

APPENDIX II-G

COVER SHEET FOR FINAL PROPOSAL

Notice Number 2021-55 Rule Number He-E 801

<p>1. Agency Name &amp; Address:</p> <p><b>Department of Health &amp; Human Services Division of Long Term Supports &amp; Services Bureau of Elderly &amp; Adult Services 105 Pleasant Street, Main Building Concord, NH 03301</b></p>	<p>2. RSA Authority: <u>RSA 161-F:4; RSA 161:4-a, IX</u></p> <p>3. Federal Authority: <u>42 USC 1397</u></p> <p>4. Type of Action:</p> <p><input checked="" type="checkbox"/> Adopt</p> <p><input type="checkbox"/> Amendment (only if Initial Proposal was filed before 9/27/20.)</p> <p><input type="checkbox"/> Repeal</p> <p><input type="checkbox"/> Readoption</p> <p><input type="checkbox"/> Readoption w/amendment</p>
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5. Short Title: **Choices for Independence Program**

6. Contact person for copies and questions:

Name:	<b>Allyson Zinno</b>	Title:	<b>Administrator-Administrative Rules Unit</b>
Address:	<b>Dept. of Health &amp; Human Services Administrative Rules Unit 129 Pleasant Street, Brown Bldg. Concord, NH 03301</b>	Phone #:	<b>(603) 271-9604</b>

7. The rulemaking notice appeared in the Rulemaking Register on **May 20, 2021**.

**SEE THE INSTRUCTIONS--PLEASE SUBMIT ONE COPY OF THIS COVER SHEET AND ONE COPY OF THE FOLLOWING:  
(optional to number correspondingly)**

8. The "Final Proposal-Fixed Text," including the cross-reference table required by RSA 541-A:3-a, II as an appendix.
9. Yes  N/A  Incorporation by Reference Statement(s) because this rule incorporates a document or Internet content by reference for which an Incorporation by Reference Statement is required pursuant to RSA 541-A:12, III.
10. Yes  N/A  The "Final Proposal-Annotated Text," indicating how the proposed rule was changed because the text of the rule changed from the Initial Proposal pursuant to RSA 541-A:12, II(d).
11. Yes  N/A  The amended fiscal impact statement because the change to the text of the Initial Proposal affects the original fiscal impact statement (FIS) pursuant to RSA 541-A:5, VI.

Notice Number 2021-55

Rule Number He-E 801

<p>1. Agency Name &amp; Address:</p> <p><b>Dept. of Health &amp; Human Services Division of Long Term Supports and Services Bureau of Elderly &amp; Adult Services 105 Pleasant Street, Main Building Concord, NH 03301</b></p>	<p>2. RSA Authority: <u>RSA 161-F:4; RSA 161:4-a, IX</u></p> <p>3. Federal Authority: <u>42 USC 1397</u></p> <p>4. Type of Action:</p> <p>Adoption <u>X</u></p> <p>Repeal _____</p> <p>Readoption _____</p> <p>Readoption w/amendment _____</p>
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5. Short Title: **Choices for Independence Program**

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

**He-E 801 describes eligibility for, services covered by, and provider requirements for the Choices for Independence (CFI) program, which is a Medicaid 1915(c) waiver program for seniors and adults with disabilities, also known as the Home and Community Based Care program (HCBS-CFI) or CFI waiver program. The program serves individuals who are financially eligible for Medicaid coverage and clinically eligible for long-term services and supports (LTSS), and who choose to receive care in their home or another community setting instead of an institutional setting. He-E 801 was an interim rule and expired on February 3, 2020.**

**The Department of Health and Human Services (Department) is proposing to adopt He-E 801. The proposed changes as compared to the expired rule are as follows:**

- **Updating the rule for better clarity, program integrity, and to be consistent with language used to included updated definitions, updated structure, and updated terminology;**
- **Updating the definitions by:**
  - **Adding the definitions of “adult day services”, “adult family care”, “appeal”, “authorized representative”, “community transition services”, “congregate meals”, environmental accessibility services”, “fading plan”, “financial management services”, “home delivered meals”, “home health aide services”, “homemaker services”, “in-home care”, “instrumental activities of daily living”, “non-medical transportation”, “nursing facility”, “participant-directed and managed services”, “personal care services”, “personal emergency response system”, “residential care facility”, “skilled professional medical personnel”, “skilled nursing services”, “special medical equipment”, “supported employment services”, “supportive housing services”, and “targeted case management”;**
  - **Amending the definitions of “activities of daily living”, “annual aggregate medicaid cost”, “case management agency”, “case manager”, “choices for independence” as “choices for independence waiver program”, “comprehensive care plan”, “home-based services”, “legally responsible relative”, and “person-centered planning”; and**
  - **Deleting the definition of “Bureau”;**
- **Replacing the term “registered nurse” with “skilled professional medical personnel” in sections He-E 801.03 on eligibility, He-E 801.04 on initial clinical eligibility determination, and He-E 801.30 on specialized medical equipment services, as skilled professional medical personnel will now determine clinical eligibility;**
- **Replacing the term “individual” with “participant” throughout;**

- Adding new sections He-E 801.19, He-E 801.24, and He-E 801.32, respectively, on financial management services, participant-directed and managed services, and supported employment services, as these services were added to the CFI waiver as a result of the Centers for Medicare and Medicaid Services (CMS) approved 2017 amendment to the waiver;
- Updating references to targeted case management throughout to refer to the rule covering that service, He-E 805;
- Clarifying in He-E 801.03(a)(3) that to be eligible for CFI services an individual must be financially and categorically needy;
- Clarifying that if the requested additional information for eligibility determination from the applicant or the applicant's licensed practitioner is not received within 20 calendar days, the Department will send a second request;
- Clarifying that the Department shall request within 2 business days additional information from the case manager when there is conflicting or missing information in the service authorization request, and requiring the case manager to provide the requested information within 2 business days;
- Clarifying that the Department shall authorize services consistent with the clinical assessment within 6 business days, and that the clinical assessment is person-centered;
- Removing the word "applicant" from He-E 801.06 because service authorizations are requested by case managers for CFI participants, and not for applicants to the program. Once an individual is found eligible for CFI services pursuant to He-E 801.03 and He-E 801.04, they are considered a participant, and service authorizations are then performed;
- Clarifying that when services are no longer requested by the participant, the Department shall have the ability to terminate eligibility or reduce the services previously authorized;
- Clarifying that a request by the CFI participant for a clinical redetermination shall be in accordance with the eligibility provision of the rule in He-E 801.03 and He-E 801.04. This does not represent a program change but rather a minor change which should result in less confusion about the process of redetermination;
- Amending He-E 801.09 to state that the costs associated with services rendered for acute care needs, environmental accessibility services, and community transition services shall not be included in the methodology used to determine whether the requested service costs less than institutional care;
- Removing the words "home-based services" and replacing them with "long term services and supports" (LTSS) which is a more accurate description of the services being provided;
- Clarifying that when the Commissioner does not approve the applicant's request to participate in the CFI waiver program or the participant's request for additional services or a reduction in services, the Department will send a letter stating that the services will not be delivered, continued, or reduced until after a safety risk assessment is completed;
- Amending He-E 801.11 to refer to only participants for post-eligibility computation of cost of care because that calculation is done after the eligibility determination;
- Clarifying that CFI waiver services shall be provided in accordance with the federal regulation found at 42 CFR 441.301(c)(4) which is the regulation requiring services to be delivered in accordance with the CMS approved waiver and delivered in certain settings;

- **Inserting language that CFI participants have a right to receive targeted case management while residing in a nursing home or facility pursuant to RSA 151-E:17;**
- **Inserting into the non-covered services section He-E 801.13 the stipulation that if the requested services would result in the Department's inability to obtain federal Medicaid funding, then the service shall not be covered pursuant to 42 CFR 441.301(c)(4). This is not a new requirement as it exists in federal law, but the Department is including it so that participants and case managers are notified about this requirement;**
- **Deleting paragraph (c) in He-E 801.14 because the requirements for adult family care providers can be found at He-P 813;**
- **Updating He-E 801.15 so that maintaining a safe environment, rearranging light-weight furniture, grocery shopping, and ADLs or instruction in self-care based on the participant's needs in the care plan are included as in-home services;**
- **Updating He-E 801.16 on covered adult day services and clarifying what the covered adult day services include;**
- **Updating He-E 801.18 on environmental accessibility services (EAS)to:**
  - **Clarify that an enrolled Medicaid physician or nurse practitioner shall make the determination of need;**
  - **Require that the EAS provider must affirm that the work will meet the requirements of RSA 155-A:2;**
  - **Clarify that participants shall submit an explanation to the case manager when there is a preference for one bid over another. This isn't a new requirement as the expired rule stated that the participant needed to do this, but didn't state to whom the explanation needed to be submitted;**
  - **Inserting a requirement that the case manager not request an authorization for the EAS if there is a discrepancy between the provider's recommended specifications for the EAS and the EAS provider's quote. Further He-E 801.18 will now state that the Department will not approve the service request in such a situation; and**
  - **Inserting that the EAS provider's restocking fee may be submitted and paid by the Department in the situation where a replacement or modification is required;**
- **Amending the documentation and prior authorization requirements for non-medical transportation services. Case managers will still need to request authorization but will not need to provide as extensive information as they currently provide. Additionally, language has been added to stipulate that transportation provided with the participant's vehicle shall not be covered;**
- **Deleting the requirement that personal care services shall not include food preparation for meals and snacks provided to CFI participants and other individuals;**
- **Stipulating that personal care services shall not include transportation when no other assistance is being provided;**
- **Removing the prohibition that personal care services shall not be provided at an adult day program;**
- **Amending He-E 801.23, renumbered as He-E 801.26, on personal emergency response systems services:**
  - **To move the definition for the service to the definitions section;**

- To remove the requirement that a nurse, or an occupational or physical therapist, perform a risk of fall assessment; and
  - To simply state that the risk of having a medical emergency shall be documented in the comprehensive care plan;
- Adding the requirement that skilled nursing services shall not be coverable when determined to be needed for the provision of acute needs under the Medicaid state plan;
  - Inserting a requirement that the case manager shall not request an authorization for the specialized medical equipment if there is a discrepancy between the provider's recommended specifications for the equipment and the specialized medical equipment provider's quote. Further He-E 801.30 on specialized medical equipment services, renumbered from He-E 801.27, will now state that the Department will not approve the service request in such a situation;
  - Inserting that the specialized medical equipment provider's restocking fee may be submitted and paid by the Department in the situation where a replacement or modification is required;
  - Inserting language to require providers and case managers to provide a copy of the comprehensive care plan to the Department upon request;
  - Inserting language to stipulate providers must maintain supporting documents, and that the Department has the ability to recover federal or state Medicaid payments made pursuant to CFR 455, 42 CFR 447, and 42 CFR 456. Medicaid-enrolled providers are already aware that payment recovery can occur as it is stated in the provider contract signed with the Department;
  - Inserting language to require personal care services (PCS) workers to adhere to the electronic visitation requirement in the 21<sup>st</sup> Century Cures Act;
  - Updating language in the utilization review to specify that the Department will monitor the utilization of the CFI waiver services to identify, prevent, and correct potential occurrences of fraud, waste and abuse. Additionally, the Department is inserting the federal regulation that contains the prohibition on certain types of providers from participation in the Medicaid program, 42 CFR 1001;
  - Including that the medical credential of the person determining clinical ineligibility will be on the notice of ineligibility;
  - Adding electronic communication devices to the list of what is considered specialized medical equipment;
  - Removing the requirement that a participant whose LTSS needs exceed 80% of the average annual nursing facility cost be approved by the Commissioner before beginning CFI pursuant to Chapter 32 of the Laws of 2020 (HB 578); and
  - Inserting language to clarify that participant-directed and managed services shall include promotion of the participant's designing of the services, selecting service providers, deciding how funding is to be spent, and performing oversight of services being provided.

