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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #:18-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

July 12, 2018

Jeffrey Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers,

Enclosed is an approved copy of New Hampshire's (NH) State Plan Amendment (SPA) No 18-0002 entitled, *"Home and Community Based Care for High Risk Children with Severe Emotional Disturbance,"* which transmitted language to amend the NH Title XIX State Plan to include a 1915(i) section in order to provide home and community-based services to children with serious behavioral health issues through a coordinated model.

Transmittal # 18-0002	-- 1915(i) State Plan Home and Community Based Care for High Risk Children with Severe Emotional Disturbance --Effective July 1, 2018

Since the state has elected to target the population who can receive these Section 1915(i) state plan services, CMS approves this SPA for a five-year period in accordance with Section 1915(i)(7) of the Social Security Act (the Act) and 42 CFR 441.745(a)(2)(vi)(A). NH will be able to renew this SPA for an additional five-year period if CMS determines, prior to the beginning of the renewal period, that the state met Federal requirements and that the state's monitoring is in accordance with the quality improvement strategy specified in NH's approved SPA. To renew state plan HCBS for an additional 5-year period, the state must submit a SPA for renewal to CMS at least 180 days prior to the end of the approval period.

It is important to note that CMS' approval of this waiver solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm. If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Henry Lipman, State Medicaid Director
Diane Peterson, Medicaid Business and Policy

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 18-0002

2. STATE: NH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

1915(i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
Remainder of FFY 2018: $652,561.87
FFY 2019: $2,610,247.50

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-i, pages 1-49 1-51
Attachment 4.19-B, ~~3~~ pages 1-3
Attachment 2.2-A, 2 pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New Pages
New Pages
New Pages

10. SUBJECT OF AMENDMENT:
Home and Community Based Care for High Risk Children with Severe Emotional Disturbance

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: comments, if any, will follow

12. SIGN: /s/

13. TYPED NAME: Jeffrey A. Meyers

14. TITLE: Commissioner

15. DATE SUBMITTED: 4/18/2018

16. RETURN TO:

Dawn Landry
Office of Medicaid Business and Policy/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 18, 2018

18. DATE APPROVED: July 12, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations, Boston, MA

23. REMARKS: 06/26/2018: NH requested a pen & ink change to Box 8 of the 179 to reflect page numbering changes that occurred due to edits made during the SPA approval process; also, to actually number pages 1-3 and 1-2 of Attachment 4.19-B and 2.2A as the state was not able to insert the page numbers in the template

FORM HCFA-179 (07-92)

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Wrap around facilitation/care coordination
Family Peer Support
Youth Peer Support
In Home Respite care
Out of home respite care
Customizable Goods and Services

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

●	**Not applicable**
○	**Applicable**
	Check the applicable authority or authorities:
☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

	☐	§1915(b)(2) (central broker)		§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
☐	**A program authorized under §1115 of the Act.** *Specify the program*:			

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	●	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	NH Department of Health and Human Services (DHHS): Division for Behavioral Health, Bureau for Children's Behavioral Health.
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

● *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☐	☐
3 Review of participant service plans	☑	☐	☐	☐
4 Prior authorization of State plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☐	☐	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The Care Management Entity (CME) shall not conduct eligibility or re eligibility determinations for the 1915(i) HCBS. The Wraparound Care Coordinator, employed by the CME, shall not provide any other service to the participant and his/her family other than the wraparound care coordination.

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/18	6/30/19	100
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.

☑ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

● Directly by the Medicaid agency

○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The independent evaluation and reevaluation will be completed by the DHHS. The individual(s) performing this function shall have the following minimum qualifications;

a. A bachelor's degree in the healing arts or related field.
b. At least 2 years experience in the mental health or social services field.
c. Demonstrates an understanding of the behavioral health system and its components.
d. Demonstrates an understanding of behavioral health diagnosis and how lives can be impacted by behavioral health issues.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

NH DHHS will evaluate eligibility and re-eligibility and perform the independent evaluation of needs-based criteria.

