencies and BDS meet to review any questions the group came up with during their 2-230 timeframe. Typically stakeholders have jumped off the zoom.

The individual subcommittees meets the following days/times via Zoom. BDS does not typically attend these meetings. However, during November and December BDS attended the individual sub committees to review their task according to the I H S waiver. The larger committee did not meet for the month of December. The group picked back up in January to start fresh.

Self-Assessment Sub Committee: 2nd Monday every month from 230-4 via zoom or phone

This committee is tasked with the development of a self-assessment tool to assist participant/families in determining the level of assistance they need to manage and direct their services. From this tool they will be able to best determine what model of IHS would work best for them as outlined in the waiver.

Estimated time of completion: Spring 2022

Delegation/Responsibilities Group: 2nd Wednesday every month from 11-12 via Zoom or phone

This committee is tasked with the development of a reference guide to be included in the PDMS Manual, what the

responsibilities are for each entity/team member involved depending on what model of PDMS the individual/family representative selects. As well as the specific expectations relative to delegating direct services to another entity.

Estimated time of completion: Spring 2022

Manual group: 2nd Thursday every month from 3-4 via zoom or phone

This committee is tasked with the development of an orientation and training manual that will be provided to participants/families to educate them regarding the documentation and management requirements associated with the use of Medicaid funds for Medicaid services.

Estimated time of completion: Late Spring/ Early Summer 2022

The next step will be for a committee to begin working on an Orientation, Remediation and Transition policy to be implemented, as needed, to ensure the expectations of service delivery are met. I suspect this will go to the Self-Assessment committee, as they seem to be the closest to completion at this time. We are looking for this to be completed Summer 2022.

Once these tools are developed for the I H S waiver they will be adopted and edited as needed to be used for the DD and ABD waiver.

Thank you

Sandy Hunt

Bureau Chief

Bureau of Developmental Services

105 Pleasant St.

Concord, NH 03301

Sandy.Hunt@dhhs.nh.gov

603-271-5026 direct line

603-931-0930 cell

COVID-19 ATTENTION: Visit the NH.GOV website for the latest COVID-19 information, resources, and guidance. Click here https://link.edgepilot.com/s/89af563a/m1CJpHBV4EmmWCGbhViuqw?u=https://www.nh.gov/covid19/ for tips and resources.

Links contained in this email have been replaced. If you click on a link in the email above, the link will be analyzed for known threats. If a known threat is found, you will not be able to proceed to the destination. If suspicious content is detected, you will see a warning.

Attachment D

Email Communications of 3/9/2022

2 PAGES

To: Melissa Nemeth and Jessica Gorton
From: Michelle Winchester
In Re: Follow-up to Subcommittee Meetings, Review of "IP Rule Text He-M 524-MCAC Edits 030122"
Date: March 9, 2022

On behalf of the MCAC Subcommittee on He-M 524, I am submitting this memo to more or less bullet out items that I found to be key overarching issues in our discussions and that I hope will be resolved in the final rule proposal.

In addition, I would also very much like to express our appreciation for the time you have dedicated to the review of this rule proposal and your efforts to respond to our comments and recommendations.

He-M 524.25(c) proposed edits.

To follow up on our conversation this morning, relative to the source of the language proposed in the MCAC edits of March 1, 2022, regarding the appeal notice in He-M 525.25(c), that language can be found here, as well:

He-M 503.05 (2015);

He-M 503.06 (2015);

He-M 522.05 (2018);

He-M 522.06 (2018);

He-M 522.07 (2018); and

He-M 523.05 (2018).

I do see the language proposed by the MCAC to be stronger and clearer than that in He-M 525, which, as I understood it, was the BDS model for language here.

Overarching Issues to Be Clarified

Services:

1. The inclusion of personal care as part of the habilitation service.
2. A mechanism whereby the area agency and family might easily identify what is otherwise covered under the Medicaid State Plan/EPSDT and a routine process for readily obtaining a covered/not covered decision from the Medicaid Bureau in those instances where the coverage is not clearly identified.
3. Identification of the party responsible for determining and ensuring that the IHS waiver funding is the payor of last resort. This is particularly important when the primary coverage for a service is under a different Medicaid category than He-M 524; here the process for determining the coverage source should: (1) not be a family responsibility; and (2) be streamlined and timely in light of the "single state agency" requirement under federal law.
4. Identification of the party responsible for maintaining a provider registry.

5. The aspects of service direction and management that the family is required to undertake and the aspects in which there is flexibility in the undertaking. (The responsibilities for the different aspects should be made clear and agreed upon in the service agreement.)