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

**The groups affected by this rule include individuals who are financially eligible for Medicaid coverage and clinically eligible for long-term services and supports, and the service providers.**

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

<b>RULE</b>	<b>STATUTE OR FEDERAL REGULATION IMPLEMENTED</b>
He-E 801.01	RSA 151-E:1
He-E 801.02	RSA 151-E:1, 2
He-E 801.03	42 USC 1396n(c)(1) and (2); RSA 151-E:3, 4
He-E 801.04	RSA 151-E:3
He-E 801.05	RSA 151-E:4
He-E 801.06	RSA 151-E:1
He-E 801.07	RSA 151-E:8
He-E 801.08	42 USC 1396n(c)(1) and (2); RSA 151-E:3, 4
He-E 801.09	RSA 151-E:11, II-IV
He-E 801.10	RSA 151-E:11, IV
He-E 801.11	42 CFR 435.217; 42 CFR 435.735
He-E 801.12	42 USC 1396n(c)(4)(B); RSA 161-I
He-E 801.13	42 USC 1396n(c)(1)
He-E 801.14 - 801.32	42 USC 1396n(c)(4)(B); RSA 161-I
He-E 801.33	42 CFR 447.15; 42 CFR 431.107
He-E 801.34	42 CFR 431.107
He-E 801.35	42 CFR 447.50; 42 CFR 447.300; RSA 161:4, VI(a)
He-E 801.36	42 CFR 455; 42 CFR 456
He-E 801.37	RSA 167:14-a, III; 42 CFR 433 Subpart D
He-E 801.38	42 USC 1396n(c)

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

Name: **Allyson Zinno** Title: **Administrator- Administrative Rules Unit**  
 Address: **Dept. of Health and Human Services** Phone #: **(603) 271-9604**  
**Administrative Rules Unit** Fax#: **(603) 271-5590**  
**129 Pleasant Street, Brown Bldg.** E-mail: [Allyson.E.Zinno@dhhs.nh.gov](mailto:Allyson.E.Zinno@dhhs.nh.gov)  
**Concord, NH 03301**

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

**The proposed rules may be viewed and downloaded at:**

<http://www.dhhs.nh.gov/oos/aru/comment.htm>

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Thursday, June 24, 2021**

Fax

E-mail

Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Thursday, June 17, 2021 at 2:30pm**

Place: **[DHHS Brown Bldg., Auditorium, 129 Pleasant St., Concord, NH](#)**

**This meeting may also be accessed using Microsoft Teams using the information below:**

**Join on your computer or mobile app**

**[Click here to join the meeting](#)**

**Or call in (audio only)**

**[+1 603-931-4944,,314348048#](#) for calls within the United States to Concord, NH**

**Phone Conference ID: 314 348 048#**

**[Find a local number](#) |**

**The following email address will be monitored during the meeting if there is any public access or technical problems during the meeting: [Allyson.E.Zinno@dhhs.nh.gov](mailto:Allyson.E.Zinno@dhhs.nh.gov).**

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

FIS # 21:041 , dated April 20, 2021

**1. Comparison of the costs of the proposed rule(s) to the existing rule(s):**

Not applicable, as the proposed rules expired February 3, 2020. The Department states that when compared to the expired rules, the proposed rule changes will not result in an increase or decrease in costs to the State general fund or to political subdivisions of the State. However, the proposed changes may have an indeterminable fiscal impact on State citizens, and an indeterminable increase in administrative costs to independently owned businesses (providers and case management entities).

**2. Cite the Federal mandate. Identify the impact on state funds:**

No federal mandate, no impact on state funds.

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

**A. To State general or State special funds:**

The Department of Health and Human Services states that when compared to the expired rules, the proposed rule changes will not impact general funds since overall appropriations for the Choices for Independence program are set by the Legislature. However:

- The changes to environmental accessibility services or specialized medical equipment payment coverage may result in the Department expending less for additional modifications, and may decrease the Department's administrative costs for contacting the case managers multiple times when environmental accessibility services or specialized medical equipment was installed improperly.
- The changes to the documentation and prior authorization requirements for non-medical transportation may or may not result in an increase in costs.



- There is an additional administrative cost for the Department to implement the requirement that a second notice be sent when seeking additional information from the applicant or the applicant's licensed practitioner for eligibility determinations.

**B. To State citizens and political subdivisions:**

The proposed rules will not result in an increase or decrease in costs to political subdivisions, but may have indeterminable costs and benefits for State citizens, including:

- Choices for Independence participants may benefit because they will be able to access supported employment, financial management, and participant directed and managed services.
- Choices for Independence participants will benefit from the change to the methodology in He-E 801.09 which excludes services rendered for acute care needs, environmental accessibility services, and for community transition services to determine whether the requested services cost less than institutional care.
- The requirement that case managers not submit service authorizations when the environmental accessibility services provider's quote conflicts with the provider's specifications will be beneficial to participants because it should result in work being completed correctly and according to the participant's needs.
- Transportation provided to the participant with the participant's own vehicle will no longer be a covered service (reimbursable under the program), which could impact participants to the extent this practice was occurring.
- Choices for Independence participants may benefit from expanded coverage related to personal care workers preparing meals and snacks.

**C. To independently owned businesses:**

The proposed changes may lead to an indeterminable increase in administrative costs to independently owned businesses, including:

- Case managers will now have to provide additional documentation for service authorizations when there is conflicting or missing information, which may modestly increase their administrative costs.
- Providers of services to Choices for Independence participants may have an indeterminable cost associated with adhering to the setting requirements in 42 CFR 441.301(c)(4).
- Adding the requirement that skilled nursing services are not coverable when determined to be needed for the provision of acute needs under the Medicaid State plan could impact how the case managers review and submit requests for these services, leading to a modest fiscal impact.
- The stipulation that when a requested service was not approved that there be a risk assessment performed may create additional administrative costs for case managers who are not routinely performing them as part of the comprehensive service plan development.



- The changes to the documentation and prior authorization process for non-medical transportation should result in less administrative work for case managers.
- The new requirement that providers and case managers provide a copy of the comprehensive care plan to the Department upon request may modestly increase the providers' and case managers' administrative costs.
- The requirement that personal care services not include transportation when no other service is required could result in an impact to personal care services workers to the extent that this was occurring.
- The requirement that providers must maintain supporting documents, and that the Department has the ability to recover federal or State Medicaid payment, will have an indeterminable impact on the providers.
- Inserting language to require personal care services workers to adhere to the electronic visitation requirements in the 21st Century Cures Act could impact these providers to the extent that they are not already adhering to the federal law.

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

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

## CHAPTER He-E 800 MEDICAL ASSISTANCE

<p><b>Note to JLCAR.</b> The Committee may have questions about enforcement of the expired rules.</p>
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**Adopt He-E 801, previously effective 8-7-19 (Document #12830, Interim), and expired 2-3-20, to read as follows:**

## PART He-E 801 CHOICES FOR INDEPENDENCE PROGRAM

He-E 801.01 Purpose. The purpose of the rules is to describe the requirements for eligibility and the services provided through the Choices for Independence (CFI) home and community based services (HCBS-CFI) medicaid waiver program. The program serves individuals who are financially eligible for medicaid coverage and clinically eligible for long-term-services and supports (LTSS), who choose to receive care in their home or another community setting instead of care in an institutional setting.

He-E 801.02 Definitions.

(a) “Activities of daily living (ADLs)” means the primary activities necessary to carry out daily self-care activities that involve eating, toileting, transferring, bathing, dressing, and continence.

(b) “Adult day services” means one or more of the services delivered by a facility licensed in accordance with He-P 818 and listed in He-E 801.16, provided for fewer than 12 hours a day. This term includes “adult medical day services”.

(c) “Adult family care (AFC)” means participant housing option for eligible participants under the CFI waiver program, which includes a combination of personal care, homemaking, and other services that are provided to a participant who is a resident in a certified residence of an unrelated individual or the CFI waiver participant’s relative in accordance with a person-centered plan.

(d) “Annual aggregate medicaid cost” means the total medicaid costs for nursing home residents, combining both the initial medicaid payments and quarterly supplemental payments.

(e) “Appeal” means a request to review a decision or action made by the department which adversely affected the individual pursuant to RSA 126-A:5, VIII.

(f) “Average aggregate payment” means the value of the annual aggregate medicaid cost of nursing facility services divided by the number of paid medicaid bed days in nursing facilities.

(g) “Authorized representative” means any adult other than a department staff member or provider representative who is 18 years of age or older, and who, with the applicant’s or participant’s permission, acts on behalf of the individual for CFI waiver services.

(h) “Provider care plan” means a written guide that:

- (1) Is developed and maintained by the service provider in consultation with the participant, his or her legal representative, if any, or both, and the participant’s primary care provider, if applicable;
- (2) Is developed as a result of an assessment process which includes communication with the participant’s case manager;
- (3) Is consistent with and addresses the applicable service needs identified in the participant’s comprehensive care plan; and
- (4) Contains specific instructions on providing a defined service to the participant.

(i) “Case management agency” means an agency licensed under He-P 819 and enrolled as a New Hampshire medicaid provider to provide targeted case management services to CFI participants in accordance with He-E 805.

(j) “Case manager” means an individual employed by, or contracted with, a case management agency who:

- (1) Meets the qualifications described in He-E 805.06;
- (2) Is responsible for the ongoing assessment, person-centered planning, coordination, and monitoring of the provision of services included in the comprehensive care plan; and
- (3) Does not have a conflict of interest.

(k) “Choices for Independence (CFI) waiver program” means a system of long-term services and supports (LTSS) provided under Section 1915(c) of the Social Security Act to participants who meet the eligibility requirements in He-E 801.03 and He-E 801.04.

(l) “Commissioner” means the commissioner of the New Hampshire department of health and human services, or his or her designee.

(m) “Community transition services” means non-recurring services, including case management services to support CFI participants who are transitioning from an institutional setting or another provider-operated living arrangement to a living arrangement in a private residence, in which the participant is directly responsible for his or her own living expenses in accordance with He-E 801.17.

(n) “Comprehensive care plan” means an individualized person-centered plan described in He-E 805.05(c) that is:

- (1) The result of a person-centered process that identifies the strengths, capacities, preferences, and desired outcomes of the participant;
- (2) Developed by the participant’s case manager; and
- (3) Is an integrated plan of all the participant’s services.

(o) “Conflict of interest” means a conflict between the private interests and the official or professional responsibilities of a person, such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant.

(p) “Congregate meals” means the provision of meals to groups of participants in a community setting.

(q) “Department” means the New Hampshire department of health and human services.

(r) “Environmental accessibility services (EAS)” means the installation of ramps, grab bars, widening of doorways, electronic aids to daily living, and other adaptations as authorized by the department, in a participant’s home or vehicle as necessary to support the participants’ health and safety.

(s) “Fading plan” means a specific plan that is developed to assist an individual to achieve maximum independence on the job through a variety of activities including cultivating natural supports.