Evaluation of eligibility/re-eligibility will include;

Review and evaluate all information based upon New Hampshire's definition of medically necessary treatment which requires services or benefits to be:
(1) directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
(2) consistent with currently accepted standards of good medical practice;
(3) the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
(4) Not primarily for the convenience of the consumer, family, or provider.

The evaluator will be familiar with the medical necessity criteria and will use those criteria and the individual's clinical history to determine eligibility. The evaluator will review the results of the Child and Adolescent Needs and Strengths (CANS) assessment tool or comprehensive psychosocial assessment conducted by the treating practioner, at the time of initial evaluation and by the treating practioner or CME every 12 months thereafter to evaluate continued eligibility.

Specific eligibility criteria are outlined in #5 below.
Once the evaluator has determined eligibility, the CME will work with the child and family and the family's wrap around team, to develop an individualized Plan of Care (POC) that is consistent with the principles of Wraparound (i.e. strengths-based, individualized, community-based, culturally and linguistically competent), as defined by the National Wraparound Initiative.

The CME will submit for review the most recent POC along with other documentation at least

annually as part of the review for re- eligibility for services. The medical/behavioral health re-evaluation, including a review of the most recent CANS assessment, will be completed by the DHHS based upon up to date information described above as well as a review of HCBS benefits service utilization over the past 6 months.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The criteria below is used to determine that the child has support needs that exceed that of the current services he/she may be receiving and requires programing to assist with;
Reducing symptomology or increase symptom management, increasing resiliency, stabilize behaviors that are placing the child/youth at risk for placement outside of home, repeated hospitalizations, and juvenile justice involvement, school and education disruptions. Assist the child/youth with his/her activities of daily living that are age appropriate and that are identified as problematic due to symptomology associated with his /her behavioral health condition.

- Have a serious psychosocial impairment as determined through the assessment using the Child Adolescent Needs and Strengths Assessment (CANS) to determine the youth's functioning in the following domains: life functioning, risk behaviors, transition or caregiver strengths and needs.
- The assessment of functional impairment demonstrating; (see explanations of ratings below)
  - At least 1 of the following:
    - 3 ratings of '1' or more in any A item (A items includes Self-injurious behaviors, school attendance, medical/physical, intellectual, other self-harm, danger to self, danger to others, sexual aggression, exploited, crime/delinquent, fire setting, animal cruelty, intentional misbehavior, bullying, elopement/runaway, aggression, psychosis, attention/impulse, depression, conduct behavior, adjustment to trauma, substance use, anxiety, oppositional behavior, anger control, eating disorder, attachment, living situation, peer relations, regulatory: body control/emotional control.); **or**
    - 1 rating of '2' or more in any A item described above; or

Explanation of ratings:

1-Watchful Waiting/Prevention

This level of rating indicates that you need to keep an eye on this area or think about putting in place some preventive actions to make sure things do not get worse (e.g. a child/youth who has been suicidal in the past). We know that the best predictor of future behavior is past behavior, and that such behavior may recur under stress, so we would want to keep an eye on it from a preventive point of view.

2-Action Needed

This level of rating implies that something must be done to address the identified need. The need is sufficiently problematic, that it is interfering in the child/youth's or family's life in a notable way.

3-Immediate/Intensive Action Needed

This level rating indicates a need that requires immediate or intensive effort to address. Dangerous or disabling levels of needs are rated with this level. A child/youth who is not attending school at all or an acutely suicidal child/youth would be rated with a "3" on the relevant need.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are