6. Clarification of the role and independence of the service coordinator, both in the definition and in the service rule. For example:

   He-M524.02(x) "Service coordinator" means a person who is engaged in planning and arranging services for an individual, in accordance with He-M 503.08 and He-M 524.06, and is not otherwise engaged in or associated with the direct delivery of other services. The individual or the individual's representative has the choice of any qualified service coordinator who meets the criteria in He-M 503.08(e) – (f), including: ~~and is chosen or approved by an individual and his or her guardian or representative and designated to organize, facilitate, and document service planning and to negotiate and monitor the provision of the individual's services and who is~~: . . . .

   In turn, the service rule should make clear that this is not a role meant to merely document and schedule/facilitate meetings, but much more, including tracking service delivery and goal achievement. (Amy Girouard's email, dated today, provides much information related to our discussion on this matter.)

7. Identification of the elements of the Bureau's "authorization" of the service agreement, as well as the area agency's authorizations. Who is authorizing what, including service authorization, budget, etc.?

Administration:

8. Identification of the He-M 500 rules that apply in He-M 524.
9. Clarification of appeal rights and process in the areas of the rule identified.
10. Clarification of provider qualifications.
11. Identification of the elements of area agency "oversight."
12. A mechanism for joint oversight, between the area agency and the family, of a detailed In Home Supports budget.

Attachment E

CMS Corrective Action Plan Letter 10/28/2020

1 PAGE

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

October 28, 2020

Lori A. Shibinette
Department of Health and Human Services
Office of the Commissioner
129 Pleasant Street
Concord, NH 03301-3857

Dear Ms. Shibinette,

Thank you for your recent request to extend the compliance date for New Hampshire's current corrective action plan (CAP) concerning conflict of interest and direct billing requirements. The Centers for Medicare & Medicaid Services (CMS) is granting the extension for implementation of the CAP from August 31, 2021 to July 1, 2023. This extension is granted due to the significant impact of the COVID-19 pandemic including the ability of the state to establish and/ or build an independent provider pool.

New Hampshire is currently under a CAP for three of the state's 1915 (c) Home and Community-based Services (HCBS) waivers. The 1915 (c) waivers impacted by this CAP are Developmental Disability (DD) NH.0053, Acquired Brain Disorder (ABD) NH.4177, and the Children's In-Home Support Services (IHS) NH.0397.

CMS will continue to monitor New Hampshire's progress through monthly meetings and progress reports to address timely completion of the established milestones and any concerns with the state, as needed. Should you have any questions or require additional information, please feel free to contact Christopher Semidey, Field Office analyst at 212-616-2328 or Christopher.Semidey@cms.hhs.gov. You may also reach Ciera Lucas, CMS Baltimore analyst at 410-786-0832 or by email to Ciera.Lucas@cms.hhs.gov.

Sincerely,

Ralph F. Lollar -S
Digitally signed by Ralph F. Lollar -S
Date: 2020.10.27 17:31:39 -04'00'

Ralph F. Lollar, Director
Division of Long Term Services and Supports

C: Wendy Hill Petras
Christopher Semidey
Ciera Lucas

Attachment F

CMS HCBS (1915 C) Waiver Application Instructions

4 PAGES

definition. Also, as appropriate, **guidance** is included concerning service coverage.

As noted in the instructions, states are not required to use these core service definitions. They are suggested rather than mandatory definitions and are provided solely to assist states in waiver design. A state may propose an alternate definition. However, each service must be fully described and not described in open-ended terms. Alternate definitions will be reviewed by CMS to determine whether the scope and nature of the service as defined is consistent with waiver service coverage policy.

In addition, a state may propose to cover services beyond those that are included here. When coverage of another service is proposed, CMS will review the proposed coverage to ensure that the service is necessary in order to avoid institutionalization and addresses participant needs that stem from their disability or condition.

In Appendix C-3 of the waiver application, separate provision has been made for specifying limitations on the amount, frequency and duration of waiver services (e.g., limiting respire care to no more than 720 hours in a year). Such limitations should not be incorporated in the service definition itself but instead specified in the appropriate location in the waiver service specification template. However, limitations on the scope of the service should be included in the definition. For example, if a service (e.g., personal assistance) is available only to participants who reside in their own private residence, the limitation should be reflected in the service definition. Similarly, any additional criteria that apply to the provision of a service also should be incorporated into the definition (e.g., the provision of a service requires the determination by a professional that the service is necessary to address specific participant needs). Also, do not include provider qualifications in the service definition. Provider qualifications are specified separately in the Appendix C-3 waiver service specification template.

A. Statutory Services

Statutory services are services specifically contained in §1915(c) of the Act and 42 CFR §440.180. They also are listed in the Appendix C1/C3 Service Specification section of the web-based application. Core service definitions are provided for each of these services. As discussed in the instructions for Appendix C-1, a waiver is considered to cover a statutory service as long as the state's definition aligns with the core service definition included here, even though an alternate title is used (e.g., support coordination instead of case management or attendant care instead of personal care).