(t) “Financial management services (FMS)” means assisting participants that elect to receive PDMS with the following:

- (1) Management and disbursement of funds contained in the participant-directed budget;

- (2) Performing fiscal accounting, and budget management;
- (3) Creating expenditure reports;
- (4) Facilitating the employment of staff, and furnishing orientation; and
- (5) Conducting skills training to participants who function as the co-employer of their direct support workers.

(u) “Home-based services” means long-term services and supports provided to a participant either in a private home setting or in a mid-level residential facility, including:

- (1) CFI waiver services pursuant to this part; and
- (2) The following medicaid state plan services:
  - a. Targeted case management services pursuant to He-E 805;
  - b. Personal care attendant;
  - c. Home health aide;
  - d. Home health nursing;
  - e. Physical therapy;
  - f. Occupational therapy;
  - g. Speech therapy;
  - h. Adult medical day; and
  - i. Private duty nursing.

(v) “Home-delivered meals” means prepared meals that are provided to a participant in his or her home.

(w) “Home health aide services” means services provided by a nursing assistant licensed in accordance with RSA 326-B.

(x) “Homemaker services” means non-hands-on services to support a participant’s household management, including light housecleaning tasks, laundry, preparation of meals and snacks, and errands.

(y) “In-home care” means nonmedical non-hands on care, supervision, and socialization provided to isolated participants to prevent institutionalization. This term includes “adult in-home care”.

(z) “Instrumental Activities of Daily Living” (IADL) means light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

(aa) “Legal representative” means one of the following individuals, duly appointed or designated in the manner required by law to act on behalf of another individual, and who is acting within the scope of his or her authority:

- (1) An attorney;
- (2) A guardian or conservator;

- (3) An agent acting under a power of attorney;
- (4) An authorized representative acting on behalf of an applicant in some or all of the aspects of initial and continuing eligibility in accordance with He-W 803.01; or
- (5) A representative acting on behalf of another individual pursuant to RSA 161-I, Personal Care Services.

(ab) “Legally responsible relative” means the participant’s spouse.

(ac) “Licensed practitioner” means:

- (1) Medical doctor;
- (2) Physician assistant;
- (3) Advanced practice registered nurse;
- (4) Doctor of osteopathy;
- (5) Doctor of naturopathic medicine;
- (6) Physical therapist;
- (7) Occupational therapist; or
- (8) Anyone with diagnostic and prescriptive powers licensed by the appropriate New Hampshire licensing board.

(ad) “Medicaid bed days” means the total unduplicated number of days of nursing facility care that were paid for by the medicaid program in a 12 month period.

(ae) “Non-medical transportation” means transportation provided to enable participants to access the community when personal care services are required to do so as articulated in the comprehensive care plan.

(af) “Nursing facility” means nursing facility licensed pursuant to RSA 151 that provides for 2 or more persons’ basic domiciliary services, including board, room and laundry, continuing health supervision under competent professional medical and nursing direction, and continuous nursing care as may be individually required.

(ag) “Other qualified agencies” means those entities certified in accordance with RSA 161-I and He-P 601.

(ah) “Participant-directed and managed services (PDMS)” means services that allow CFI waiver participants to direct and manage a menu of any CFI waiver service, except for residential care facility services in accordance with He-E 801.24. PDMS allows the participant to design the services that will be provided, select service providers, decide how authorized funding is to be spent base on the needs identified in the participant’s comprehensive care plan, and perform ongoing oversight of the services provided.

(ai) “Person-centered planning” means a planning process to develop an individual support plan that is directed by the participant, his or her representative, or both, and which identifies his or her preferences, strengths, capacities, needs, and desired outcomes or goals.

(aj) “Personal care services (PCS)” means hands-on assistance with ADLs and IADLs, assisting with self-administration of oral and topical medications, performing light housekeeping, providing cueing

with eating or dressing, and accompanying a participant into the community when the assistance of the personal care worker is required by the participant, as provided by staff employed by an agency licensed under He-P 809, He-P 822, or an agency certified under He-P 601.

(ak) “Personal emergency response system” means an electronic device that enables participants at high risk of institutionalization and who are alone for periods of time to summon help in an emergency 24-hours per day 7 days per week. It also includes a portable help button to allow for the participant’s mobility.

(al) “Residential care facility” means an assisted living residence-residential care or assisted living-supported residential health care facility licensed in accordance with RSA 151.

(am) “Skilled professional medical personnel” means “skilled professional medical personnel” as defined in RSA 151-E:3.

(an) “Skilled nursing services” means services listed in the comprehensive plan of care that are within the scope of RSA 326-B and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse licensed to practice in New Hampshire within the scope of RSA 326-B. This service provides intermittent skilled nursing services for the purpose of administering injections, medical monitoring of wounds that are not healing, providing wound care, physical therapy, monitoring vital signs, obtaining laboratory specimens when a chronic condition exacerbates, or overseeing a bowel program.

(ao) “Specialized medical equipment” means the following:

- (1) Devices, controls, or appliances that are specified in the comprehensive care plan which enable a participant to increase his or her ability to perform ADLs or IADLs;
- (2) Devices, controls, or appliances that are specified in the comprehensive care plan to perceive, control, or communicate with the environment in which the participant lives;
- (3) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
- (4) Other durable and non-durable medical equipment not available under the New Hampshire Medicaid state plan that are necessary to address participant functional limitations; and
- (5) Necessary medical supplies not available under the New Hampshire Medicaid state plan.

(ap) “Supported employment services (SEP)” means individual employment services that help a participant who, because of his or her disabilities, require intensive on-going supports to obtain and maintain competitive employment customized employment or self-employment in an integrated work setting, and includes the following:

- (1) Vocational or job-related discovery or assessment and job skill trainings necessary to assist with integration in a job setting;
- (2) Job placement;
- (3) Job development and negotiation with prospective employers;
- (4) Job incentives planning and management;
- (5) Transportation to employment; and
- (6) Asset development and career advancement services.

(aq) “Supportive housing services” means services provided by a federal housing authority licensed as a home health agency or by a home health agency contracted with a federal housing authority to provide services in apartments located in publicly funded apartment buildings that include the following:

- (1) Personal care services, including assistance with ADLs and IADLs;
- (2) Supervision;
- (3) Medication reminders; and
- (4) Other supportive activities as specified in the comprehensive care plan or which promote and support health and wellness, dignity, and autonomy within a community setting.

(ar) “Targeted case management” means the collaborative process of assessment, planning, facilitation, advocacy, coordination, and monitoring performed by the case manager that is accomplished with a person-centered program, and which:

- (1) Assists participants to gain access to needed CFI waiver services, services contained in the medicaid state plan, and other medical, social, spiritual, vocational, educational, and community supports, regardless of the funding source; and
- (2) Provides for coordination of participant service plans from all providers to assure adequacy and appropriateness of care and cost effectiveness of planned services that yield positive outcomes.

#### He-E 801.03 Eligibility.

(a) An individual shall be eligible to receive CFI waiver services if he or she meets all of the following requirements:

- (1) Submission of a signed and dated application, as defined in He-W 601.01(p), to the department;
- (2) Is at least 18 years of age;
- (3) Meets the financial and categorical requirements for medicaid;
- (4) Meets the clinical eligibility requirements for nursing facility care in RSA 151-E:3, I(a), namely, the person requires 24-hour care for one or more of the following purposes, as determined by skilled professional medical personnel:
  - a. Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;
  - b. Restorative nursing or rehabilitative care with patient-specific goals;
  - c. Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or
  - d. Assistance with 2 or more ADLs;
- (5) Requires the provision of at least one of the CFI waiver services pursuant to He-E 801.12, as documented in the identified needs list, and receives at least one of the CFI waiver services monthly; and



(6) Has chosen, or whose legal representative has chosen, by signing the application in (1) above, CFI waiver services as an alternative to institutional care.

(b) Pursuant to 42 CFR 441.301 (b)(1)(iii) and (b)(6), eligibility shall be restricted to individuals who meet the target population criteria approved by the centers for medicare and medicaid services (CMS) for the CFI waiver program and who, without the CFI waiver services, would require the level of care provided in a nursing facility as described in He-E 802.

(c) While receiving care as a resident in a nursing facility, an individual shall not be eligible for coverage of CFI waiver services listed in He-E 801.12 except for targeted case management in accordance with RSA 151-E:17.

(d) An individual shall not be considered to be a resident of a nursing facility in (c) above if he or she is a CFI participant who is admitted to a nursing facility on a temporary basis for treatment or care for an acute episode.

(e) For those CFI participants who are receiving short-term inpatient care in a hospital or nursing facility, the following shall apply:

(1) Services described in He-E 801.12(d) shall not be provided while the participant is in the facility, except for services that have been prior authorized for the purpose of enabling the participant to transition back to his or her community; and

(2) The participant's clinical eligibility shall be maintained until such time that an eligibility redetermination is conducted in accordance with He-E 801.07 and the participant is determined ineligible.

#### He-E 801.04 Initial Clinical Eligibility Determination.

(a) The department shall make the clinical eligibility determination of the applicant as follows:

(1) Skilled professional medical personnel shall:

- a. Conduct an on-site, face-to-face visit with the applicant;
- b. Perform a clinical assessment of the applicant; and
- c. Develop the identified needs list with the applicant;

(2) The applicant shall sign the following:

- a. A consent for participation in the CFI waiver program, including whether or not he or she has a preference of a case management agency;
- b. An authorization for release of information; and
- c. An authorization for release of protected health information;

(3) Pursuant to RSA 151-E:3, IV, if the department is unable to determine an applicant's clinically eligible based on the assessment in (a) above, the department shall send notice to the applicant and the applicant's licensed practitioner(s), as applicable, requesting additional medical information within 30 calendar days of the notice and stating that the failure to submit the requested information will impede processing of the application and delay service delivery;

(4) Within the 30-day period in (3) above, if the requested information is not received within 20 calendar days, the department shall send a second notice to the applicable licensed

practitioner(s), with a copy to the applicant, as a reminder to provide the requested information by the original deadline;

(5) Upon request from the treating licensed practitioner or applicant within the 30-day period in (3) above, the department shall extend the deadline in (3) above for a maximum of 30 days if the practitioner or applicant states that he or she has documentation that supports eligibility and will provide it within that time period; and

(6) If the information required by (3) above is not received by the date specified in the notice, or as extended by the department in accordance with (5) above, the applicant shall be determined to be clinically ineligible.

(b) The applicant shall be determined eligible for the CFI waiver program if it is determined that the applicant meets the financial eligibility requirements described in He-W 600 and He-W 800, the clinical eligibility requirements of He-E 801.03(a)(4), and the other eligibility requirements pursuant to He-E 801.03.

(c) Upon a determination of eligibility, the applicant or his or her legal representative shall be sent an approval notice, including:

(1) The name and contact information of the case management agency chosen by the applicant or assigned to the applicant by the department, if available at the time of the notice; and

(2) The eligibility start date.

(d) Upon a determination of ineligibility, because the applicant does not meet the eligibility requirements of He-E 801.03 or because required information is not received pursuant to (a)(6) above, the applicant or his or her legal representative shall be sent a notice of denial, including:

(1) A statement regarding the reason and legal basis for the denial;

(2) Information concerning the applicant's right of appeal pursuant to He-C 200, including the requirement that the applicant has 30 calendar days from the date of the notice of denial to file such an appeal;

(3) An explanation that an applicant who is denied services and who chooses to appeal this denial pursuant to He-C 200 shall not be entitled to medicaid payments for CFI waiver services pending the appeal hearing decision; and

(4) The medical credentials of the skilled professional medical personnel making the determination of ineligibility.