more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
The criteria below is used to determine that the child has support needs that exceed that of the current services he/she may be receiving and requires programing to assist with; Reducing symptomology or increase symptom management, increasing resiliency, stabilize behaviors that are placing the child/youth at risk for placement outside of home, repeated hospitalizations, and juvenile justice involvement, school and education disruptions. Assist the child/youth with his/her activities of daily living that are age appropriate and that are identified as problematic due to symptomology associated with his /her behavioral health condition. • Have a serious psychosocial impairment as determined through the assessment using the Child Adolescent Needs and Strengths Assessment (CANS) to determine the youth's functioning in the following domains: life functioning, risk behaviors, transition or caregiver strengths and needs. • The assessment of	NH has two facilities that will take skilled nursing level care children under the age of 18. Both facilities require a skilled nursing need as determined by the DHHS. These two facilities typically take skilled level care on a short term basis only. Admission criteria for these facilities are; • Medical scoring, A medical evaluation usually expressed numerically, based on specific achievements or the degree to which certain qualities are manifest. Examples: Apache Score assess the severity of illness; Apgar Score is a numerical expression of an infant's condition at birth; Bishop Score estimates the prospects of induction of labor; Stroke Score are any of various scoring systems that seek to characterize a patient's clinical state following a stroke and Trauma Score rating system used in the evaluation of patients with traumatic injury. • Medication administration	There are two facilities that accept and care for children with complex medical needs. These facilities are sub-acute, ICF level of care for infants to age 21 with a primary concern of complex medical with co-occurring developmental needs/behavioral needs. These facilities do not accept children and youth with a Severe Emotional Disturbance as his/her primary concern. Admission criteria for these facilities are; • Medical scoring: A medical evaluation usually expressed numerically, based on specific achievements or the degree to which certain qualities are manifest. Examples: Apache Score assess the severity of illness; Apgar Score is a numerical expression of an infant's condition at birth; Bishop Score estimates the prospects of induction of labor; Stroke Score are any of various scoring systems that seek to characterize a patient's clinical state following a stroke and Trauma Score rating system used in the evaluation of	NH Acute Psychiatric Hospital admission criteria: New Hampshire Hospital (NHH) provides inpatient psychiatric treatment to patients admitted on an involuntary basis through an emergency admissions process, a non-emergency court order or on a limited voluntary basis, depending on the availability of facilities. Most admissions to NHH are through the Involuntary Emergency Admission (IEA) process pursuant to NH state law, RSA 135-C: 27-33. The IEA process begins with a visit to a local hospital emergency department or Community Mental Health Center (CMHC), and the completion of an IEA petition requesting admission to New Hampshire Hospital. The person being admitted must pose a likelihood of danger to self or others as a result of a mental health condition, which requires an immediate intervention. This level of need would be rated as a '3' using the Child Adolescent Needs and Strengths(CANS) tool. A doctor at the Emergency Department or

functional impairment demonstrating: (see explanations of ratings below) at least 1 of the following: • 3 ratings of '1' or more in any A item (includes Self-injurious behaviors, school attendance, medical/physical, intellectual, other self-harm, danger to self, danger to others, sexual aggression, exploited, crime/delinquent, fire setting, animal cruelty, intentional misbehavior, bullying, elopement/runaway, aggression, psychosis, attention/impulse, depression, conduct behavior, adjustment to trauma, substance use, anxiety, oppositional behavior, anger control, eating disorder, attachment, living situation, peer relations, regulatory: body control/emotional control.) ;or • 1 rating of '2' or more in any A item described above; or • Explanation of ratings: 1-Watchful Waiting/Prevention This level of rating indicates that you need to keep an eye on this area or think about putting in place some preventive actions to make sure	• Assistance with 2 or more ADL's. • A need for medical monitoring Intellectual disability or behavioral concerns.	patients with traumatic injury. • Medication administration • Assistance with 2 or more ADL's. • A need for medical monitoring • Intellectual disability or behavioral concerns.	CMHC will perform a medical evaluation and a psychiatrist or a mental health clinician will perform a psychiatric/mental health evaluation. The results of the evaluations must be included in the petition for an IEA.

things do not get worse (e.g. a child/youth who has been suicidal in the past). We know that the best predictor of future behavior is past behavior, and that such behavior may recur under stress, so we would want to keep an eye on it from a preventive point of view. 2-Action Needed This level of rating implies that something must be done to address the identified need. The need is sufficiently problematic, that it is interfering in the child/youth's or family's life in a notable way. 3-Immediate/Intensive Action Needed This level rating indicates a need that requires immediate or intensive effort to address. Dangerous or disabling levels of needs are rated with this level. A child/youth who is not attending school at all or an acutely suicidal child/youth would be rated with a "3" on the relevant need.			