1. Case Management

Core Service Definition

Services that assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Instructions

- When case managers perform other activities/functions (e.g., crisis response) that are not included in the core definition, specify the additional activities/functions.
- When case managers are responsible for the ongoing monitoring of the provision of services included in the participant's service plan and/or participant health and welfare, include a statement to that effect in the service definition.
- When case managers are responsible for initiating the process to evaluate and/or re-

evaluate the individual's level of care and/or the development of service plans as specified in Appendices B & D of the application, include a statement to that effect in the service definition.

- When the state claims the cost of case management furnished to institutionalized individuals prior to their transition to the waiver (as provided in Olmstead Letter No.3 (see Attachment D), include a statement to that effect in the service definition. Specify the period that such services may be furnished. Providers may not bill for this service until the date of the person's entry into the waiver program.
- When case management includes providing supports to assist participants to direct their services, specify the types of supports that case managers furnish. For example, a case manager may have responsibility for monitoring the expenditure of funds included in the participant-directed budget when the Budget Authority opportunity is provided under the waiver.

Guidance

- When case management is furnished as a waiver service, a state may not limit the providers of case management to specific classes of entities (e.g., county human services agencies). All willing and qualified providers must be offered a provider agreement. Participants must be able to select from among all qualified providers.
- When activities related to the assessment of level of care and service plan development are furnished as waiver case management activities, payment for such services may not be made until the individually is actually enrolled in the waiver.
- The scope of case management services may not include activities/services that constitute the provision of direct services to the participant that normally are covered as distinct services.
- Case management must comport with conflict of interest requirements at 42 CFR 441.301(1)(vi) and in accordance with Appendix D-1-b. ← The appendix is attached below.

  Carolyn, the citation here is incorrect. Should be 42 CFR 441.301(c)(1)(vi).

2. Homemaker Services

Core Service Definition

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

Instructions

- If homemaker services include other activities/functions that are not reflected in the core definition, modify the core definition to specify the activities/ functions.
- If homemaker services are limited to the performance of a specific household task(s), list the specific task(s) in the definition.

Guidance

- Homemaker services are distinguished from personal care services. Personal care services include assistance in activities of daily living whereas homemaker services usually are confined solely to the performance of household tasks.
- The core service definition may be modified to include the performance of "chore-type" services by a homemaker.

Item D-1-b: Service Plan Development Safeguards

Instructions

Indicate whether the entities and/or individuals responsible for the development of the person-centered service plan are permitted to provide other direct (non-case management) services to the waiver participant, or whether they have an interest in or are employed by a provider of HCBS. If such entities are permitted to furnish other services, explain how and why they are the only willing and qualified entity to be responsible for the person-centered service plan, and describe the safeguards that the state has established to ensure that person-centered service plan development is conducted in the best interests of the waiver participant.

Technical Guidance

Regulations at 42 CFR 441.301(c)(1)(vi) require that providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the state demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the state must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

The safeguards to mitigate and addresses the potential problems that may arise when the individual's HCBS provider, or an entity with an interest in or employed by a provider of HCBS, performs service plan development (ex. self-referral) need to include, at a minimum:

a. Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
b. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
c. Direct oversight of the process or periodic evaluation by a state agency;
d. Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
e. Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

CMS Review Criteria

When a state allows for an entity that is responsible for person-centered service plan development to also provide other direct waiver services, the state has:

1. Demonstrated that the entity is the only willing and qualified provider to develop the person-centered service plan; and
2. Described safeguards that mitigate and addresses the potential problems that may arise, with the service providers' influence on the person-centered planning process (exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) including:
   a) Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
   b) An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
   c) Direct oversight of the process or periodic evaluation by a state agency;
   d) Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
   e) Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Item D-1-c: Supporting the Participant in Service Plan Development

Instructions

In the text field, 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.

Technical Guidance

An effective service plan development process provides the waiver participant the opportunity to actively lead and engage in the development of the plan, including identifying individuals who will be involved in the process. The participant should be furnished supports that are necessary to enable the participant to actively engage in the planning process, including providing information about the range of services and supports offered through the waiver in advance of service plan development and engaging individuals (e.g., a support broker) to assist the participant or facilitate a person-centered planning process. Participants also may be offered other education/training opportunities initially and on an ongoing basis.

