STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LEGAL AND REGULATORY SERVICES

BUREAU OF GENERAL COUNSEL – ADMINISTRATIVE RULES UNIT

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June 6, 2022

The Honorable John Reagan, Chairman and Members
Joint Legislative Committee on Administrative Rules
State House Annex, Room 219
25 Capitol Street
Concord, NH 03301

RE: Department of Health and Human Services Response to JLCAR Preliminary Objection to Final Proposal/Conditional Approval Request 2021-120, He-M 524 "In-Home Supports"

Dear Chairman Reagan and Members of the Committee:

In response to the Joint Legislative Committee on Administrative Rules' (hereinafter "JLCAR" or "Committee"), April 15, 2022, preliminary objection and in accordance with RSA 541-A:13, V(c), the Department of Health and Human Services (hereinafter "Department") is requesting that the Committee approve with further amendment Final Proposal 2021-120, He-M 524 entitled "In-Home Supports".

The Committee's preliminary objection was made with the understanding that the Department would submit an objection response addressing the public testimony that was presented to the Committee on April 15, 2022.

Please find attached an annotated version of the rule that reflects the changes made within the conditional approval request that satisfies Committee staff's comments on the final proposal and makes further changes to He-M 524.03 on eligibility by reordering (a)(4) and (a)(5) and adding an additional reference in (b) to reflect the amendment in (a) for clarity based on public testimony.

In response to the issues identified in testimony submitted to Committee staff prior to the April 15, 2022 JLCAR meeting and the JLCAR meeting/transcript, the Department responds as follows:

I. Background.

The existing He-M 524 was scheduled to expire on November 17, 2021. The Department began revisions to He-M 524 in approximately May 2021, to ensure consistency between the rule and the In-Home Supports Home and Community Based Waiver that was renewed in January 2021.The Department entered into formal rulemaking by filing the Rulemaking Notice Form and the Initial Proposal on November 15, 2021. The Rulemaking Notice Form was published in the Rulemaking Register on November 24, 2021. A public hearing was held on January 5, 2022 with no members of the public in attendance. The Department did receive written public testimony within the allotted public comment period and the Department considered and made adjustments to the rule based on those comments.

The Department submitted the proposed He-M 524 to the Medical Care Advisory Committee (hereinafter "MCAC") to be placed on their December 13, 2021 meeting agenda. At that meeting, a subcommittee was formed to review, ask clarifying questions, and provide input for the revisions to the proposed He-M 524. The subcommittee was comprised of 6 members:

- Amy Girouard, Chair/Consumer Advocate;
- Michelle Winchester, Policy Analyst;
- Carolyn Virtue, MCAC Chair;
- Jessica Gorton, Department HCBS Waiver Administrator III;
- Erica Peaslee, Consumer; and
- Melissa Cote, Consumer.

The subcommittee met several times between January 2022 through March 2022, specifically on January 10, January 24, February 2, March 2, March 7, and March 9 resulting in many discussions and revisions on various topics throughout the proposed rule and concluded with the recommendation that He-M 524 be approved at the April 15, 2022 JLCAR meeting. After these meetings occurred and all public comment periods had expired, the committee received written and verbal testimony. The Department will address that written testimony now.

II. He-M 524 does not adequately provide services to recipients of waiver.

Written testimony submitted to JLCAR indicates that there should be a "recognized definition for case management" in the proposed rule, specifically stating that the Department's rationale for not using a Federal definition of service coordination (case management) in the proposed rule is due to a Corrective Action Plan (CAP) the Department is currently under by the Centers for Medicare and Medicaid Services (CMS). This is not correct. During MCAC subcommittee meetings, the Department explained that the Federal definition is applicable only for Medicaid services provided on the State Plan. The services provided in accordance with this rule, He-M 524, are provided in accordance with a 1915(c) Home and Community Based Services (HCBS) Medicaid Waiver. The Department clarified this prior to the submission of written testimony filed with Committee staff (see Attachment, pages 1-2). The Department addressed this comment fully and believes this matter is resolved.

In addition, the written testimony indicates that some pages from the HCBS waiver technical guidance supports an overarching Federal definition of case management. To the contrary, the guidance provides that the service is covered if the definition "aligns with the core service definition included here, even though an alternate title is used (e.g., support coordination instead of case management…)" The core definition of case management in the technical guide is as follows: "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." He-M 524.06(a) provides: "Service coordination services shall be services that assist individuals in gaining access to needed waiver and or Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of funding source." The Department's definition is in alignment with CMS requirements for this waiver and is included in the State's In Home Supports (IHS) 1915(c) waiver that was approved by CMS in January 2021.

The written testimony also indicates that the Department is out of compliance with Federal Regulations relative to conflict free case management. This is not accurate. As explained throughout the MCAC subcommittee process, as well as in an e-mail directly to Ms. Virtue on April 6, 2022 (see Attachment, page 5), that the Department is currently under a CAP with CMS. Conflict free case management is one part of the CAP and the Department has until June 2023 to be in full compliance with this requirement. The system is not yet required, nor prepared, to implement the CAP. Therefore, it is

premature to put this requirement in to the rule. The Department plans to review and revise the rule as necessary to be in compliance with the CAP.

III. He-M 524 impacts state cost for long term care- jeopardizes the states 50% funding match.

Written testimony states that the rule impacts the state's cost for long term care and indicated that the match is jeopardized when services are not provided in accordance with federal guidance. As noted above, the definition of Service Coordination is in line with CMS guidance and the Department is providing services in accordance with Federal regulations, and there are no provisions of this rule that put the 50% match at risk.

IV. The Department is drafting rules, specifically definitions, outside of rulemaking.

Verbal testimony during the JLCAR hearing on He-M 524 stated, "The Department has testified during the course of this that the reason for not including definitions in rule is that they have another process going on simultaneously where they are developing a manual, and the manual will define the services." In response, the Department offers the following:

The Department has coordinated a Long Term Supports and Services participant directed and managed services committee. This committee is developing a manual to clearly define the rights and responsibilities of individuals and families relative to managing Medicaid funds, and to detail budget authority and employment authority. The Department included this as part of the approved In Home Supports 1915(c) waiver (see Attachment, page 7). The purpose of this manual is to assist families with understanding how to manage the services for their child. The Department, in working with the MCAC subcommittee, added to He-M 524.18 that agencies provide the manual to an individual or family prior to services being delivered. The consumers on the MCAC subcommittee were very pleased with this addition. The manual is not being used to define any services. While the manual may include definitions so families can understand the terms, only terms defined in the proposed rule will be included. It is important to note that the manual is currently a work in progress and is not final. The Department will review the manual before it is provided to families to ensure that any definitions are consistent with the approved rule definitions. This manual is not considered rule or law and is simply a tool for families. The rule as adopted by JLCAR is the authority and the definitions in the rule are law.