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will

operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

This HCBS benefit is targeted to children, youth and young adults with serious emotional disturbances (SED)

- Age: 5- up to 21 years of age. Have a qualifying Axis 1 disorder with the exception of substance use disorders; and who have a Serious Emotional Disturbance.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	⊙	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution.

All participants receiving HCBS will be residing in his/her own home in his/her community or that of a parent, guardian or designated caregiver, in a family setting and not in a residential treatment setting or any other institutional setting.

Assurances set forth by the state that the HCBS are delivered in appropriate settings are;

1. Attestation as part of the HCBS state plan application/eligibility determination that the participant is living or will be living in an approved setting prior to the provision of HCB Services.
2. Quality Assurance activities conducted by the NH DHHS shall include a review of the Care Management Entity documentation that indicates the setting is in compliance for each participant.
3. Quality Assurance activities conducted by the NH DHHS shall include a site visit for a random sampling of participants each year.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Wraparound Care Coordinators will be responsible for conducting a face-to-face assessment of an individual's support needs and capabilities. Wraparound Care Coordinators are employed by the Care Management Entity (CMEs) and have met all the requirements of being a wraparound care coordinator.

Wraparound Care Coordinators employed by the CME must demonstrate the following:

Education:

i. Bachelor's degree from a recognized college or university with major study in social work, sociology, psychology, counseling, nursing or a related field; or

ii. A high school diploma or equivalency; and

a. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who received services from the public and child- and family-serving system; and

b. Meets the training and certification requirements for wraparound care coordinator

Experience:

i. Two years of professional, paraprofessional, or parental advocacy/education experience providing direct service to families, children or youth in social work, psychology, human services, counseling, mental health or equivalent.

License/Certification:

i. Valid State driver's license and/or access to transportation with liability coverage as required by state laws for travel throughout the State of NH.

Upon hire, Wraparound Care Coordinators must complete the required trainings within one year of hire date, including, but not limited to:

i. Orientation

ii. High Fidelity Wraparound Training

iii. Mental Health (Adult and/or Youth) First Aid

iv. Better Together with Birth Parents Training

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Wraparound Care Coordinators will be responsible for helping and guiding the wraparound team in developing the person centered plan (individual/family driven) Plan of Care (POC). The System of Care approach being utilized requires an individual and family driven plan which exceeds the definition and requirements of a person centered plan. Wraparound Care Coordinators are employed by the Care Management Entity (CMEs) and have met all the requirements of being a wraparound care coordinator;

Wraparound Care Coordinators employed by the CME must demonstrate the following:
Education:

i. Bachelor's degree from a recognized college or university with major study in social work, sociology, psychology, counseling, nursing or a related field; or
ii. A high school diploma or equivalency; and
   a. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who received services from the public and child- and family-serving system; and
   b. Meets the training and certification requirements for care coordinator

Experience:

i. Two years of professional, paraprofessional, or parental advocacy/education experience providing direct service to families, children or youth in social work, psychology, human services, counseling, mental health or equivalent.

License/Certification:

i. Valid State driver's license and/or access to transportation with liability coverage as required by state laws for travel throughout the State of NH.

Upon hire, Wraparound Care Coordinator must complete the required trainings within one year of hire date, including, but not limited to:

i. Orientation
ii. High Fidelity Wraparound Training
iii. Mental Health (Adult and/or Youth) First Aid
iv. Better Together with Birth Parent Training (family engagement)

As part of the Care Management Entity (CME) functions, a licensed mental health professional, will supervise the development and ongoing implementation of the POC and review and approve the POC and changes to the POC.