#### He-E 801.05 Development of the Comprehensive Care Plan.

(a) The case manager assigned to the participant shall develop and maintain a comprehensive care plan through a person-centered planning process in accordance with He-E 805.

(b) The participant shall review the identified needs section of the comprehensive assessment, indicating his or her agreement or disagreement with the identified needs.

(c) The case manager shall request authorization from the department for coverage of the CFI waiver services contained in the comprehensive care plan, including the specific service providers selected by the participant.

(d) The department shall, within 5 business days of the request for service authorization, request additional information from the case manager, including the comprehensive care plan or the section of the comprehensive care plan as needed to support the authorization.

(e) The case manager shall provide the department with the information requested in (d) above within 5 business days of the request. .

He-E 801.06 Service Authorization.

(a) Upon review of the information provided in He-E 801.05(c) and within 6 business days, the department shall authorize services that meet the needs identified in the clinical assessment in He-E 801.04(a) and other later established needs.

(b) Service authorizations shall include specific types, units, and frequencies of the needed services.

(c) Service authorizations shall be issued to specific service providers identified by the participant and his or her case manager as a result of person-centered planning.

(d) When the service authorization does not include all the services requested, the participant shall be sent a notice, to include:

- (1) The requested service;
- (2) The authorized service;
- (3) A statement regarding the reason and legal basis for the denial;
- (4) Information regarding the participant's option to request reconsideration pursuant to (e) below; and
- (5) Information concerning the participant's right of appeal pursuant to He-C 200, including the requirement that the participant has 30 calendar days from the date of the notice authorizing services to file such an appeal.

(e) A participant who disagrees with a denial of a service authorization may request a reconsideration of the service authorization, as follows:

- (1) The participant, or his or her representative, shall submit a written request to the department within 30 days of the service authorization; and
- (2) The written request shall include an explanation of the reason why a specific service authorization should be changed, including any supporting documentation.

(f) The department shall review the request in (e) above and provide a written notice to the participant, or his or her representative, of its decision based on the criteria for applicable service authorization to maintain or change the original service authorization, including the reason therefor.

(g) Requesting a service authorization reconsideration shall not:

- (1) Preclude in any way a participant's right to appeal a disputed service authorization in accordance with He-C 200;
- (2) Change the timeframes established for filing an appeal; and
- (3) Affect the amount or type of services authorized.

He-E 801.07 Redetermination of Eligibility and Service Authorization.

(a) The eligibility of each participant, as determined in accordance with He-E 801.04, shall be subject to redetermination at least annually.

(b) The redetermination shall be conducted in accordance with He-E 801.04, except that (e)(2)c.2. below shall apply.

(c) The annual redetermination required in (a) above shall not preclude earlier redetermination or reevaluation and subsequent changes to the identified needs list or service authorizations.

(d) Upon a redetermination of eligibility, the department shall review and update, as necessary, the service authorization(s).

(e) If a participant is determined ineligible, or if services are no longer requested by the participant or considered necessary by the department pursuant to He-E 801.03(a) above, the department shall either terminate the participant's CFI eligibility or reduce the services previously authorized as follows:

(1) Payment for services shall be terminated 30 calendar days from the date of the notice described in (2) below, unless an appeal has been filed within 15 calendar days of the date of the notice; and

(2) A written notice of eligibility termination or the reduction or termination of the services previously authorized, as applicable, shall be sent to the participant, or his or her legal representative, and the participant's case manager, including:

a. The reason and legal basis for the termination or reduction;

b. The date that service coverage shall be terminated or reduced, absent the filing of an appeal; and

c. Information concerning the participant's right to appeal pursuant to He-C 200, as follows:

1. The participant shall have 30 calendar days to file an appeal, otherwise the department's decision shall be final; and

2. If the participant files an appeal within 15 calendar days of the date of the notice of service coverage termination or reduction, continued payments for CFI waiver services shall be authorized until 30 calendar days after a hearing decision has been made.

He-E 801.08 Request for Clinical Redetermination After Clinical Denial. An applicant or participant may reapply at any time following a denial or termination of services, and eligibility shall be determined in accordance with He-E 801.03 and He-E 801.04.

He-E 801.09 Cost Control Methodology.

(a) The total cost of a participant's or applicant's home-based services shall include the costs of all LTSS services provided under the CFI waiver program.

(b) Costs associated with services rendered for acute care needs, EAS, and community transitions shall not be included in the calculation in (a) above.

(c) The average annual cost for the provision of services to a person in a nursing facility shall be calculated by adding:

- (1) The basic medicaid cost, determined by dividing the total annual medicaid cost stated in the nursing facility budget line by the number of paid medicaid bed days for that budget year; and
- (2) The average aggregate payment made under the medicaid quality incentive program, through the nursing facility trust fund as described in RSA 151-E:14 and 151-E:15, divided by the number of paid medicaid bed days.

He-E 801.10 Post-Eligibility Computation of Cost of Care for CFI Waiver Services.

(a) Except for participants who reside in residential care facilities, the amount of income that an participant is liable to contribute toward the cost of his or her CFI waiver services shall be computed as follows:

- (1) The amount of the participant's gross earned income as defined in He-W 601.04(o) shall be determined;
- (2) The employment expense disregard, as specified in He-W 654.18 for old age assistance (OAA) or aid to the needy blind (ANB) recipients or the earned income disregard, as specified in He-W 854.18 for aid to the permanently and totally disabled (APTD) recipients, shall be subtracted from the participant's gross earned income to obtain the participant's net earned income;
- (3) The total amount of the participant's unearned income, as defined in He-W 601.08(k), shall be added to the net earned income to determine the participant's net income;
- (4) The allowable deductions, as defined in He-W 854.20 and He-W 654.21, shall be subtracted from the participant's net income;
- (5) For the maintenance needs of the participant, 300% of the maximum supplemental security income (SSI) benefit for an eligible participant as determined in accordance with 20 CFR 416.410, adjusted by cost of living increases pursuant to 20 CFR 416.405 shall be subtracted from the amount in (4) above;
- (6) The cost of the following medical expenses incurred by the participant that are not subject to third-party payment shall be subtracted from the amount in (5) above:
  - a. Health insurance premiums, including Medicare Part A, Part B, Part C, and Part D, coinsurance payments, and deductibles;
  - b. Necessary and remedial care that would be covered by medical assistance except that allowable payment limits have been exceeded;
  - c. Necessary and remedial care that is recognized by state law, but not covered by medical assistance; and
  - d. Currently obligated, unpaid prior medical debt;
- (7) The amount of any continuing SSI benefits, under section 1611 (e) (1) (E) and (G) of the Social Security Act, shall be subtracted from the amount in (6) above;
- (8) The veterans affairs aid and attendance allowance shall be added to the amount in (6) or (7) above as required by 42 CFR 435.733 (c); and
- (9) The result in (8) above shall be the amount of income for which the individual is liable to remit as payment toward the cost of his or her CFI waiver services.

(b) For participants who reside in residential care facilities, the amount of income that the participant is liable to contribute toward the cost of his or her CFI waiver services shall be computed as follows:

- (1) The amount of the participant's gross earned income as defined in He-W 601.04(o) shall be determined;
- (2) The employment expense disregard, as specified in He-W 854.18 for OAA or ANB recipients or the earned income disregard, as specified in He-W 854.15 for APTD recipients, shall be subtracted from the participant's gross earned income to obtain the participant's net earned income;
- (3) The total amount of the participant's unearned income, as defined in He-W 601.08(k), shall be added to the net earned income to determine the participant's net income;
- (4) The allowable deductions, as defined in He-W 854.20 and He-W 654.21, shall be subtracted from the participant's net income;
- (5) The personal needs allowance as defined in He-W 854.17(b) shall be subtracted from the amount in (4) above;
- (6) The cost of the following medical expenses incurred by the participant that are not subject to third-party payment shall be subtracted from the amount in (5) above:
  - a. Health insurance premiums, including Medicare Part A, Part B, Part C, and Part D, coinsurance payments, and deductibles;
  - b. Necessary and remedial care that would be covered by medical assistance except that allowable payment limits have been exceeded;
  - c. Necessary and remedial care that is recognized by state law, but not covered by medical assistance; and
  - d. Currently obligated, unpaid prior medical debt;
- (7) The amount of any continuing SSI benefits, under section 1611 (e) (1) (E) and (G) of the Social Security Act, shall be subtracted from the amount in (6) above;
- (8) The veterans affairs aid and attendance allowance shall be added to the amount in (6) or (7) above as required by 42 CFR 435.733 (c); and
- (9) The result in (8) above shall be the amount of income for which the participant is liable to remit as payment toward the cost of his or her CFI waiver services.

He-E 801.11 Covered Services and Requirements of Service Provision.

- (a) CFI waiver services shall be covered for eligible participants when the services:
  - (1) Are provided as specified in the participant's comprehensive care plan;
  - (2) Are provided in accordance with the service descriptions in He-E 801.14 through He-E 801.33; and
  - (3) Are authorized by the department in accordance with He-E 801.06.
- (b) CFI waiver services shall be provided in accordance with the setting standards of 42 CFR 441.301(c)(4).

(c) A participant shall have the right to receive independent targeted case management services in accordance with He-E 805 while residing in a nursing facility, hospital, or rehabilitation hospital.

(d) CFI waiver services shall include one or more of the following services as described in this part:

- (1) Adult family care services;
- (2) In-home care services;
- (3) Adult day services;
- (4) EAS;
- (5) Home-delivered meals services;
- (6) Home health aide services;
- (7) Homemaker services;
- (8) Non-medical transportation services;
- (9) Personal care services;
- (10) Personal emergency response system services;
- (11) Residential care facility service;
- (12) Respite services;
- (13) Skilled nursing services;
- (14) Specialized medical equipment services;
- (15) Supportive housing services;
- (16) Community transition services;
- (17) Financial management services;
- (18) Participant directed and managed services;
- (19) Supported employment services; and
- (20) Targeted case management services pursuant to He-E 805.

He-E 801.12 Non-Covered Services.

(a) No service or item shall be covered through the CFI waiver program if the service or item:

- (1) Is covered through the medicaid state plan, and the participant is eligible for that coverage;
- (2) Is covered through Medicare or any other insurance, and the participant is eligible for that service;
- (3) Is provided as a component of any other covered service;
- (4) Duplicates another service being provided to the participant;
- (5) Addresses needs being met by another paid or unpaid service;



- (6) Is provided by a legally responsible relative;
- (7) Is primarily for the purpose of recreation;
- (8) Cannot be provided in accordance with the setting requirements of 42 CFR 441.301(c)(4); or
- (9) The requested service would result in the department’s inability to obtain federal financial participation.

(b) With the exception of respite care provided in an intermediate care facility or residential care facility, payment for CFI waiver services shall exclude room and board.

He-E 801.13 Adult Family Care.

**Edit.** Move to after “Adult family”.

(a) Adult family, as defined in He-E 801.02(c), care shall be covered:

- (1) When provided at a private residence in the community that is either:
  - a. Certified in accordance with RSA 151 and He-P 813; or
  - b. Not required to be licensed pursuant to RSA 151:2, II(b); and
- (2) When the services are organized and managed by an adult family care oversight agency, as defined in He-P 813.03(z), as authorized by the department.

(b) Adult family care shall include the services required by He-P 813.

He-E 801.14 In-Home Care Services.