Attachment G

Email communication 4/6-8/ 2022
42 CFR 441.301(c)(1) (vi)(vi)

4 PAGES

From: Carolyn Virtue <carolyn@granitecm.us>
Subject: Re: He-M 524 Final Proposal
Date: April 8, 2022 at 10:45:35 AM EDT
To: "Nemeth, Melissa" <Melissa.M.Nemeth@dhhs.nh.gov>
Cc: Michelle Winchester <m.winchester@maine.rr.com>, "Gorton, Jessica" <Jessica.D.Gorton@dhhs.nh.gov>, "Allyson E. Zinno" <Allyson.E.Zinno@dhhs.nh.gov>, Amy Girouard <amygirouard4@gmail.com>, "Ross-Skianes, Erica" <Erica.M.Ross-Skianes@dhhs.nh.gov>

Good Morning Melissa,

Thank you for your clarification in regard to the SPA, I find the information very interesting. I did not know there was a mechanism to provide case management for the population under discussion here outside of the waiver and the waiver system under the state plan. I am very interested to learn more, but that is best left for another day. For now, I will stand corrected and agree the SPA is not applicable and apologize for my misunderstanding.

In an effort to acknowledge in this rule participants should have meaningful choice of case management service providers, from qualified enrolled providers which are free from conflict of interest, utilizing solely references to the 1915 (c) waiver regulation guidance, I recommend inclusion of the following by reference to 42 CFR 441.301(c)(1)(vi)
(vi) the Appendix of the rule regulation and an edit to the service coordination language to clarify applicable guidance:

42 CFR 441.301(c)(1)(vi)
(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to

provide case management and/or develop
person-centered service plans in
a geographic area also provides HCBS.
In these cases, the State must devise
conflict of interest protections including
separation of entity and provider
functions within provider entities,
which must be approved by CMS. Individuals
must be provided with a clear
and accessible alternative dispute resolution
process.

Please also see attached the waiver instructions with highlights regarding the above which clearly defines 42 CFR 441.301(c)(1)(vi) (vi) as applicable to the waiver. Additionally, I'd comment that if utilized to determine the spirit and intent of CMS, I do not see how we are reaching the bar on service coordination with what is included in the rule presently.

Thank you for your consideration, Carolyn

Carolyn A Virtue
Granite Case Management
Cell: (603) 848-7345

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On Apr 7, 2022, at 12:28 PM, Nemeth, Melissa
<Melissa.M.Nemeth@dhhs.nh.gov> wrote:

Hi Carolyn

The service coordination provided for in IHS is not without federal authority. As IHS is provided through a 1915(c)waiver approved by CMS. The waiver provides that for this waiver, case management is provided solely as a waiver service that is defined in the waiver. I've attached page 86 of the approved IHS waiver for reference. The waiver allows the state to define service coordination.

The SPA for targeted case management in your attached e-mail is only for case management provided on the state plan. The case management (service coordination) for IHS participants through He-M 524 is not provided under the State plan, but in accordance with the waiver.

Thank you

Melissa

Melissa M. Nemeth, Esq.
Director, Office of Client and Legal Services
105 Pleasant Street
Concord, NH 03301
Phone (603) 271-5144
Fax (603) 271-5058

From: Carolyn Virtue <carolyn@granitecm.us>
Sent: Wednesday, April 6, 2022 4:30 PM
To: Nemeth, Melissa <Melissa.M.Nemeth@dhhs.nh.gov>
Cc: Michelle Winchester <m.winchester@maine.rr.com>; Gorton, Jessica <Jessica.D.Gorton@dhhs.nh.gov>; Zinno, Allyson <Allyson.E.Zinno@dhhs.nh.gov>; Amy Girouard

<amygirouard4@gmail.com>; Ross-Skianes, Erica <Erica.M.Ross-Skianes@dhhs.nh.gov>
Subject: Re: He-M 524 Final Proposal

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

Hi Melissa,

My comment was "similar" to what was done in the CFI rule, not "exactly" what was done with the CFI Rule.

What references would you be inclined to include for the IHS rule? Or is your position that the IHS Waiver and the case management (service coordination) provided is outside of federal authority?

Carolyn A Virtue
Granite Case Management
Cell: (603) 848-7345

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On Apr 6, 2022, at 4:04 PM, Nemeth, Melissa
<Melissa.M.Nemeth@dhhs.nh.gov> wrote:

Hi Carolyn

The language below and reference to work done in the CFI rule is relative to case management provided under the state plan. As the service coordination for these particular services is provided through the waiver and not the state plan, it wouldn't be appropriate to include federal regulations that solely relate to the state plan. If those are the references you were planning to get together to send to us, the department wouldn't be able to agree to adding them for this reason.

Thank you

Melissa

Melissa M. Nemeth, Esq.
Director, Office of Client and Legal Services
105 Pleasant Street
Concord, NH 03301
Phone (603) 271-5144
Fax (603) 271-5058