A core element of the wraparound practice model is the team approach. This team includes the Wraparound Care Coordinator, child or youth, caregiver(s), support persons identified by the family (paid and unpaid), and service providers identified by the family. The team should meet no less than every 45 days and reevaluate the Plan of Care (POC) at every meeting.

There are a variety of assessments used to develop the POC, including information collected during the application process, and all life domains are incorporated into the POC. The Child and Adolescent Needs and Strengths (CANS) is administered every 90 days by the Wraparound Care Coordinator or child/youth's clinician to support identification of strengths and needs for care planning. Information from the family and their identified supports is incorporated as a part of the process. The wraparound process and Plan of Care development meets all requirements of 42 CFR §441.725(a) and 42 CFR §441.725(b)

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the*

supports and information made available, and (b) the participant's authority to determine who is included in the process):

One of the key philosophies in the Wraparound process is family-determined or family driven care. This practice, in many ways, exceeds the requirements of a person centered planning process. This means that parent(s) or legal guardian, youth and family members are the primary decision makers in the care of their family and the treatment and services the participant receives.

The Wraparound Care Coordinator is responsible for working with the participant, family, and team to develop the Plan of Care, in a manner that adheres to the family and youth driven tenants of System of Care and Wraparound, through the process outlined below;
Within the first 7 days of notification of enrollment, the Wraparound Care Coordinator contacts the participant and family to schedule a face-to-face meeting. The Wraparound Care Coordinator is responsible for ensuring fidelity to the system of core values of family driven, youth guided , community based and culturally and linguistically competent. The family and participant identify their wraparound team members. The process for wraparound, the family/participant roles, wraparound team and wraparound care coordinator's roles and responsibility within the process are;

At the first meeting between the Wraparound Care Coordinator, participant, and family after enrollment, the Wraparound Care Coordinator will:

- Administer the appropriate CANS assessments, when necessary.
- Work with the participant and family to develop an initial crisis plan that includes response
- to immediate service needs;
- Provide an overview of the wraparound process; and
- Review Front-End Stabilization services with family and assess whether the family and participant requires that level of need.

The Wraparound Care Coordinator will facilitate the family sharing their story by using the "Timeline" tool template. The Wraparound Care Coordinator will, with the participant and family:

- identify needs that they will work on in the planning process;
- work with the family and participant to determine who will attend team meetings;
- contact potential team members,
- provide the team members with an overview of the wraparound process, and
- discuss expectations for the first team meeting;
- conduct an initial assessment of strengths of the participant, their family members and potential team members; and,
- Determine the vision statement with the family.

The team, which includes the participant and his or her family and informal and formal supports will determine the family vision which will guide the planning process and includes the following steps;

- identify strengths of the entire team;
- determine the needs that the team will be working on;
- determine outcome statements for meeting identified needs;
- determine the specific services and supports and provider required in order to achieve the goals identified in the Plan Of Care, which includes a crisis plan;
- create a mission statement that the team generates and commits to following;
- identify the responsible person(s) for each of the strategies in the Plan Of Care and,

- Meet at least every 45 days to coordinate the implementation of the POC and update the POC as necessary.

Before the provision of services in the POC, the CME shall review and authorize the services designated in the POC to ensure the services identified will clearly meet the prioritized need of the participant. The CME in collaboration with the team shall reevaluate the POC at least every 45 days with re-administration of NH DHHS-approved assessments as appropriate. During the development of the plan of care, family members and other supports identified by the family participate as a part of the team. These participants may change as the child's or youth's needs change particularly as he/she is transitioning out of the formal Wraparound services.