**Edit.** (y)

(a) In-home care services, as defined in He-E 801.02(x), shall be covered when provided by an agency licensed in accordance with RSA 151:2 and either He-P 809 or He-P 822, or RSA 161-I and He-P 601.

**Edit.** period.

(b) Covered services shall include socialization and supervision

(c) Covered services may include:

**Unclear.** Who/what determines if a service will be provided and what criteria are used to determine whether a service will be covered?

- (1) Laundering the participant’s personal clothing items, towels, and bedding;
- (2) Light cleaning limited to the participant’s bedroom, bathroom, common living spaces, and mobility and medical devices;
- (3) Preparing non-communal meals and snacks, unless for multiple CFI participants, including cleaning the food preparation area after the food is served;
- (4) Maintaining a safe environment in areas of the home used by the participant;
- (5) Rearranging light-weight furniture to assure the participant can safely ambulate to reach food, water, medicine, and other essential items; and
- (6) Grocery shopping and other errands for the CFI participant.

(d) In-home care shall not be covered when provided to a participant receiving residential care facility services.

He-E 801.15 Adult Day Services.

(a) Adult day services, as defined in He-E 801.02(b) shall be covered when provided by an adult day program licensed in accordance with RSA 151:2 and He-P 818.

(b) Covered adult day services shall include the following services, based on the participant's needs in the provider care plan:

- (1) Supervision;
- (2) Personal care services;
- (3) Monitoring of the participant's condition and counseling, as appropriate, on diet, hygiene, or other related matters;
- (4) Referrals, as appropriate, to other services and resources that could assist the participant, including any necessary follow-up; and
- (5) The following He-P 818 services:
  - a. Health and safety services;
  - b. Dietary services;
  - c. Nursing services;
  - d. Social services;
  - e. Rehabilitative services; and
  - e. Recreational activities.

(c) Adult day services shall not be a covered service under this part when:

- (1) Provided to a participant receiving residential care facility services; or
- (2) Provided to a participant receiving adult family care services.

(d) Adult day service providers shall comply with the provider and documentation requirements specified in He-E 803 and He-P 818, in addition to the requirements in He-E 801.33.

He-E 801.16 Community Transition Services.

(a) Community transition services, as defined in He-E 801.02(m), shall be covered only to the extent that they are reasonable and necessary as determined through the comprehensive care plan development process, and meet the following:

- (1) The need for the community transition service is clearly identified in the comprehensive care plan;
- (2) The participant is unable to meet the expenses of community transition services; and
- (3) The community transition services cannot be obtained from other sources.

(b) The maximum limit for community transition services for a participant shall be \$1,500 per transition.

(c) Community transition services shall be one-time services per transition and represent one-time costs as described in this part.

(d) The following shall be coverable expenses under community transition services, subject to the service limit in (c) above:

- (1) A security deposit required to obtain a lease on an apartment or house;
- (2) Set-up fees or deposits for utility or service access, including telephone, electricity, heat, and water;
- (3) Items required to occupy and use a community domicile, such as essential household furnishings, window coverings, household appliances needed for basic food preparation, and bed and bath linens; and
- (4) Services necessary for the participant's health and safety, such as pest eradication, and one-time cleaning done prior to occupancy.

(e) Community transition services shall not include monthly rent or mortgage payments, food, monthly utility expenses, or costs for household appliances or items that are intended for entertainment, recreational or diversional purposes or use.

He-E 801.17 Environmental Accessibility Services. Edit. (r)

(a) EAS, as defined in He-E 801.02(q) shall be a covered service when:

- (1) A NH medicaid-enrolled licensed practitioner has determined the need for one or more of the services in (b) below;
- (2) The participant's case manager has requested prior authorization for the service in accordance with (d) below;
- (3) The department has provided the prior authorization for the service;
- (4) The service is completed by an EAS provider who is enrolled with the department in accordance with (e) below; and
- (5) When the services are prior authorized and do not exceed the limit specified in the HCBS-CFI waiver approved by CMS.

(b) The following EAS shall be covered:

- (1) Installation of ramps;
- (2) Installation of grab bars;
- (3) Widening of doorways to accommodate the participant's wheelchair or other mobility access equipment;
- (4) Electronic aids to daily living; and
- (5) Other adaptations authorized by the department that are necessary for the health and safety of a participant that are not otherwise covered under the medicaid state plan.

(c) The following EAS shall not be covered:

- (1) Improvements that are of general utility and do not have direct medical or remedial benefit to the participant;

- (2) Adaptations which add to the square footage of the home except when necessary to complete an adaptation such as to improve the entrance or egress to the residence or to configure a bathroom to accommodate the participant's wheelchair;
- (3) Purchase of a motor vehicle;
- (4) Electrical or plumbing work that is beyond what is required to support the authorized adaptation;
- (5) Electrical or plumbing work, unless the EAS provider states, in writing, that the proposed adaptation can be done within the current electrical or plumbing capacity of the home; and
- (6) Adaptations to a residential care facility or other licensed facility, except for adaptations in an adult family care home when approved for a specific participant.

(d) The participant's case manager shall submit the following when requesting prior authorization for an EAS:

- (1) A completed Form 3715, "Choices for Independence Prior Authorization Request Form" (December 2021);
- (2) A copy of the evaluation in (a)(1) above that describes:
  - a. The medical or functional need for the adaptation;
  - b. The description and measurements required for the adaptation; and
  - c. The proposed training plan for the participant and as applicable, the caregiver, to ensure safe use of the adaptation;
- (3) Proposals from at least 2 EAS providers for proposals that have a total cost more than \$5,000, except that one proposal may be submitted with a written explanation of why only one proposal is available or appropriate or when a proposal indicates the total cost is \$5,000 or less, including the following, as applicable to the project:
  - a. A list of supplies and materials;
  - b. Blueprints or scaled drawings;
  - c. The name(s) of any subcontractors that will be involved;
  - d. Written confirmation of whether or not a state or local building permit is required;
  - e. If electrical or plumbing work is required to support the adaptation, then:
    1. A statement signed by the EAS provider stating that the requested adaptation can be done within the current electrical or plumbing capacity of the residence; and
    2. A copy of the electrician or plumber's license;
  - f. A statement signed by the EAS provider affirming knowledge of all applicable building codes and permit requirements, affirming that the work will meet the requirements of RSA 155-A:2, and affirming that any subcontractors involved in the work are appropriately licensed; and

- g. An agreement signed by the EAS provider stating that reimbursement for the authorized service through the CFI waiver program shall be considered as payment in full;
- (4) If a participant prefers one bid over the other(s), then an explanation of the preference shall be submitted to the case manager; and
- (5) A notarized written statement from the property owner granting permission to complete the project if the participant is not the owner of the residence.
- (e) In order to be enrolled to perform EAS, the EAS provider shall:
- (1) Be licensed if the work to be completed requires licensure, such as plumbing or electrical work;
  - (2) Be registered with the NH secretary of state to do business in the state of NH;
  - (3) Be insured with general liability insurance for person and property for a minimum amount of \$50,000; and
  - (4) Have submitted documentation of (1)-(3) above to the department's fiscal agent.
- (f) When there is a discrepancy between the recommended specifications pursuant to (a)(1) above, and the EAS provider's quote, the case manager shall not request an authorization for the service, and the department shall not authorize the service until the discrepancy is resolved to the recommended specifications.
- (g) An initial authorization shall be made for the first 50% of the expense for the modification.
- (h) Final authorization for payment for EAS shall not be made until the department receives the following:
- (1) A copy of any required state or local building permit(s) and written confirmation from the building inspector that the work was completed as allowed by the permit(s);
  - (2) A signed statement from the participant, and if the participant is not the owner of the residence, the property owner, stating that the work has been completed according to the approved bid and plans to the satisfaction of the participant and, if applicable, the property owner;
  - (3) A signed confirmation from the case manager stating that the work was completed; and
  - (4) A signed confirmation from the participant that he or she was trained as described in the training plan to ensure safe use of the adaption.
- (i) Payment for EAS shall not exceed the limit specified in the HCBS-CFI waiver approved by CMS.
- (j) If, within 90 days of an EAS installation:
- (1) There is a discrepancy between the EAS provider's quote and the delivered or installed materials for a participant, the EAS provider shall replace the equipment or modification;
  - (2) The replacement includes a restocking fee that the EAS provider will incur as a result of the needed modification or replacement, the EAS provider may provide a revised quote for the replacement at the same cost and add a restocking fee, and the case manager shall submit the

Edit. "shall be"

revised quote that includes the restocking fee for authorization to the department. Any restocking fee is limited to the actual restocking fee incurred by the EAS provider; and

(3) There is a need to modify the EAS because it did not meet the local or state codes or the EAS provider's quote, the repair, replacement, or modification shall be made at the EAS provider's expense.

He-E 801.18 Financial Management Services.

Edit. (t)

(a) FMS, as defined in He-E 801.02(s) shall be provided in accordance with the budget developed by the participant with the case manager as part of the participant's comprehensive care plan.

(b) The FMS provider shall:

(1) Manage and direct the disbursement of funds in accordance with the PDMS budget and plan;

(2) Facilitate the employment of staff by the family or CFI participant;

(3) Provide orientation and skills training to the participant or the participant's legal representative who is to act as co-employer of direct support staff about responsibilities as co-employers for the direct support workers employed;

(4) Provide fiscal accounting to include:

a. Disbursements for goods and services approved in the comprehensive care plan and the balance of the participant's available funds; and

b. Ensuring separation of each participant's budget and expenses; and

(5) Provide employer functions, including but not limited to:

a. Hiring workers chosen by the participant;

b. Verifying worker citizenship status;

c. Ensuring completion of required background checks and obtaining a waiver if necessary pursuant to He-E 801.37;

d. Processing payroll and issuing payment to employees;

e. Withholding all federal, state, and local taxes and making tax payments to the applicable tax authorities; and

f. Documenting required training.

(c) FMS providers shall enroll with NH medicaid as FMS providers and have the capabilities to perform the required tasks in accordance with 26 USC 3504 and revenue procedure 70-6.

(d) The participant's budget shall include the following, based on the needs identified by the case manager in the comprehensive care plan:

(1) The specific PDMS components:

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

(3) An itemized cost of the PDMS.

(e) The FMS provider shall prepare a budget worksheet that details how the participant intends to spend the funds allocated in the participant’s budget and the worksheet shall be reviewed monthly by the participant.

(f) Expenses that exceed the limits allowed under a participant’s PDMS budget or that exceed service limits allowed for SME or EAS, or that are not allowed under this program as authorized by CMS, shall not be paid.

(g) All FMS providers shall:

- (1) Provide services as described in this part;
- (2) Maintain an account for the participant for the purposes of tracking expenditures from the participant’s budget;
- (3) Inform participants of procedures for payment requests for goods and services;
- (4) Review and submit for payment to the department the items or services that the participant purchases based on his or her budget; and
- (5) Provide the participant with a monthly statement to track expenditures and to ensure that the FMS provider is handling the participant’s budget appropriately and accurately.

He-E 801.19 Home-Delivered Meals Services.

Edit. (v)

(a) Covered home-delivered meals services, as defined in He-E 801.02(u) shall include:

**Unclear.** This is the defined phrase, not “covered home-delivered meals”.

- (1) The delivery of nutritionally balanced meals to the participant’s home; and
- (2) Concurrent with meal delivery, monitoring of the participant’s wellbeing, and the reporting of emergencies, crises, or potentially harmful situations shall be made to emergency personnel or the participant’s case manager, as appropriate.