V. Remote Services- He-M 524.16(d) - potential error in rule.

Verbal testimony stated an error existed in He-M 524.16(d), specifically that the word "can" should be the word cannot. The word "can" does not appear in He-M 524.16(d). The Department does not need to make any changes.

VI. Remote services v. Telehealth services: Different services.

Verbal testimony indicated there is an error in using the term "remote services," testifying that "telehealth" would be the more appropriate term. Specifically, it was pointed out that this rule conflicts with two bills currently being considered by the legislature. The Department disagrees. The current bills before the legislature relative to telehealth relate to licensed health care practitioners and not this waiver program. The services provided to recipients of In Home Supports are not provided by practitioners who are regulated by these laws, but instead are provided by individuals who meet the criteria set out in He-M 524 and the waiver. Therefore, the term remote was used deliberately as not to confuse the services in the waiver provided remotely from telehealth services provided by practitioners.

VII. Providers question what determines the eligibility date as well as issues with completing the functional screen before the person-centered plan and/or health or screening tool assessment.

The Department has reviewed the comments regarding potential confusion as to when the functional screen needs to be submitted. To that end, the Department has made revisions to He-M 524.03 (a), by reversing the order of subparagraphs (4) and (5), and making a revision at the end of He-M 524.03(b) to indicate the timeframe begins when an eligibility decision in accordance with 524.03(a)(1)-(4) has been made. These changes are being made to make this portion of the rule more intuitive and to avoid any confusion as to when the functional screen needs to be submitted.

VIII. Recommendation that the Department keep the requirements of He-M 524 on face to face to what is documented in the waiver.

Verbal testimony given to the committee stated that the area agencies would like the Department to require face to face services in accordance with the waiver only and not make any changes to He-M 524. The waiver requires monthly contact either in person or via phone and quarterly documentation showing completion of satisfaction surveys with the individual/guardian. He-M 524.20 states "Service coordinator shall visit the individual and contact the guardian in person or through video call at least quarterly." This language is in line with the waiver. Please note, not all requirements on agencies are reflected in the waiver. The waiver is the State's agreement with CMS that outlines how the services are provided and reporting requirements. The waiver does not limit the requirements on agencies to perform services with quality and efficiency and in accordance with all Department regulations.

Importantly, the requirements of He-M 524.20 are not new and were previously written in He-M 503.10 which clearly included services under He-M 524. For better clarity to the regulated community, the Department included the service requirements directly in He-M 524 instead of only in He-M 503. The following are excerpts from both rules to show 1) these are not new requirements and 2) how they align with the waiver:

"(m) When an expanded service agreement has been approved by the individual, guardian, or representative and area agency director, the services shall be implemented and monitored as follows:

(3) The service coordinator shall visit the individual and contact the guardian, if any, at least quarterly, or more frequently if so specified in the individual's expanded service agreement, to determine and document:

a. Whether services match the interests and needs of the individual;

b. Individual and guardian satisfaction with services; and

c. Progress on the goals in the expanded service agreement; and

(4) If the individual receives services under He-M 1001, He-M 521 or He-M 524, at least 2 of the service coordinator's quarterly visits with the individual shall be in the home where the individual resides."

The Department's April 7, 2022 Conditional Approval Request includes, at He-M 524.20(f)(4) and (5), the following:

"(f) When the service agreement has been approved by the individual, guardian, or representative and area agency director, the services shall be implemented and monitored as follows:

(3) The service coordinator shall visit the individual and contact the guardian, if any, in person or through a video call at least quarterly, or more frequently if so specified in the individual's expanded service agreement, to determine and document:

a. Whether services match the interests and needs of the individual;

b. Individual and guardian satisfaction with services;

c. Progress on the goals in the expanded service agreement; and

d. The utilization of allocated funds.

(4) At least 2 of the service coordinator's quarterly visits with the individual shall be conducted in person in the home where the individual resides."

The Department has not been made aware of any families or individuals being concerned by the number of interactions from the service coordinator. To the contrary, the Department often hears from families and individuals that they don't have enough interaction from the service coordinator.

I thank you, the Committee, and the Office of Legislative Services for your comments and for your cooperation and assistance with this process.

Sincerely,

Lori Shibinette

Lori A. Shibinette
Commissioner

Countersigned by:

Christine L. Santaniello
Associate Commissioner

Enclosures

Readopt with amendment He-M 524, effective 11-17-11 (Document #10027), to read as follows:

PART He-M 524 IN-HOME SUPPORTS

Statutory Authority: RSA 161-I:7; 171-A:3; 18, IV

He-M 524.01 Purpose. The purpose of these rules is to establish minimum standards for the provision of Medicaid-covered home- and community-based in home residential habilitation, including personal care and other related supports and services that promote greater independence and skill development for a child, adolescent, or young adult who:

(a) Has a developmental disability;

(b) Has significant medical or behavioral challenges as determined pursuant to He-M 524.03 (a)(4) and (5) a.; and

(c) Lives at home with his or her family.

He-M 524.02 Definitions.

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

(b) "Bureau" means the bureau of developmental services of the department of health and human services.

(c) "Bureau administrator" means the chief administrator of the bureau of developmental services.

(d) "Cultural competence" means the knowledge, attitudes, and interpersonal skills applied to a provider's practice methods that allow the provider to understand, appreciate, and work effectively with individuals from cultures other than his or her own.

(e) "Department" means the New Hampshire department of health and human services.

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

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

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

(g) "Direct and manage" means to be actively involved in all chosen aspects of the service arrangement, including but not limited to:

(1) Designing the services;

(2) Selecting the service providers;

(3) Deciding how the authorized funding is to be spent based on the needs identified in the individual's service agreement; and

(4) Performing ongoing oversight of the services provided.

(h) "Employer" means an area agency, subcontract agency, or person that handles legally defined and other employer-related functions such as, but not limited to:

(1) Paying employer taxes;

(2) Withholding employee taxes;

(3) Performing other payroll functions, including issuing paychecks;

(4) Providing workers' benefits; and

(5) Obtaining workers' compensation and liability insurance.

(i) "Family" means a group of 2 or more persons related by ancestry, marriage, or other legal arrangement, including foster care as defined in 45 C.F.R. § 1355.20, that has at least one member who has a developmental disability.

(j) "Guardian" means a person appointed pursuant to RSA 547-B, RSA 463, or RSA 464-A or the parent of a child under the age of 18 whose parental rights have not been terminated or limited by law.