The participant/family will sign a document that is part of the POC next to the statement that reads, "My family had voice and choice in the selection of services, providers and interventions, when possible, in the Wraparound process of building my family's Plan of Care."
The DHHS will monitor the fidelity to the System of Care and Wraparound values and principles through fidelity tools described in the Quality Grid. These will include but not be limited to issues of family driven and youth guided process and practice (family and participant voice and choice)

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

NH DHHS, along with the Care Management Entity (CME) will have and maintain a database and/or directory available to the CME and the family from which to choose providers to implement the plan of care that also indicates which Managed Care Organization that the family is working with. Providers are selected by the family with the support of the team and the CME. Participants are active members who will, depending on age and/or cognitive development, assist in the selection of providers based on the POC and the expertise of the team members. NH DHHS will conduct an ongoing adequacy review of the provider network. NH DHHS along with the CME will connect with regional and community based groups that identify gaps in services and resources for each area of the state. One such network of groups is the Regional Public Health Network.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

1. Approval of initial POC's and then current POC at reevaluation of eligibility every 12 months.

2. The Quality Assurance activities identified in the Quality Improvement Strategy grid shall ensure that all activities and functions of the Care Management Entity shall be monitored and measured with reliable wraparound tools as well as defined activities for the monitoring of practice, fidelity and outcomes, by the DHHS. These activities shall include but not be limited to the review of the Plans of Care and the services and supports outlined in the Plan of Care by site visits to the CME for a random sampling of participants each year. The site visit and review will include reviewing each chosen participant's case and reviewing all documentation and records associated with that participant, including the POC.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
✓	Other (*specify):*	Care Management Entity			

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Wraparound Care Coordination
Service Definition (Scope)*:*	

A wraparound care coordinator must be in place for every child/youth/family that is found eligible and is receiving services under the State Plan HCBC.

The wraparound care coordinator assists the child and family to access mental health, social services, educational information, and other services and supports that may be available in their community, and support the child/youth/family needs in meeting the needs and objectives of the Plan of Care. wraparound coordination services include;

- Assessment/evaluation of service needs
- Identifying team members involved with the child/youth
- Support family and youth to identify team members
- Planning meetings
- Facilitate High Fidelity Wraparound meetings in accordance with the NH Wraparound model and curriculum.
- Support the child/youth and his/her family in meeting the needs and objectives in the Plan of Care.
- Developing a Plan of Care based on strengths and needs and that have a solution based focus, with the team
- Obtain and arranging for formal services from agencies in the provider network or within the family's insurance network, and informal services in the community;
- Monitoring the Plan of Care and revising as needed;
- Ensuring that services from providers are being provided as called for in the Plan of Care by agencies that have agreed to participate in the Plan of Care;
- Providing educational materials to families;
- Collecting and reviewing wraparound team meeting participation stipend invoices;
- Advocating for the child/youth and family's needs; and
- Coordinating emergency intervention and assisting the family in the implementation of their crisis plan.

Wraparound care coordination services are provided through face to face and telephone contact with the wrap around child/youth and family as well as significant family supports, and providers involved with the Plan of Care and can be conducted anywhere in the community. In addition to the care coordination, the Wraparound care coordinator is responsible for guiding the family and the

family wraparound team through the wraparound process and its phases. This includes working directly with the family using and completing all applicable tools, identifying and coordinating family wraparound team members, educating those team members on their roles and the wraparound process and facilitating the family's wraparound team meetings.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Wraparound care coordinator		The NH Wraparound Coordinator certification process is designed to maintain the integrity, competency, and rigor for which the practice was intended. Individuals must obtain certification within 12-18 months of beginning to work with families and may not begin to work with families until they have trained in Modules 1-3. The certification is good for 24 months, and the recertification process can begin after 18 months of the initial certification. All certifications expire at 24 months after the certification date. NH Wraparound Coordinator Initial Certification Requirements: Is hired to be a NH Wraparound Coordinator by a DHHS-approved entity. Completed the 3 days of NH Wraparound Coordinator	Meets qualifications for a Care Coordinator. Care Coordinators employed by the CME must demonstrate the following: **Education:** ii. Bachelor's degree from a recognized college or university with major study in social work, sociology, psychology, counseling, nursing or a related field; or ii. A high school diploma or equivalency; and a. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who received services from the public and child- and family-serving system; and b. Meets the training and certification requirements for care coordinator **Experience:** ii. Two years of professional,