(b) All home-delivered meals shall:

- (1) Include at least one-third of the dietary reference intakes r, established by the U. S. Department of Agriculture for dietary reference intakes as specified in the United States Department of Agriculture’s, “Dietary Guidelines for Americans 2020-2025” (Ninth Edition), available as noted in Appendix A; and
- (2) Meet the U.S. Department of Agriculture recommended Dietary Guidelines for Americans as specified in the United States Department of Agriculture’s, “Dietary Guidelines for Americans 2020-2025” (Ninth Edition), incorporated in (1) above and available as noted in Appendix A.

**Unclear** what is intended.

(c) Providers of home-delivered meals services shall:

- (1) Be enrolled and contracted with the department to provide home-delivered meal services to adults;
- (2) Ensure that meals are prepared and delivered in compliance with the comprehensive care plan and with any applicable state, federal, or local requirements;
- (3) Provide meals that accommodate diabetic or salt restricted diets, or both, as requested by the case manager;



(4) Provide visual verification that the participant is home and that there are no unusual circumstances that may cause someone to suspect harm or potential harm to the participant; and

(5) Report any observations of unusual circumstances to the designated agency supervisor or, in the case of an emergency, call emergency personnel.

(d) Home-delivered meals services shall not be a covered service when the meal is provided at an adult day program, residential care facility, or a congregate meal site.

He-E 801.20 Home Health Aide Services.

Edit. (w)

(a) Home health aide services, as defined in He-E 801.02(v) shall be covered when provided by a licensed nursing assistant (LNA) licensed in accordance with RSA 326-B and Nur 700 and employed by a home health care agency licensed in accordance with RSA 151:2 and He-P 809.

(b) The following home health aide services shall be covered:

(1) Those services allowed within the LNA scope of practice, pursuant to Nur 700 that are not personal care services; and

(2) Personal care services, as described in He-E 801.25, when the participant's provider care plan contains documentation that his or her medical condition necessitates the performance of such tasks by an LNA and not an unlicensed provider.

(c) Home health aide services shall not be covered separately when provided at an adult day program or at a residential care facility.

He-E 801.21 Homemaker Services.

Edit. (x)

(a) Homemaker services, as defined in He-E 801.02(w), shall be covered when provided by employees of:

(1) Home health care providers licensed in accordance with RSA 151:2 and He-P 809;

(2) Home care service providers licensed in accordance with RSA 151:2 and He-P 822; or

(3) Other qualified agencies certified in accordance with RSA 161-I and He-P 601.

(b) Homemaker services shall be limited to the following non-hands-on general household services:

(1) Laundering the participant's personal clothing items, towels, and bedding;

(2) Light cleaning limited to the participant's bedroom, bathroom, and mobility and medical devices and common living spaces;

(3) When the participant lives alone, light cleaning of the kitchen and entry way areas, and common living spaces in order to maintain a safe environment;

(4) Errands for necessary tasks identified in the comprehensive care plan; and

(5) Preparation of non-communal meals and snacks, unless for multiple CFI participants, including cleaning the food preparation area after the food is served.

(c) Homemaker services shall not be covered as a separate service when provided at a residential care facility.

He-E 801.22 Non-Medical Transportation Services.

(a) Non-medical transportation services, as defined in He-E 801.02(ad), provided to enable participants to access the community when personal care services are required to do so as articulated in the comprehensive care plan.

Edit. (ae)

Edit. "shall"

(b) The participant's case manager shall:

- (1) Document in the participant's record what public transportation resources were considered by the case manager and why these resources cannot meet the participant's needs;
- (2) Include in the authorization request the destination where the participant will be transported; and
- (3) Be included in the participant's comprehensive care plan.

(c) Non-medical transportation services shall be covered when provided by employees of:

- (1) Home health care providers licensed in accordance with RSA 151:2 and He-P 809;
- (2) Home care service providers licensed in accordance with RSA 151:2 and He-P 822;
- (3) Other qualified agencies certified in accordance with RSA 161-I and He-P 601; or
- (4) Agencies under contract with the department to provide services, which include the provision of transportation, funded by the Older Americans' Act or the Social Services Block Grant.

(d) The agencies in (c) above shall ensure that:

(1) Vehicles used for providing non-medical transportation services have a current inspection sticker; and.

(2) Drivers providing non-medical transportation services:

- a. Have a current and valid driver's license;
- b. Have automobile insurance that:

**Authority/Legis. Intent.** Unless insurance is specifically required by statute, there is a basis for objection under Committee rules 401.05(c)(4) and 402.03(d)(4).

1. Includes uninsured motorist coverage; and

2. Is for a minimum of \$100,000 per passenger per occurrence and \$300,000 per occurrence; and

(3) Are 18 years of age or older.

(e) The following services shall not be covered as non-medical transportation:

- (1) Transportation provided with the participant's vehicle;
- (2) Transportation to or from medical appointments or services; and
- (3) Transportation provided to a participant who resides at a residential care facility or adult family care home.

(f) The prohibition on use of a participant's vehicle in (f)(1) above, shall not preclude a licensed provider from using a participant's vehicle in offering another authorized service, such as personal care service pursuant to He-E 801.25.

He-E 801.23 Participant Directed and Managed Services.

(a) PDMS, as defined in He-E 801.02(ah), shall:

- (1) Be tailored to the participant's competencies, interest, preferences, and needs;
- (2) Promote the health, safety, and emotional wellbeing of the participant;
- (3) Be provided in a manner which protects the participant's rights as described in RSA 151:21-b;
- (4) Provide the degree of support a participant needs in order to direct services, increase his or her level of independence, and advocate for himself or herself; and
- (5) Allow the participant to serve as co-employer along with an FMS provider for the providers serving the participant.

(b) PDMS shall allow the participant or the participant's legal representative to define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

He-E 801.24 Personal Care Services.

(a) PCS shall be documented in the provider care plan and covered when provided by employees of:

- (1) Home health care providers licensed in accordance with RSA 151:2 and He-P 809;
- (2) Home care service providers licensed in accordance with RSA 151:2 and He-P 822; or
- (3) Other qualified agencies certified in accordance with RSA 161-I and He-P 601.

(b) Covered personal care services shall include the following services:

- (1) Hands-on assistance with the ADLs or IADLs or cuing a participant to perform a task;
- (2) Assisting the participant with eating;
- (3) Under the direction of the participant, assistance with self-administration of oral or topical medication as prescribed, including:
  - a. Reminding the participant regarding the timing and dosage of the medication, and to take his or her medication as written on the medication container;
  - b. Placing the medication container within reach of the participant;
  - c. Assisting the participant with opening the medication container;
  - d. Assisting the participant by steadying shaking hands; and
  - e. Observing the participant take the medication and recording the same in the participant's record;
- (4) Accompanying the participant in the community when:
  - a. The assistance of the personal care worker is required by the participant ; and

b. The need for re-direction or direct assistance, or both, is required;

(5) When non-medical transportation services are authorized, hands-on assistance at the authorized destination when the provider care plan documents that this assistance is required at the destination;

(6) General household tasks, limited to the following:

- a. Laundering the participant's personal clothing items, towels, and bedding;
- b. Light cleaning limited to the participant's bedroom, bathroom, mobility and medical devices, and common living spaces;
- c. Light cleaning of the kitchen, entry way areas, and common living spaces, to maintain a safe environment for the participant;
- d. Errands for necessary tasks identified in the provider care plan;
- e. Preparing meals and snacks for CFI participants including cleaning the food preparation area after the food is served; and

(7) Care, grooming, or feeding of service animals as defined by the Americans with Disabilities Act (ADA), Title III Subpart A 36.106, or assistance animals as defined by the Fair Housing Act. ←

**Edit.** Use United States Code (U.S.C.) citations.

(c) Personal care services shall not be covered:

(1) For the purpose of transportation only, when no other assistance is required;

(2) When provided in any of the following settings:

- a. A residential care facility;
- b. A hospital;
- c. A nursing facility;
- d. A rehabilitation facility;
- e. An adult family care home; and
- f. An adult day care; and

(3) When provided by any of the following individuals:

- a. The participant's personal care services representative, designated in accordance with (d) and (e) below;
- b. The participant's agent acting under a designated power of attorney pursuant to RSA 564-E; or
- c. The participant's legal guardian.

(d) The participant, his or her legal guardian, or a person granted authority under a power of attorney of the participant may designate a PCS representative to act on the participant's behalf:

(1) To direct the PCS being provided; and

## (2) Under the following conditions:

a. The following persons shall not serve as a PCS representative for purposes of directing personal care services:

1. The personal care worker providing services;
2. The participant's case manager; and
3. Anyone having a financial relationship with any agency providing personal care services or intermediary services, as defined in RSA 161-I:2, VII, to the participant;

b. The PCS representative shall be designated through a written document, stating that:

1. The PCS representative's role applies only to decisions made regarding the personal care services described in this section;
2. The appointment of a PCS representative may be revoked by the participant at any time; and
3. The responsibilities of the PCS representative shall be to:
  - (i) At a minimum, have weekly face-to-face contact with the participant and the personal care worker;
  - (ii) At a minimum, have monthly contact with the participant's case manager concerning PCS;
  - (iii) Ensure that the personal care worker is taking the participant's care preferences into consideration; and
  - (iv) Communicate concerns or satisfaction to the provider agency that employs that personal care worker; and

c. The written document designating the PCS representative shall be signed by the participant or his or her legal guardian or by the person granted authority under a power of attorney and a witness and be maintained by the provider agency.

(e) When a PCS representative is designated, the participant, his or her guardian, or the person granted authority under a power of attorney shall:

- (1) Notify the provider agency in writing of the PCS representative's name and scope of authority; and
- (2) Notify the provider agency in writing of any changes in representation within 30 days of the date that the change occurs.

He-E 801.25 Personal Emergency Response Systems Services.

Edit. (ak)

(a) Personal emergency response systems (PERS), as defined in He-E 801.02(ai), services shall be a covered service for participants who:

- (1) Live alone, live only with someone in poor or failing health, or who are alone at home for 8 hours or more per day, and who are:
  - a. Ambulatory and at risk of falls as assessed by a physician, registered nurse, or occupational or physical therapist; or

b. Identified as at risk of having a medical emergency as identified in the comprehensive care plan; and

(2) Would require ongoing supervision if the PERS were not provided.

(b) PERS shall not be covered separately when provided to a participant receiving residential care services.

(c) For each participant receiving a PERS, the coverage shall include:

(1) Setting up the PERS in the participant's home;

(2) Demonstrating to the participant how to use the PERS;

(3) Providing 24/7 monitoring, including the capacity to summon emergency assistance on behalf of the individual as needed; and

(4) Repairing and replacing faulty units.

He-E 801.26 Residential Care Facility Services.

(a) The following residential care services shall be covered:

(1) Those services described in He-P 804 or He-P 805; and

(2) Transportation to medical services except when a course of prescribed treatment requires any of the following:

a. Emergency transportation;

b. Transportation more than once per week; or

c. Transportation to a treatment location that is a greater distance from the facility than the participant's primary care physician.

(b) Residential care facility services shall be covered when provided by facilities licensed in accordance with RSA 151:2 and either He-P 804 or He-P 805.

Edit. "3"

(c) Reimbursement for all residential care facility services shall be included in one of three per diem rates in accordance with (d) below, established by the department in accordance with RSA 161:4, VI(a), and individual services shall not be reimbursed separately when provided in a residential care facility setting.