(k) "Home- and community-based care waiver" means a waiver pursuant to the authority of section 1915 (c) of the Social Security Act which allows the federal funding of long-term care services in non-institutional settings for persons who are elderly, disabled, or chronically ill.

(l) "In-home supports" means an array of home and community-based care waiver services provided to an individual and his or her family in the home and in the community to enhance the family's and other caregivers' ability to care for the individual and to provide the individual with opportunities to develop a variety of life skills as listed in He-M 524.05~~(d)(1)~~.

(m) "Individual" means a child, adolescent, or young adult with a developmental disability who is eligible to receive services pursuant to He-M 503.03 if aged 3 to 21 or pursuant to He-M 510 if under the age of 3.

(n) "Individualized family support plan (IFSP)" means a written plan for providing services and supports to a child and his or her family who are eligible for family-centered early supports and services under He-M 510.06.

(o) "Informed decision" means "informed decision" as defined in RSA 171-A:2, XI, namely, "a choice made by a client or potential client or, where appropriate, his legal guardian that is reasonably certain to have been made subsequent to a rational consideration on his part of the advantages and disadvantages of each course of action open to him."

(p) "Medicaid" means the federal medical assistance program established pursuant to Title XIX of the Social Security Act.

(q) "Nursing-related tasks" means those services that are delegated by a licensed nurse to unlicensed personnel in accordance with RSA 326-B and Nur Part 404.

(r) "Parent" means an individual's:

(1) Mother;

(2) Father;

(3) Adoptive mother;

(4) Adoptive father; or

(5) Legal guardian(s).

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

(t) "Representative" means, where applicable:

(1) The parent or legal guardian of an individual under the age of 18;

(2) The legal guardian of an individual 18 or over;

(3) A person who has power of attorney for the individual; or

(4) The division of children youth and families (DCYF) in cases where DCYF has responsibility for the placement and care of an individual.

(u) "Respite services" means the provision of short-term care, in accordance with He-M 513, for an individual in or out of the individual's home for the temporary relief and support of the individual's family.

(v) "Service" means any paid assistance to the individual and his or her family.

(w) "Service agreement" means "individual service agreement" as defined in RSA 171-A:2, X, namely, "a written document for a client's services and supports which is specifically tailored to meet the needs of each client."

(x) "Service coordinator" means a person who meets the criteria in He-M 503.08(e) – (f) and is chosen or approved by an individual and his or her guardian or representative, if applicable, and designated to organize, facilitate, and document service planning and to negotiate and monitor the provision of the individual's services and who is:

(1) An area agency service coordinator, family support coordinator, or any other area agency or subcontract agency employee;

(2) A friend of the individual; or

(3) Any other person chosen by the individual or representative who is not a spouse, parent, relative or guardian of the individual.

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(y) "Staff" means a person employed by an area agency, subcontract agency, or other employer.

(z) "Subcontract agency" means an entity that is under contract with any area agency to provide services to individuals who have a developmental disability.

(aa) "Team" means the group of people that participates in service planning meetings and includes the individual and his or her service coordinator and representative, if applicable, and others invited by the individual.

He-M 524.03 Eligibility.

(a) In-home supports shall be available to any individual birth through the age of 21 who lives at home with his or her family, and who:

(1) Is found eligible for services by an area agency pursuant to:

a. He-M 503.05 for individuals aged 3 to 21; or

b. He-M 510 for individuals under the age of 3;

(2) Is found eligible for Medicaid by the department pursuant to applicable rules in He-W 600 and He-W 800;

(3) Has not graduated or exited the school system;

~~(4) Is determined by the department to meet institutional level of care as demonstrated by requiring one of the following:~~

~~a. Services on a daily basis for:~~

~~1. Performance of basic living skills;~~

~~2. Intellectual, communicative, behavioral, physical, sensory motor, psychosocial, or emotional development and well-being;~~

~~3. Medication administration; or~~

~~4. Medical monitoring or nursing care by a licensed professional person such as:~~

~~(i) A registered nurse;~~

~~(ii) A licensed practical nurse;~~

~~(iii) A physical therapist;~~

~~(iv) An occupational therapist;~~

~~(v) A speech pathologist; or~~

~~(vi) An audiologist; or~~

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

(4~~5~~) Has 2 or more factors specific to the individual or a combination of at least one factor specific to the individual and one factor specific to the parent which complicate care of the individual or impede the ability of the care-giving parent to provide care, including:

a. The following factors specific to the individual:

1. Lack of age appropriate awareness of safety issues so that constant supervision is required;

2. Destructive or injurious behavior to self or others;

3. Inconsistent sleeping patterns or sleeping less than 6 hours per night and requiring supervision when awake; or

4. Any other condition that impedes the ability of the:

(i) Care-giving parent to provide care; or

(ii) Individual to participate in local community childcare or activity programs without support(s); or

b. The following factors specific to the parent:

1. Care responsibilities for other family members with disabilities or health problems;

2. Age of either parent being less than 18 years or above 59;

3. Physical or mental health condition which impedes the ability of the care-giving parent to provide care;

4. Founded child neglect or abuse as determined by a district court pursuant to RSA 169-C:21; or

5. Availability of only one parent for care-giving~~.~~; and

(5) Is determined by the department to meet institutional level of care as demonstrated by requiring one of the following:

a. Services on a daily basis for:

1. Performance of basic living skills;

2. Intellectual, communicative, behavioral, physical, sensory motor, psychosocial, or emotional development and well-being;

3. Medication administration; or

4. Medical monitoring or nursing care by a licensed professional person such as:

(i) A registered nurse;

(ii) A licensed practical nurse;

(iii) A physical therapist;

(iv) An occupational therapist;

(v) A speech pathologist; or

(vi) An audiologist; or

Edit: Fix formatting by alligning b. with a. above.

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

(b) To obtain determination of home and community based services waiver eligibility, in addition to the eligibility letter pursuant to He-M 503.05 or 510, the area agency shall complete and submit to the bureau a "NH Bureau of Developmental Services Functional Screen for Waiver Services" form (May 2013) and a "Bureau of Developmental Services In-Home Supports Waiver Individual/Parent Factors Form" (April 2022) within 3 business days of the eligibility determination made in accordance with He-M 524.03(a)(1)-(4) above.

(c) A person shall not be eligible for services under He-M 524 if he or she is:

(1) Not living with his or her family; or

(2) Receiving services under another home and community based Medicaid waiver.

(d) The bureau shall deny in-home supports if it determines that the provision of services will result in the loss of federal financial participation for such services.

He-M 524.04 Provisions Applicable to All Services.

(a) All in-home supports shall be directed and managed by the individual or the individual's representative.