		training. Completed a Cultural and Linguistic Competency training. Completed worker safety and mandated reporting module. Completed a minimum of 5 hours shadowing family team meetings; 3 hours initial team meetings; 7 hour in between meetings A minimum of 15 hours of co-facilitating with a Certified NH Wraparound Coordinator. Receives weekly 1:1 coaching (in person or via distance) from an individual who has been certified as a NH Wraparound Coach (revisit). Observation by a NH Wraparound coach of one or more Wraparound Team meetings and received a score of 80% or higher on the NH Wraparound Coordinator Observation Tool and Plan of Care Coaching Tool. Complete the Application with the portfolio for NH Wraparound Coordinator Certification. NH Wraparound Coordinator Certification Renewal Requirements: Completed initial certification requirements within the previous 24 months. Documentation that the individual has provided NH Wraparound continuously with 3 or more families within the past 12 months. Obtained CANS certification. Completed Better Together with Birth Parents training. Complete DHHS orientation training and mental health first aid. Documentation of 6 hours of continuing education directly related to Wraparound, such as	paraprofessional, or parental advocacy/education experience providing direct service to families, children or youth in social work, psychology, human services, counseling, mental health or equivalent. **License/Certification:** ii. Valid State driver's license and/or access to transportation with liability coverage as required by state laws for travel throughout the State of NH. Upon hire, Wraparound Care Coordinators must complete the required trainings, including, but not limited to: v. Orientation vi. High Fidelity Wraparound Training vii. Mental Health (Adult and/or Youth) First Aid Better Together with Birth Parent Training, Family engagement

		(1) Methods, Models, and Tools, (2) trauma training, (3) suicide prevention, (4) RENEW Facilitator Training, (5) Motivational Interviewing, 6) Youth MH First Aid, or related training. Receives weekly 1:1 coaching (in person or via distance) from an individual who has been certified as a NH Wraparound Coach. Observation by a Wraparound coach of one or more Wraparound Team meetings and received a score of 80% or higher on the NH Wraparound Coordinator Observation Tool and Plan of Care Coaching Tool. Complete this Application with the portfolio for Wraparound Re-certification.	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Wraparound Care coordinator	**CME and NH DHHS**	At time of hire and through random sample during annual quality assurance reviews.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✓	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	In Home Respite care
Service Definition (Scope)*:*	
Respite Services are temporary care which is arranged on a planned basis.	

Respite provides stabilization and relieves a caregiver from the stress of care-giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help prevent a potential crisis situation, and to help reduce caregiver strain.

In home respite is available for caregivers to receive short periods of relief. In home respite can be provided in the participant's home, but can also encompass taking the child out into the community to work on symptom management and community integration. Respite is provided by (a) "natural supports" which are individuals identified by the family such as friends or relatives who can and are willing to provide support to the child/youth while the parent is absent, or (b) by agencies certified by DHHS to provide Behavioral Health support in the home setting. The agencies are neither home health agencies nor personal care agencies. The respite care being provided is not personal care, i.e., it is not assistance with ADL's or IADL's. Rather, it is behavior management and reducing the symptoms of the child's mental illness. In home respite is provided by a certified agency that can provide staff with experience and training to assist in a rehabilitative manner or by a natural support identified by the family or the wraparound team that can assist in this manner.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

✓	Categorically needy *(specify limits):*
	In home respite services are available to all enrolled participants. In home respite should be provided at a minimum of 1 hour to bill. In home respite is limited to a total of 360 hours per participant per year. The limit may be exceeded only by determination of need in accordance with the person centered service plan. Individuals who may require services beyond the stated limit may work with their care coordinator and family wraparound team to request additional service authorization by the CME. The CME will review the request for medical necessity and demonstrated need to extend the service beyond the limit, based on criteria developed by the Department; however, the limit shall not exceed 30 consecutive days in any year.
✓	Medically needy *(specify limits):*
	In home respite services are available to all enrolled participants. In home respite is billed at a minimum of 1 hour to bill. In home respite is limited to a total of 360 hours per participant per year. The limit may be exceeded only by determination of need in accordance with the person centered service plan. Individuals who may require services beyond the stated limit may work with their care coordinator and family wraparound team to request additional service authorization by the CME. The CME will review the request for medical necessity and demonstrated need to extend the service beyond the limit, based on criteria developed by the Department however the limit shall not exceed 30 consecutive days in any year.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