(d) Residential care facilities licensed under He-P 804 shall be reimbursed at the base residential care facility rate, supported residential care facilities licensed under He-P 805 shall be reimbursed at different rates depending on the needs of the participant in accordance with (e) below.

(e) Supported residential care facilities shall be reimbursed at the base residential care facility rate unless the supported residential care facility has qualified staff assess the needs of the participant using BEAS 3755, "Resident Level of Care Sheet" (December 2021).

(f) Supported residential care facilities that complete BEAS 3755 shall be reimbursed a per diem rate based on the participant's needs as follows:

(1) The base residential care facility rate for participants with needs assessed 0-8 on BEAS 3755;

(2) Residential Care Dementia Level 1 for participants with needs assessed 9-17 on BEAS 3755; or

(3) Residential Care Dementia Level 2 for participants with needs assessed 18-39 on BEAS 3755.

He-E 801.27 Respite Care Services.

(a) Respite care services shall be a covered service when provided by or in one of the following settings:

(1) A medicaid-enrolled nursing facility, licensed in accordance with RSA 151:2 and He-P 813;

(2) A medicaid-enrolled residential care facility licensed in accordance with RSA 151:2 and He-P 804 or He-P 805; or

(3) In the participant's own residence, by:

a. Home health care providers licensed in accordance with RSA 151:2 and He-P 809;

b. Home care service providers licensed in accordance with RSA 151:2 and He-P 822; or

c. Other qualified agencies certified in accordance with RSA 161-I and He-P 601.

(b) Respite care services shall be:

(1) Provided to the participant on a short-term basis, as described in (2) below, because of the temporary absence or need for relief of those persons normally providing that participant's care; and

(2) Limited to 30 24-hour days of care per state fiscal year.

He-E 801.28 Skilled Nursing Services.

Edit. (an)

(a) Skilled nursing services, as defined in He-E 801.02(am), shall be provided by a registered nurse (RN) or by a licensed practical nurse (LPN) who is employed by a home health care provider licensed in accordance with RSA 151:2 and He-P 809.

(b) Skilled nursing services shall be covered for the provision of chronic long-term care and not short-term care.

(c) Skilled nursing services shall not be covered when provided:

(1) On the same day as the participant attends an adult day program if the identified need is within the scope of what would normally be provided by the program;

(2) For the purpose of nursing oversight of authorized LNA services;

(3) At a residential care facility; or

(4) When determined to be needed for the provision of acute needs under the New Hampshire medicaid state plan.

He-E 801.29 Specialized Medical Equipment Services.

(a) Specialized medical equipment shall be a covered service when:



- (1) A NH medicaid-enrolled licensed practitioner or physical or occupational therapist has determined the clinical need for one or more of the items in (b) below;
  - (2) The participant's case manager has requested prior authorization for the item in accordance with (c) below;
  - (3) The department has provided the prior authorization for the item; and
  - (4) The service is completed by a NH enrolled medicaid provider.
- (b) Covered specialized medical equipment services shall include the following durable medical equipment items:
- (1) Raised toilet seats;
  - (2) Shower/tub seats and benches;
  - (3) Tub lifts;
  - (4) Transfer benches;
  - (5) Bedside commodes;
  - (6) Dressing aids and grabbers;
  - (7) Non-slip grippers to pick up and reach items;
  - (8) Adaptive utensils;
  - (9) Transport wheelchairs;
  - (10) Wheelchair cushions;
  - (11) Walkers;
  - (12) Patient lifts;
  - (13) Slings;
  - (14) Semi-electric beds;
  - (15) Bed rails;
  - (16) Mattress overlay pads;
  - (17) Electronic communication devices;
  - (18) Seat lifts, including the chair, or seat lift mechanisms when the following criteria are met:
    - a. The participant has a severe condition that causes the participant to require assistance to come to a standing position;
    - b. The participant is completely incapable of standing up from a regular armchair or any chair in their home; and
    - c. The participant's attending physician, or a consulting physician treating the participant for the disease or condition resulting in the need for a seat lift, documents

that the seat lift mechanism is a part of the physician's course of treatment to provide support for a condition that is not likely to improve and that may worsen;

- (19) Medication dispensing devices, including training on their use, when the following conditions are met:
- a. The participant or caregiver is able to use the device;
  - b. The participant does not live in a licensed facility;
  - c. When the use of this service is documented to either:
    1. Replace another service of equal or greater cost; or
    2. Avoid the addition of another service; and
  - d. The type of device is determined by the department's skilled professional medical personnel to be the least costly device that is appropriate for the participant; and
- (20) Other durable medical equipment items that are:
- a. Specified in the comprehensive care plan which enable participants to increase their ability to perform activities of daily living;
  - b. Specified in the comprehensive care plan to help the participant perceive, control, or communicate with the environment in which they live;
  - c. Necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
  - d. Not available under the state plan that is necessary to address the participant's functional limitation; or
  - e. Necessary medical supplies not available under the state plan.
- (c) The participant's case manager shall submit the following when requesting prior authorization for specialized medical equipment:
- (1) A completed Form 3715, "Choices for Independence Prior Authorization Request Form" (July 2021);
  - (2) A written copy of the determination in (a)(1) above that describes:
    - a. The medical or functional need for the equipment;
    - b. Any specifications necessary to meet the participant's needs; and
    - c. The proposed training plan for the participant and caregiver to ensure safe use of the equipment;
  - (3) Proposals from at least 2 medicaid enrolled providers, except that one proposal may be submitted when the equipment costs less than \$1,000, already has a set or fixed rate, or with a written explanation of why only one proposal is available or appropriate, including the following, as applicable to the equipment:
    - a. A list of supplies and materials; and
    - b. A description of the equipment, including measurements when necessary; and

- (4) If a participant prefers one proposal over the other(s), then an explanation of the preference.
- (d) Specialized medical equipment services shall not be covered separately for participants receiving residential care facility services.
- (e) Payment for specialized medical equipment shall:
- (1) Be for the most cost-effective item, as identified by the department, that would effectively meet the participant's needs; and
  - (2) Not exceed the participant limit specified in the HCBs-CFI waiver approved by CMS.
- (f) If, within 90 days of delivery of the specialized medical equipment:
- (1) There is a discrepancy between the proposal and the delivered or installed equipment for a participant, the specialized equipment provider shall replace the equipment; and
  - (2) The replacement includes a restocking fee that the specialized medical equipment provider will incur as a result, the provider may submit a revised proposal for the replacement equipment at the same cost and add a restocking fee, and the case manager shall submit the revised proposal that includes the restocking fee for authorization to the department.

He-E 801.30 Supportive Housing Services.

Unclear as worded.

- (a) Supportive housing services shall be covered when provided by a federal housing authority licensed as a home health care provider in accordance with RSA 151:2 and He-P 809 or by a home health care provider licensed in accordance with RSA 151:2 and He-P 809 or other qualified agency certified in accordance with RSA 161-I and He-P 601 that is contracted with a federal housing authority to provide services.
- (b) Supportive housing services shall be provided in federally subsidized individual apartments.
- (c) The following supportive housing services shall be covered:
- (1) Personal care services, as described in He-E 801.25;
  - (2) Assistance with ADLs;
  - (3) Assistance with the IADLs including the following activities:
    - a. Making telephone calls; and
    - b. Obtaining and keeping appointments;
  - (4) Home health aide services as described in He-E 801.21;
  - (5) Homemaker services, as described in He-E 801.22;
  - (6) Personal emergency response systems services as described in He-E 801.26; and
  - (7) Medication reminders and other supportive activities as specified in the comprehensive care plan or which promote and support health and wellness, dignity, and autonomy within a community setting.
- (d) Supportive housing services shall be included in a per diem rate, established by the department in accordance with RSA 161:4, VI(a), and shall not be reimbursed as a separately covered service when provided in a supportive housing setting.

He-E 801.31 Supported Employment Services.

## (a) All supportive employment (SEP) services shall:

- (1) Be designed in accordance with the participant's specific needs, interests, competencies, and learning style, as described in the person-centered comprehensive care plan developed in accordance with He-E 805 and employment profile; and
- (2) Assist each participant to assume as much personal responsibility in job seeking and job retention as is possible for that participant.

## (b) SEP shall be provided by an employment professional.

## (c) Employment professionals shall:

## (1) Meet one of the following criteria:

a. Have completed, or complete within the first 6 months of becoming an employment professional, training that meets the national competencies for job development and job coaching, as established by the Association of People Supporting Employment First's (APSE) "Universal Employment Competencies" (January 2019), available as noted in Appendix A; or

**Edit.** no caps

**Edit.** "professional"?

b. Have obtained the designation as a Certified Employment Services Profession through the Employment Services Professional Certification Commission (ESPCC), an affiliate of APSE; and

## (2) Obtain 12 hours of continuing education annually in subject areas pertinent to employment professionals including, at a minimum:

- a. Employment;
- b. Customized employment;
- c. Task analysis/systematic instruction;
- d. Marketing and job development;
- e. Discovery;
- f. Person-centered employment planning;
- g. Work incentives for individuals and employers;
- h. Job accommodations;
- i. Assistive technology;
- j. Vocational evaluation;
- k. Personal career profile development;
- l. Situational assessments;
- m. Writing meaningful vocational objectives;
- n. Writing effective resumes and cover letters;

- o. Understanding workplace culture;
- p. Job carving;
- q. Understanding laws, rules, and regulations;
- r. Developing effective on the job training and supports;
- s. Developing a fading plan and natural supports;
- t. Self-employment; and
- u. School to work transition.

**Unclear.** Define these terms unless understood by the regulated community.

(d) Payment for SEP shall include:

- (1) All supported employment services identified in the provider care plan;
- (2) Job opportunity development;
- (3) Assistance, as needed, with employment including:
  - a. Job applications;
  - b. Resume-writing;
  - c. Obtaining references;
  - d. Development of a career portfolio;
  - e. Interview preparation; and
  - f. All other activities related to obtaining and maintaining employment except as described in (10) below;
- (4) Training for the participant to learn the responsibilities and expectations of employment, including:
  - a. Acquiring or developing acceptable work standards and workplace behavior;
  - b. Adjusting to the job site and work culture; and
  - c. Using accommodations, including any customized modifications made to perform the job;
- (5) Implementation of the fading plan;
- (6) Consultations or contacts with the businesses and the participant, as needed to assist the participant to remain successfully employed;
- (7) Outreach to employers for building relationships that lead to immediate or future job opportunities for the participant;
- (8) Training for direct support staff as it relates to the participant's employment goals;
- (9) Training for employers and co-workers to support the participant by understanding his or her:
  - a. Learning style;

- b. Environmental needs;
- c. Medical needs;
- d. Physical needs; and
- e. Safety needs;

(10) When combined with another employment service, transportation, and training in accessing transportation, as appropriate, to and from work;

(11) Referral, evaluation, and consultation for adaptive equipment, environmental modifications, communications technology, or other forms of assistive technology, and educational opportunities related to the participant's employment services and goals;

(12) Accessing work incentives information and work incentives planning services for the participant; and

(13) Any other employment service identified in the participant's provider care plan.