(b) In-home supports shall be:

(1) Specifically tailored to the competencies, interests, preferences, and needs of the individual and his or her family and respectful of the cultural and ethnic beliefs, traditions, personal values, and lifestyle of the family;

(2) Designed to facilitate, maintain, and enhance supports from family members, friends, neighbors, child care organizations, religious organizations, and community programs;

(3) Responsive to the individual's and family's changing needs and choices within the limitations of federal and state laws and rules;

(4) Specified in the individual's service agreement, or individual family support plan (IFSP);

(5) Provided only after the informed consent of the individual or representative;

(6) In compliance with the rights of the individual established under RSA 171-A:14 and He-M 310;

(7) Supportive of the individual's or representative's efforts to direct and manage the services to be provided; and

(8) Delivered in collaboration with other related support plans when applicable, and consistent with other services provided in additional environments such as the community, school, and work.

(c) The individual and the individual's representative shall have free choice of any willing provider meeting the qualifications of this part.

He-M 524.05 In Home Residential Habilitation. In home residential habilitation services are services that assist an individual with the acquisition, retention, or improvement of skills related to living in the community, personal care, activities of daily living (ADL), assistance with ADL's, and community inclusion, including, but not limited to, instruction and skill building to develop greater independence in:

(a) Performing basic living skills such as, but not limited to, eating, drinking, toileting, personal hygiene, and dressing;

(b) Improving and maintaining mobility and physical functioning;

(c) Maintaining health and personal safety;

(d) Carrying out household chores and preparation of snacks and meals;

(e) Communicating;

(f) Learning to make choices, to show preferences, and to utilize opportunities for satisfying those interests;

(g) Developing and maintaining personal relationships;

(h) Participating in community experiences and activities;

(i) Pursuing interests and enhancing competencies in leisure and avocational activities; and

(j) Addressing behavioral challenges.

He-M 524.06 Service Coordination.

(a) Service coordination services shall be services that assist individuals in gaining access to needed waiver and or Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of funding source.

(b) Service coordination services shall include the following:

(1) Coordinating, facilitating, and monitoring services provided under He-M 524;

(2) Assessing and re-assessing service needs, goals and outcomes;

(3) Facilitating development, review, and modification of service agreements;

(4) Assisting with recruiting, screening, hiring, and training providers;

(5) Identifying, providing information about, and assisting families to access community resources;

(6) Providing counseling and support;

(7) Providing advocacy education and skill development to the individual, family, or his or her representative;

(8) Initiating, collaborating, and facilitating the development of a transition plan so that:

a. When the individual turns age 3, he or she can access school services as described in He-M 510; and

b. When the individual graduates or exits the school system, he or she can access adult supports, services, and community resources with planning to start no later than age 16, or earlier if determined necessary by the team in collaboration with the school district;

(9) Assisting in accessing the registry of available providers and staff;

(10) Reviewing the actual expenditures and revenues in the individualized budget and assisting the individual or representative and providers in managing the authorized funds; and

(11) Monitoring individual, family, and representative satisfaction with services provided.

He-M 524.07 Consultative Services.

(a) Consultative services shall include any of the following services that are not otherwise available under the Medicaid state plan, including but not limited to, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) under He-W 546, benefits or services under the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Act:

(1) Evaluation, training, mentoring, and special instruction to improve the ability of the service provider, family, and other caregivers to understand and care for the individual's developmental, functional, health, and behavioral needs; and

(2) Support and counseling regarding diagnosis and treatment of the individual to families for whom the day-to-day responsibilities of caregiving have become overwhelming and stressful.

(b) Consultative services shall be limited to 100 hours per calendar year.

(c) The bureau shall authorize consultative services exceeding 100 hours upon the written recommendation of a licensed professional, the recommendation of the area agency, and the availability of funds.

He-M 524.08 Respite Services.

(a) Respite services shall be:

(1) The provision of short term assistance, in or out of an individual's home, for the temporary relief and support of the family; and

(2) Provided pursuant to He-M 513.

(b) Respite services shall be limited to no more than 20% of an individual's total budget.

(c) The cost of training respite providers shall be outside of the total funds available for respite.

He-M 524.09 Environmental and Vehicle Modification Services.

(a) Environmental and vehicle modification services shall consist of physical adaptations to the home environment of the individual or vehicle that is the primary means of transportation of the individual that are necessary to ensure the health, welfare, and safety of the individual or enable the individual to function with greater independence in the home and community, and without which the individual would require institutionalization.

(b) Adaptations to the home environment shall include, but are not limited to the following:

(1) Installation of ramps and grab-bars;

(2) Widening of doorways:

(3) Modification of bathroom facilities; or

(4) 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.

(c) The following shall not be included as environmental modifications:

(1) Adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the individual, such as, but not limited to, carpeting, roof repair, or central air conditioning; and

(2) Adaptations that add to the total square footage of the home, except when necessary to complete an adaption.

(d) The following shall not be included as vehicle modifications:

(1) Adaptations that are of general utility and not of direct medical or remedial benefit to the individual;

(2) The purchase or lease of a vehicle; and

(3) Regularly scheduled upkeep and maintenance, unless it is upkeep and maintenance of the modification.

(e) All modifications shall be included in the individual's service agreement.

(f) All home modifications shall be made in accordance with all applicable State or local building codes.

(g) For individuals with unsafe wandering and running behaviors, outdoor fencing may be provided under this waiver.

(h) Waiver funds allocated toward the cost of the fence in (g) above shall not exceed $2,500 which can provide approximately 3,500 square feet of a safe play area.

He-M 524.10 Assistive Technology.

(a) "Assistive technology" means an item, piece of equipment, certification and training of service animal, or product system, used to increase, maintain, or improve functional capabilities of an individual, including, but not limited to, the following:

(1) Devices, controls, or appliances, specified in the individual service agreement that enable the individual to increase their ability to perform activities of daily living, or perceive, control, or communicate with the environment in which they live;

(2) The evaluation of the assistive technology needs of an individual, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the individual;

(3) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology or devices;

(4) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(5) Coordination and use of necessary therapies, interventions, or services associated with other services in the service agreement;

(6) Training or technical assistance for the individual or the individual's family members, guardians, advocates, or authorized representatives;

(7) Training or technical assistance for professional or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of an individual; and

(8) Training and certification of a service animal, defined in federal regulations implementing the Americans with Disabilities Act, 28 C.F.R. § 36.104 as "service animal means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals for the purposes of this definition. The work or tasks performed by a service animal must be directly related to the individual's disability."

(b) "Adaptive equipment" means items of durable and non-durable medical equipment necessary to address the individual's functional limitations.

(c) Adaptive equipment shall not be covered if used for recreational purposes.

(d) Payment for assistive technology shall be limited to $10,000 over the course of 5 years.

(e) The bureau shall authorize assistive technology in excess of the limitation in (d) above upon written request which shall include documentation supporting the need and the correlation of the request to the individual's service agreement.

(f) Assistive technology provided through the home and community based services waiver shall be in addition to, and not duplicative of, assistive technology which is available under the Medicaid state plan, or that is the obligation of the individual's employer.

(g) In order to obtain prior authorization for payment for assistive technology, the individual service agreement (ISA) shall specify the following:

(1) The item;

(2) The name of the healthcare practitioner recommending the item;

(3) An evaluation or assessment regarding the appropriateness of the item;

(4) A goal related to the use of the item;

(5) The anticipated environment that the item will be used; and

(6) Current modifications to the item or product and anticipated future modifications and anticipated cost.

He-M 524.11 Community Integration Services.

(a) Community integration services shall be services designed to support and enhance an individual'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 shall include, but not be limited to the following:

(1) Water safety training;

(2) Community based camperships; and

(3) A pass or membership for admission to community based activities only when needed to address assessed needs.

(b) Community based activity passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.

(c) Community integration services, inclusive of therapeutic services and camperships, shall be capped annually at $8,000.

(d) Any single community integration service, other than a campership, over $2,000 shall require a licensed healthcare practitioner's recommendation.

He-M 524.12 Individual Goods and Services.

(a) Individual goods and services shall include equipment or supplies that address an identified need in the ISA, and meet at least one of the following requirements:

(1) The good or service decreases the need for other Medicaid services;

(2) The good or service promotes inclusion in the community; or ~~and~~

(3) The good or service increases the individual's safety in the home environment.

(b) Payment for individual goods and services shall be made through the home and community based services waiver if:

(1) The individual and their family do not have the funds to purchase the item or service;

(2) The item or service is not covered under the Medicaid State Plan; or

(3) The item or service is not available through other sources.

(c) Payment for experimental or prohibited treatments shall be prohibited.

(d) Payment for individual goods and services shall not exceed $1,500 annually for an individual.

(e) The bureau shall authorize individual goods and services in excess of the limitation in (d) above upon written request which shall include documentation supporting the need and the correlation of the request to the individual's service agreement.

(f) Documentation related to the use of the item shall be maintained in monthly progress notes in accordance with He-M 524.24.

(g) Individual goods and services shall have an anticipated finite period of time to be utilized.

(h) The frequency of purchase of individual goods and services shall be determined in accordance with the documented continued need of the item and the ability of the item to continue to meet that need.

He-M 524.13 Non-Medical Transportation.

(a) Non-medical transportation services shall be services designed specifically to improve the individual'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, including, but 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.

(b) Payment for non-medical transportation shall be limited to $5,000 annually.

(c) If a family is transporting an individual, payment shall only be made for transportation that is directly related to the child's disability or specific to a provider of transportation to activities determined in the individual service agreement that are not otherwise covered by the NH Medicaid ~~S~~state ~~P~~plan, including early periodic screening, development, and training (EPSDT), and local education authority (LEA).

(d~~e~~) Youth under the age of 16 shall not be reimbursed for public transportation expenses.

He-M 524.14 Personal Emergency Response Services (PERS).

(a) "Personal emergency response services (PERS)" means smart technology devices that enable individuals to summon help in an emergency including but not limited to:~~that shall include, but not be limited to:~~

(1) Wearable or portable devices that allow for safe mobility;

(2) Response systems that are connected to the individual's telephone and programmed to signal a response center when activated;

(3) Staffed and monitored response systems that operate 24 hours a day, seven days a week;

(4) Any device that informs of elopement; and

(5) Monthly expenses that are affiliated with maintenance contracts or agreements to maintain the operations of the device or item.

(b) PERS shall also include non-smart technology items, such as seatbelt release covers, ID bracelets, and GPS devices.

(c) Payment for PERS shall not exceed $2,000 annually for an individual.

(d) The bureau shall authorize PERS in excess of the limitation in (c) above upon written request which shall include documentation supporting the need and the correlation of the request to the individual's service agreement.

He-M 524.15 Wellness Coaching.

(a) "Wellness coaching" means planning, directing, coaching, and mentoring individuals with disabilities in community based, inclusive exercise activities in accordance with the recommendations of a licensed recreational therapist or a certified personal trainer.

(b) A wellness coach shall develop specific goals for the individual's service agreement, including activities that are carried over into the individual's home and community.

(c) A wellness coach shall demonstrate exercise techniques and form, observe individuals, and explain to them corrective measures necessary to improve their skills.

(d) A wellness coach shall collaborate with the individual, his or her family and other caregivers, and with other health and wellness professionals as needed.

(e) Wellness coaching provided through the home and community based services waiver shall be in addition to, and not duplicative of, wellness coaching which is available under the Medicaid state plan.

(f) Coverage for wellness coaching shall be limited to 100 hours per year.

(g) The bureau shall authorize payment for hours in excess of the limitation in (f) above by written request, which shall include the recommendation of a licensed professional and documentation supporting the need and the correlation of the request to the individual's service agreement.

He-M 524.16 Acute and Remote Setting Services.

(a) Upon request, services in (d) and (e) below shall be provided in an acute care hospital, only when the parent or guardian is not available and under the following conditions:

(1) Identified in an individual's person-centered service agreement;

(2) Provided to meet needs of the individual that are not met through the provision of hospital services;

(3) 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

(4) Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

(b) If services in (d) are provided pursuant to (c)below, then those services shall be reviewed by the team at the quarterly meeting to ensure this method of service delivery continues to meet the individual's needs.

(c) Upon request, services in (d) below shall be provided remotely under the following conditions:

(1) This method of service delivery meets the assessed needs of the individual;

(2) The individual, guardian, or representative chose this method of service delivery; and

(3) This method of service delivery is reviewed by the team at the quarterly meeting to ensure that it continues to meet the individual's needs.

(d) Services that may be provided in an acute care hospital pursuant to (a) above or remote setting pursuant to (c) above shall include:

(1) In home residential habilitation;

(2) Service coordination; and

(3) Consultative services.

(e) Services that may be provided in an acute care hospital pursuant to (a) above shall include:

(1) Assistive ~~T~~technology;

(2) Environmental and vehicle modifications;

(3) Respite ~~S~~services; and

(4) PERS.