(e) All SEPs shall be designed to:

(1) Assist the participant to obtain employment or self-employment based on the participant's employment profile and goals in the provider care plan;

(2) Provide the participant with opportunities to participate in a comprehensive career development process that helps to identify, in a timely manner, the participant's employment profile;

(3) Support the participant to develop appropriate skills for job searching, including:

- a. Creating a resume and employment portfolio;
- b. Practicing job interviews; and
- c. Learning soft skills that are essential for succeeding in the workplace;

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

- a. Developing accommodations;
- b. Utilizing assistive technology; and
- c. Creating and implementing a fading plan;

(5) Help the participant to:

- a.. Meet his or her goal for the desired number of hours of work as articulated in the provider care plan; and
- b. Earn wages of at least minimum wage or prevailing wage, unless the participant is pursuing income based on self-employment;
- c. Assess, cultivate, and utilize natural supports within the workplace to assist the participant to achieve independence to the greatest extent possible;

- d. Help the participant to learn about, and develop appropriate social skills to actively participate in, the culture of his or her workplace;
- e. Understand, respect, and address the business needs of the participant's employer, in order to support the participant to meet appropriate workplace standards and goals;
- f. Maintain communication with, and provide consultations to, the employer to:
  - 1. Address employer specific questions or concerns to enable the participant to perform and retain his or her job; and
  - 2. Explore opportunities for further skill development and advancement for the participant;
- g. Help the participant to learn, improve, and maintain a variety of life skills related to employment, such as:
  - 1. Traveling safely in the community;
  - 2. Managing personal funds;
  - 3. Utilizing public transportation; and
  - 4. Other life skills identified in the person-centered comprehensive care plan related to employment;
- h. Promote the participant's health and safety;
- i. Protect the participant's right to freedom from abuse, neglect, and exploitation; and
- j. Provide opportunities for the participant to exercise personal choice and independence.

He-E 801.32 Provider Participation.

(a) All providers shall:

- (1) Be enrolled in NH medicaid as a CFI provider;
- (2) Meet the applicable licensing, certification, or other requirements of the specific service being provided; and
- (3) Comply with requirements contained in 42 CFR 441.301(c)(4).

(b) All providers shall:

- (1) Create and maintain an individual provider care plan for each participant served in accordance with He-E 801.33(a);
- (2) Create and maintain other documentation in accordance with He-E 801.33 and as required pursuant to applicable state and federal law;
- (3) Submit claims for payment in accordance with He-E 801.34;
- (4) Provide services in accordance with this part, 42 CFR 455, 42 CFR 456, 42 CFR 431, and 42 CFR 1001; and
- (5) Be subject to monitoring and review by the department upon request.



(c) All providers shall comply with the provisions of RSA 161-F:49 with regard to checking the names of prospective or current employees, volunteers or subcontractors against the state registry maintained by the department's bureau of elderly and adult services.

(d) All providers shall report to the appropriate departmental authority any participant who is suspected of being abused, neglected, exploited, or self-neglecting, in accordance with the adult protection law, RSA 161-F:46.

He-E 801.33 Required Documentation.

(a) All providers, with exceptions noted in (b) below, shall develop, maintain, and implement a written provider care plan and adhere to the following:

- (1) The provider shall communicate with the participant's case manager to ensure the care plan is consistent with and addresses the applicable service needs and the participant's preferences identified in the comprehensive care plan;
- (2) The provider care plan shall contain, at a minimum:
  - a. A description of the participant's needs and the scope of services to be provided;
  - b. The dates upon which services will begin and end;
  - c. The frequency of the services;
  - d. The total number of service units authorized and the amount that will be provided on each date of service;
  - e. Pertinent information on the participant's health condition, medications, allergies, and special dietary needs; and
  - f. The anticipated goals and outcomes of service provision;
- (3) The provider care plan shall be updated at least annually and as necessary to reflect change in the participant's need for services; and
- (4) The provider shall provide a copy of the provider care plan to the participant's case manager, upon the completion or revision of the plan, and shall make the provider care plan available to the department upon request.

(b) Providers of the following services shall not be required to develop a provider care plan:

- (1) EAS;
- (2) Home-delivered meals services;
- (3) Non-medical transportation services;
- (4) Personal emergency response system services;
- (5) Financial management services;
- (6) Specialized medical equipment services; and

(c) All providers shall:

- (1) Maintain documentation in accordance with applicable licensure, certification, and all other applicable federal and state laws and regulations or other requirements;

(2) Maintain any other supporting records in accordance with He-W 520; and

(3) Maintain documentation in their records to fully support each claim billed for services including the specific service provided, the number of service units provided, the name of the employee who provided the service, and the date and time of service provision, as applicable.

(d) Failure to maintain supporting records in accordance with He-W 520 and this part shall entitle the department to recoupment of state and federal medicaid payments pursuant to 42 CFR 455, 42 CFR 447, and 42 CFR 456.

(e) In addition to (c) above, documentation of PCS shall include verification of the PCS worker's time, including:

**Edit.** comma

(1) When paper timesheets are used, the signature of the participant or PCS representative indicating the reported hours are accurate, the service was provided in accordance with the provider care plan and the service was to the participant's satisfaction; or

(2) Certification that the service was provided in accordance with the electronic visit verification requirement of 42 USC 1396b(l) and the provider care plan and the service was to the participant's satisfaction.

(f) The documentation required by this section shall be made available to the department upon request.

(g) The documentation required by this section shall be maintained for a period of at least 6 years from the date of service or until the resolution of any legal action(s) commenced during the 6 year period, whichever is longer.

#### He-E 801.34 Payment for Services.

(a) Providers shall submit all initial claims to the medicaid fiscal agent, so that the fiscal agent receives the claims no later than one year from the earliest date of service on the claim.

(b) If a provider submitted a claim during the one-year billing period and the claim is subsequently rejected by the fiscal agent, the provider shall resubmit the claim within 15 months from the earliest date of service to receive reimbursement.

(c) If medicaid does not pay a provider for medicaid coverable services, supplies, or equipment due to the billing practices of the provider, the provider shall not bill the participant for the item(s), service(s) or supplies.

(d) Payment to providers of CFI waiver services shall be made in accordance with rates established by the department in accordance with RSA 161:4, VI(a) and RSA 126-A:18-a, as applicable.

He-E 801.35 Utilization Review and Control. The department shall monitor utilization of CFI waiver services to identify, prevent, and correct potential occurrences of fraud, waste, and abuse in accordance with 42 CFR 455, 42 CFR 456, He-W 520, 42 CFR 1001, and He-E 801.

#### He-E 801.36 Third Party Liability.

(a) All third party obligations shall be exhausted before medicaid is billed, in accordance with 42 CFR 433.139.

(b) All providers shall determine if third party liability exists and file a claim with the third party before billing medicaid.

(c) If third party liability exists, and the provider is not enrolled with the third party in a manner that allows the provider to submit a claim for service, the provider shall not bill medicaid or the CFI participant.

#### He-E 801.37 Waivers

(a) An applicant, case manager, provider agency, participant, or guardian, may request a waiver of specific procedures outlined in this part using the form titled BEAS 3865 “Choices for Independence Program Waiver Request Form.” (December 2021) The case management agency or provider agency shall submit the request in writing to (c) below.

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

- (1) The participant or the participant’s legal representative indicating agreement with the request; and
- (2) The case manager and provider agency executive director or designee recommending approval of the waiver.

(c) A waiver request shall be submitted electronically or mailed to:

Bureau of Elderly and Adult 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 within 30 calendar days if the alternative proposed by the requesting entity meets the objective or intent of the applicable section of this part, and it:

- (1) Does not negatively impact the health or safety of the participant(s);
- (2) Does not affect the quality of services provided to participants; and
- (3) All required criminal records checks have been completed no earlier than a year before the date of the waiver request; and

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

(g) Waivers shall be granted in writing and shall not expire except as in (h) and (i) below.

(h) Those waivers which relate to other issues relative to the health, safety, or welfare of participants that require periodic reassessment shall be effective for one year only.

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

(j) A requesting entity may request a renewal of a waiver from the department. Such request shall be made at least 90 calendar days prior to the expiration of a current waiver and shall be granted in accordance with paragraphs (a) through (f) above.

**APPENDIX A: Incorporation by Reference Information**

<b>Rule</b>	<b>Title</b>	<b>Publisher; How to Obtain; and Cost</b>
He-E 801.20(b)	United States Department of Agriculture’s “Dietary Guidelines for Americans 2020-2025” (Ninth Edition)	<p>Publisher: United States Department of Agriculture</p> <p>Cost: Free to the Public</p> <p>The incorporated document is available at:</p> <p><a href="https://www.dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf">https://www.dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf</a></p> <p>This publication can also be ordered by calling the U.S. Government Publishing Office (GPO) at (866) 512-1800 and asking for stock number 001-000-04866-0, or by accessing the GPO Online Bookstore at <a href="http://bookstore.gpo.gov">http://bookstore.gpo.gov</a>.</p>
He-E 801.31(c)(1)a.	Association of People Supporting Employment First’s “Universal Employment Competencies” (January 2019)	<p>Publisher: Association of People Supporting Employment First</p> <p>Cost: Free to the public</p> <p>The incorporated document is available at:</p> <p><a href="https://apse.org/wp-content/uploads/2019/03/Apse-universal-Comps-FINAL3-15-19.pdf">https://apse.org/wp-content/uploads/2019/03/Apse-universal-Comps-FINAL3-15-19.pdf</a></p>

**APPENDIX B**

<b>RULE</b>	<b>STATUTE OR FEDERAL REGULATION IMPLEMENTED</b>
He-E 801.01	RSA 151-E:1
He-E 801.02	RSA 151-E:1, 2
He-E 801.03	42 USC 1396n(c)(1) and (2); RSA 151-E:3, 4
He-E 801.04	RSA 151-E:3
He-E 801.05	RSA 151-E:4
He-E 801.06	RSA 151-E:1
He-E 801.07	RSA 151-E:8
He-E 801.08	42 USC 1396n(c)(1) and (2); RSA 151-E:3, 4
He-E 801.09	RSA 151-E:11, II-IV
He-E 801.10	RSA 151-E:11, IV
He-E 801.11	42 CFR 435.217; 42 CFR 435.735
He-E 801.12	42 USC 1396n(c)(4)(B); RSA 161-I
He-E 801.13	42 USC 1396n(c)(1)
He-E 801.14 - 801.32	42 USC 1396n(c)(4)(B); RSA 161-I
He-E 801.33	42 CFR 447.15; 42 CFR 431.107
He-E 801.34	42 CFR 431.107
He-E 801.35	42 CFR 447.50; 42 CFR 447.300; RSA 161:4, VI(a)
He-E 801.36	42 CFR 455; 42 CFR 456
He-E 801.37	RSA 167:14-a, III; 42 CFR 433 Subpart D
He-E 801.38	42 USC 1396n(c)

**Note to JLCAR on Legis. Intent:** The rulemaking public hearing for this proposal was to be held on 6/17/21 as an in-person public hearing with an MS Teams option. RSA 541-A:11 appears to presume in-person hearings. While the Governor's E.O. #12 amended RSA 91-A to allow for remote hearings, that did not apply to departments, and the E.O. expired on 6-11-21 in any case. The JLCAR may wish to ask the Department how the remote access option for the hearing proceeded and the public's access to it, since RSA 541-A:11, l(a) requires that an agency "shall afford all interested persons reasonable opportunity to testify...in accordance with the terms of the notice." In other words, if there are problems with the remote access option, then the principle in RSA 541-A cannot be met. A legislative fix may be needed in RSA 541-A:11, along with changes to all Chapter 200 rules, to clearly allow for remote rulemaking hearings. Please note that SB 95 in the current legislative session would have amended RSA 91-A to include the protocols for remote meetings of public bodies which are in the Governor's E.O. #12, but it did not pass.