He-M 524.17 Non-Covered Services. The following services shall not be funded under He-M 524:

(a) Educational services provided pursuant to the Individuals with Disabilities Education Improvement Act (IDEIA) of 2004, 20 U.S.C. 1400 et seq.;

(b) Vocational or employment services provided pursuant to IDEIA;

(c) Room and board;

(d) Custodial care programs;

(e) Services available to individuals birth through 21 years of age under He-W 546, including early and periodic screening, diagnosis, and treatment services~~, shall not be provided under He-M 524~~;

(f) Services available to individuals birth through 21 years of age under Title IV-E for foster care ~~shall not be provided under He-M 524~~; and

(g) All other Medicaid state plan services.

He-M 524.18 Orienting Families to In-Home Supports. Before services are delivered to an individual or a family, the area agency staff shall meet with the individual, family, and representative and provide and review a participant directed and managed services (PDMS) manual as an overview of the supports available and available methods of service delivery, and inform them of the following:

(a) The services and supports available to the individual and family through He-M 524;

(b) Services available outside of He-M 524, including other departmental services, community resources, and institutional alternatives that might be pertinent to the individual's and family's specific situation;

(c) The benefits and applicable service limits of (a) and (b) above relative to the family's needs;

(d) The features under He-M 524, including:

(1) That services are directed and managed by the individual or representative;

(2) That a service agreement is developed to include components listed in He-M 524.20 (a)(3);

(3) Area agency oversight of services provided;

(4) The completion of criminal background checks on all prospective service providers;

(5) Responsibilities of providers, family members, and the individual or representative in the provision of services and supports under each method of PDMS;

(6) The flexibility offered to identify possible providers, including people known to the family such as extended family, neighbors, or others in the local community; and

(7) The process of having providers coming into the home environment;

(e) If applicable, an explanation of alternative approaches to behavioral intervention, including a description of the theory, practice, strengths, and expected outcomes of the methods; and

(f) If applicable, medication administration requirements under He-M 524.21(a)(7).

He-M 524.19 Coordination of In-Home Supports.

(a) Once an individual, family, and representative, choose to participate and the individual is authorized pursuant to He-M 524.03 to receive services, a service coordinator shall be chosen or approved by the individual or representative.

(b) Within 30 business days of being chosen by the individual or representative the service coordinator shall hold the service planning meeting to create a service agreement in accordance with 524.20.

Edit: Insert "He-M"

(c) The service coordinator shall:

(1) Maximize the extent to which an individual, family, and representative participate in the service planning process by:

a. Explaining the individual's rights;

b. Explaining the service planning process;

c. Eliciting information regarding the preferences, goals, and service needs of the individual and his or her family;

d. Reviewing issues to be discussed during service planning meetings; and

e. Inviting and assisting the family, representative, and individual, if age appropriate, to determine the following elements in the service planning process:

1. The number and length of meetings;

2. The location and time of meetings;

3. The meeting participants; and

4. The topics to be discussed;

(2) Facilitate the service agreement meeting if the individual or representative is unable to or chooses not to select the facilitator of the meeting; and

(3) Document the service agreement.

(dc) If the individual or representative selects a service coordinator who is not employed by the area agency or a subcontract agency, the service coordinator and area agency shall enter into an agreement which describes:

(1) The specific responsibilities of the service coordinator;

(2) The reimbursement to the service coordinator; and

(3) The oversight activities to be provided by the area agency.

He-M 524.20 In-Home Supports Service Agreement.

(a) The service agreement describing services provided pursuant to He-M 524 shall:

(1) Be developed in accordance with He-M 524.19(b), He-M 503.10, excluding He-M 503.10(c)-(e), and unless otherwise listed below;

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

(3) Include the following:

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

b. The specific schedule for the provision of services;

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

d. Specific documentation requirements;

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

f. Emergency contact information; and

g. An individualized budget which specifies:

1. Service components;

2. Duration and frequency of services required; and

3. Itemized cost of services;

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

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

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

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

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

(b) Within 5 business days of completion of the service agreement, the area agency shall send the individual, guardian, or representative the following:

(1) A copy of the expanded service agreement signed by the area agency executive director or designee;

(2) The name, address, and phone number of the service coordinator or service provider(s) who may be contacted to respond to questions or concerns; and

(3) A description of the procedures for challenging the proposed expanded service agreement pursuant to He-M 524.25 for those situations where the individual, guardian, or representative disapproves of the expanded service agreement.

(c) The individual, guardian, or representative shall have 10 business days from the date of receipt of the expanded service agreement to respond in writing, indicating approval or disapproval of the service agreement. Unless otherwise arranged between the individual, guardian, or representative and the area agency, failure to respond within the time allowed shall constitute approval of the service agreement.

(d) The signature page of the service agreement shall document the individual's or representative's informed consent and that the individual or representative has been fully informed of community and institutional service alternatives and of the right to a hearing, as defined in He-C 201.02 (i), to dispute any component of the service agreement.

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

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

(2) By reconvening a service planning meeting; ~~or~~

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

(4) Filing a formal appeal pursuant to He-M 524.25

Edit: "By filing"

(f) When the service agreement has been approved by the individual, guardian, or representative and area agency director, the services shall be implemented and monitored as follows:

(1) A person responsible for implementing any part of an expanded service agreement, including goals and support services, shall collect and record information about services provided and summarize progress as required by the service agreement or, at a minimum, monthly;

(2) On at least a monthly basis, the service coordinator shall visit or have verbal or video call contact with the individual or persons responsible for implementing an expanded service agreement and document these contacts;

(3) The service coordinator shall visit the individual and contact the guardian, if any, in person or through a video call at least quarterly, or more frequently if so specified in the individual's expanded service agreement, to determine and document:

a. Whether services match the interests and needs of the individual;

b. Individual and guardian satisfaction with services;

c. Progress on the goals in the expanded service agreement; and

d. The utilization of allocated funds.

(4) At least 2 of the service coordinator's quarterly visits with the individual shall be conducted in person in the home where the individual resides.

He-M 524.21 Administrative Requirements.

(a) When in-home supports are provided, the area agency shall, in collaboration with the individual or representative and family and, if applicable, the subcontract agency, specify the roles of the area agency, family, individual or representative, and subcontract agency in service planning, service provision, and oversight including:

(1) Implementation of the service agreement;

(2) Specific training and supervision requirements for service providers;

(3) Compensation amounts and procedures for paying providers;

(4) Oversight of the service provision, as required by the service agreement;

(5) Documentation of compliance with He-M 524.21 through He-M 524.24;

(6) Employer services provided by the area agency, subcontract agency, or other person or entity to facilitate the delivery of in-home supports;

(7) Compliance with applicable laws and rules, including delegation of medication administration and other nursing-related tasks by a nurse to unlicensed providers pursuant to Nur 404 or He-M 1201;

(8) The provision of service coordination; and

(9) Procedures for review and revision of the service agreement as deemed necessary by any of the parties.

(b) When an individual or representative chooses in-home supports to be provided by an entity other than the area agency or subcontract agency, the area agency shall:

(1) Discuss items specified under (a) above with the individual, representative, and family to enable them to make an informed decision regarding the roles and responsibilities of the family and providers; and

(2) Establish a contract with the individual or representative that specifies the parties responsible for the items under (a) above.

(c) The individual or representative and the area agency shall develop an individualized budget that includes:

(1) The specific service components;

(2) The frequency and duration of the services required;

(3) An itemized cost of services; and

(4) The frequency at which budget reports pursuant to (e) below will be provided by the area agency or subcontractor to the individual or representative.

(d) The individual or representative and the area agency shall develop a job description for providers that outlines the expectations and responsibilities of the provider.

(e) As a part of the service provision, the area agency or subcontract agency shall establish a budget reporting mechanism, detailing expenditures to date and the amount remaining in the budget, to assist the individual or representative to manage the individual's budget.

He-M 524.22 Qualifications and Training.

(a) Providers who are not a member of the individual's family shall:

(1) With respect to qualifications and training, meet the requirements specified in the service agreement and, if applicable, medication administration requirements under He-M 524.21 (a)(7);

(2) Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;

(3) Supply at least one reference; ~~and~~

(4) Meet certification and licensure requirements of the position, if any; and

(5) Be either:

a. A minimum of 18 years of age; or

b. With the agreement of the individual or representative, and area agency, ages 15 through 17.

(b) All providers, including providers who are family members, shall, prior to a final hiring decision, be required by the employer to consent to:

(1) A New Hampshire criminal records check no more than 30 days prior to hire;

(2) If the provider's primary residence is out of state, a criminal records check for their state of residence;

(3) If the provider has resided in New Hampshire for less than one year, a criminal records check for their previous state of residence; and

(4) A check of the state registries of founded reports of abuse, neglect, and exploitation, as established by RSA 161-F:49 and RSA 169-C:35.

(c) Except as allowed in (d) and (e) below, an employer shall not hire a person:

(1) Who has a:

a. Felony conviction; or

b. Any misdemeanor conviction involving:

1. Physical or sexual assault;

2. Violence;

3. Exploitation;

4. Child pornography;

5. Threatening or reckless conduct;

6. Theft;

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

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

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

(d) An employer may hire a person with a criminal record listed in (c)(1)a. or b. above for a single offense that occurred 10 or more years ago in accordance with (e) and (f) below. In such instances, the individual, his or her guardian if applicable, and the area agency shall review the person's history prior to approving the person's employment.

(e) Employment of a person pursuant to (d~~e~~) above shall only occur if such employment:

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

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

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

(f) Upon hiring a person pursuant to (d~~e~~) and (e~~f~~) above, the employer shall document and retain the following information in the individual's record:

(1) The date(s) of the approvals in (e~~f~~) above;

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

(3) The name of the person hired;

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

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

(6) The employer's name and address;

(7) A full explanation of why the employer is hiring the person despite the person's criminal record;

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

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

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

(11) The signature and phone number of the person being hired.

(g) For the purposes of (b) above, the area agency shall be the employer for parents paid to provide in-home residential habilitation.

(h) The employer shall provide information regarding the staff development elements identified in He-M 506.05 to assist the individual or representative in making informed decisions with respect to orientation and training of non-family staff and providers.

(i) Subsequent to (h) above, and consistent with the area agency or subcontract agency's personnel policies, the employer shall ensure that non-family staff and providers receive the orientation and training selected by the individual or representative.

(j) The service coordinator shall:

(1) For individuals aged 3 and over, comply with He-M 503.08(e) and (f); or

(2) For individuals under age 3, comply with He-M 510.02 (ak) and He-M 510.11(j).

(k) When an individual or representative chooses in-home supports to be provided by a family member, the employer shall require the individual or representative to submit documentation describing any orientation and training provided to the family member.

(l) Providers of assistive technology, in accordance with He-M 524.10, shall have specialized training relative to the specific item of assistive technology.

(m) Providers of consultative services, in accordance with He-M 524.07, shall meet one of the following qualifications:

(1) Be a psychiatrist, psychologist, or other provider that requires a license and hold a valid license issued by the appropriate licensing board;

(2) For other disability professionals who do not require professional licensure as specified in (1) above, have specialized knowledge in the subject matter they are providing consultative services for; or

(3) A master's level clinical degree with expertise and experience to provide supports to individuals with developmental disabilities who are at risk for unsafe sexual behaviors or arson.

(n) Providers of environmental or vehicle modifications in accordance with He-M 524.09

shall have any license, certificate, or permit as required by state law or local ordinance for the particular modification provider.

(o) Providers of non-medical transportation in accordance with He-M 524.13 shall:

(1) Have a current driver's license;

(2) Consent to a New Hampshire driving record check completed by the employer within 30 days or providing transportation; and

(3) Provide proof of automobile insurance.

He-M 524.23 Quality Assessment.

(a) The service coordinator shall conduct visits and contacts as established in the service agreement pursuant to 524.20 (f) and document the individual's, family's, and representative's satisfaction with:

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

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

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

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

(5) The utilization of allocated funds.

(b) The bureau shall assess compliance with He-M 524 by reviewing documentation at the area agency of the provision of in-home supports during redesignation of area agencies pursuant to He-M 505.08.

He-M 524.24 Documentation. For each individual served, the provider, staff, or family member shall document and maintain at the area agency a record containing the following:

(a) A weekly schedule indicating the type and duration of specific in-home supports provided;

(b) The service agreement, in accordance He-M 524.20;

(c) The individualized budget;

(d) Provider or staff progress notes written at least monthly, or more frequently if so specified in the service agreement;

(e) The applicable contract as specified in He-M 524.21 (b)(2);

(f) Relevant evaluations including the health risk screening tool (HRST), supports intensity scale for individuals over the age of 16, and a current individualized education plan (IEP); and

(g) Any other documentation required by the area agency or individual or representative and specified in the service agreement.

He-M 524.25 Appeals.

(a) An individual or representative may choose to pursue informal resolution to resolve any disagreement with an area agency, or, within 30 business days of the area agency decision, she or he may choose to file a formal appeal pursuant to (e) below. Any determination, action, or inaction by an area agency may be appealed by an individual or representative.

(b) The following actions shall be subject to the notification requirements of (c~~d~~) below:

(1) Adverse eligibility actions under He-M 524.03;

(2) Area agency disapproval of service agreements or proposed amendments to service agreements pursuant to He-M 524.20~~12~~ (b)~~(2)~~; and

(3) Denial of services by the bureau pursuant to He-M 524.26 (c).

(c) The bureau or an area agency shall provide written and verbal notice to the applicant and representative of the actions specified in (b) above, including:

(1) The specific rules that support, or the federal or state law that requires, the action;

(2) Notice of the individual's right to appeal in accordance with He-C 200 within 30 days and the process for filing an appeal, including the contact information to initiate the appeal with the bureau administrator;

(3) Notice of the individual's continued right to services pending appeal, when applicable, pursuant to (g) below;

(4) Notice of the right to have representation with an appeal by:

a. Legal counsel;

b. A relative;

c. A friend; or

d. Another spokesperson;

(5) Notice that neither the area agency nor the bureau is responsible for the cost of representation;

(6) Notice of organizations with their addresses and phone numbers that might be available to provide legal assistance and advocacy, including the Disabilities Rights Center and pro bono or reduced fee assistance; and

(7) Notice of individual's right to request a second formal risk assessment from a qualified evaluator.

(d) Appeals shall be submitted, in writing, to the bureau administrator in care of the department's office of client and legal services within 30 days following the date of the notification of an area agency's decision. An exception shall be that appeals may be filed verbally if the individual is unable to convey the appeal in writing.

(e) The office of client and legal services shall immediately forward the appeal to the department's administrative appeals unit which shall assign a presiding officer to conduct a hearing, as provided in He-C 200. The burden shall be as provided by He-C 203.14.

(g) If a hearing is requested, the following actions shall occur:

(1) For current recipients, services and payments shall be continued as a consequence of an appeal for a hearing until a decision has been made; and

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

He-M 524.26 Funding and Payment.

(a) Area agencies shall submit to the bureau a proposed individualized budget for each individual requesting services under He-M 524. The proposed budget shall contain detailed line item information regarding all services to be requested.

(b) The bureau shall review the proposed budget and issue a response within 10 business days from the date of request.

(c) For each request an area agency makes for funding individual services under He-M 524, the bureau shall make the final determination on the cost effectiveness of requested services.

(d) Based on an individualized budget approved by the bureau and service agreement approved by the individual or representative, the area agency shall request a prior authorization from the bureau.

(e) Requests for prior authorization shall include the documentation in (d) above and be submitted to:

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

(f) If information submitted pursuant to (e) above, or similar information obtained at any other time by the bureau, indicates that an individual might no longer meet the criteria for home and community-based care specified in He-M 524.03 the bureau shall re-determine the individual's eligibility pursuant to He-M 524.03 above.

(g) Once an area agency obtains a prior authorization from the bureau, it shall submit claims for in-home supports electronically to the Medicaid Management Information System.

(h) Payment for in-home supports shall only be made if prior authorization has been obtained from the bureau.

(i) The bureau shall approve requests for prior authorization that meet the criteria in (j)-(k) below.

(j) Payment for in-home supports shall not be available to any service provider who:

(1) Is a person under age 18, except as specified in He-M 524.22(b)(2); or

(2) Is the spouse of an individual receiving services.

(k) Payment for provision of in-home residential habilitation shall be available to the parent of an individual receiving in-home supports when the following apply:

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

a. The individual's level of dependency in performing activities of daily living, including the need for assistance with toileting, eating, or mobility, exceeds that of his or her

developmentally disabled peers as determined by a nationally recognized standardized functional assessment tool;

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

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

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

a. The parent has exhausted all options for obtaining in-home support assistance due to the lack of availability of qualified providers, as exemplified in (l) below; or

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

(3) The parent meets all applicable provider qualifications pursuant to He-M 524.22 and all documentation requirements of He-M 524.24

(l) Examples of lack of availability of qualified providers shall include the following:

(1) A family lives in a rural or remote area and cannot secure providers;

(2) The extensive medical or behavioral needs of the child prevent the recruiting and maintaining of providers;

(3) A family whose cultural background is different from the culture of the overall pool of providers cannot secure providers who demonstrate cultural competence;

(4) A family's work schedule requires that providers be available during evening, overnight, weekend, and holiday hours, thus making it difficult to retain providers;

(5) A family's needs are such that no provider agency can be identified or is available to provide the required service; and

(6) Any other circumstance or condition of a parent or child or of local provider agencies that results in a family being unable to obtain in-home support assistance.

(m) The area agency shall administer payments to parents for in home residential habilitation and submit requests for parent payment to BDS for prior authorization.

(n) Payments to parents under (k) above shall apply solely to the provision of in home residential habilitation services.

(o) When a parent is paid to provide in-home residential habilitation, the number of hours for which a parent will receive payment shall be specified in the service agreement.

He-M 524.27 Waivers.

(a) An area agency, subcontract agency, individual, representative, or provider may request a waiver of specific procedures outlined in He-M 524 using the form titled "NH Bureau of Developmental Services Waiver Request" (July 2019). The area agency shall submit the request in writing to the bureau administrator.

(b) A completed waiver request form shall be signed by:

(1) The individual or representative indicating agreement with the request; and

(2) The area agency's executive director or designee recommending approval of the waiver.

(c) A waiver request shall be submitted to:

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

(d) No provision or procedure prescribed by statute shall be waived.

(e) The request for a waiver shall be granted by the commissioner or his or her designee within 30 days if the alternative proposed by the area agency, subcontract agency, individual, representative, or provider meets the objective or intent of the rule and it:

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

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

(f) The determination on the request for a waiver shall be made within 30 days of the receipt of the request.

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

(h) Waivers shall be granted in writing for a specific duration not to exceed 5 years except as in (i) below.

(i) Those waivers which relate to issues relative to the health, safety, or welfare of individuals that require periodic reassessment shall be effective for a one-year period only.

(j) Any waiver shall end with the closure of the related program or service.

(k) An area agency, subcontract agency, individual, representative, or provider may request a renewal of a waiver from the department. Such request shall be made at least 90 days prior to the expiration of a current waiver.

APPENDIX

RULE	SPECIFIC STATE STATUTES WHICH THE RULE IMPLEMENTS
He-M 524.01 and He-M 524.02	RSA 161-I-1; RSA 171-A:I
He-M 524.03	RSA 161-I:2, IV; RSA 171-A:4
He-M 524.04 - He-M 524.06	RSA 161-I:1; RSA 171-A:4
He-M 524.07 - He-M 524.16	RSA 171-A:3,4
He-M 524.17	RSA 161-I:1; RSA 171-A:3,4
He-M 524.18	RSA 161-I:1; RSA 171-A:4
He-M 524.19 - He-M 524.25	RSA 171-A:4
He-M 524.26	RSA 171-A:18, II; RSA 161-I:3-a
He-M 524.27	RSA 171-A:3