In Home respite-Natural Support	n/a	n/a	Family identified. Requires a criminal record check and any applicable registry checks.
In Home respite-Agency based		Certified by DHHS; Division for Children, Youth and Families	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
In Home respite-Natural Support	Family and CME via Care Coordinator	At time of support identification
In Home respite-Agency based	CME will verify/ensure that certified providers are used.	At the time of support/provider identification, DHHS will verify during site reviews.

Service Delivery Method. *(Check each that applies)*:

☐ Participant-directed	✓	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Out of Home Respite	

Service Definition (Scope)*:*

Respite Services are temporary care which is arranged on a planned basis.
Respite provides stabilization and relieves a caregiver from the stress of care-giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help prevent a potential crisis situation and to reduce caregiver strain.
Out-of-home respite is temporary, only for the duration of the respite and that are appropriately licensed, and certified, based on the age and clinical/behavioral needs of the participant.

The out of home respite options are:

- General level foster care: Foster homes that are licenses to provide foster care services to children. Level 1 for ages 6-11 and Level 2 for ages 12-21, per rate schedule.
- Therapeutic Level foster care; Foster homes that are considered therapeutic in nature by the level of experience and training outlined in the certification rules.
- Group home level: Group homes that have a milieu treatment and are rehabilitative in nature and provide structure and behavior management to children and youth.

The services provided under Out-of-Home Respite Care may not be duplicative of other Public Mental Health System or HCBS benefit services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

✓	Categorically needy *(specify limits):*

	Out-of-Home respite services only are available to children receiving the HCBS benefit. Out-of-home respite services do not include on-going child care or before or after school programs. The levels of out of home respite are intended to meet the unique behavioral and clinical needs of each participant. The level of respite utilized for each participant will be based on that participant's clinical and behavioral needs. Out of home respite must be provided for a minimum of twelve hours overnight in order to bill. Participants may receive a maximum of 24 days of out-of-home respite services annually. This limit is based on the framework of up to one weekend of respite care in a given month, or a similar reasonable configuration. The limit may be exceeded only by determination of need in accordance with the person centered service plan. Individuals who may require services beyond the stated limit may work with their care coordinator and family wraparound team to request additional service authorization by the CME. The CME will review the request for demonstrated need to extend the service beyond the limit, based on criteria developed by the Department. However, the limit may not exceed 30 days annually.
✓	Medically needy *(specify limits):*
	Out-of-Home respite services only are available to children receiving the HCBS benefit. Out-of-home respite services do not include on-going child care or before or after school programs. The levels of out of home respite are intended to meet the unique behavioral and clinical needs of each participant. The level of respite utilized for each participant will be based on that participant's clinical and behavioral needs. Out of home respite must be provided for a minimum of twelve hours overnight in order to bill. Participants may receive a maximum of 24 days of out-of-home respite services annually. This limit is based on the framework of up to one weekend of respite care in a given month, or a similar reasonable configuration. The limit may be exceeded only by determination of need in accordance with the person centered service plan. Individuals who may require services beyond the stated limit may work with their care coordinator and family wraparound team to request additional service authorization by the CME. The CME will review the request for demonstrated need to extend the service beyond the limit, based on criteria developed by the Department. However, the limit may not exceed 30 days annually.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Out of home respite: General/ level foster care respite	Licensed family foster home by NH DHHS.		Identified as a respite provider by NH DHHS.

Out of home respite: treatment level foster care respite	Licensed as a foster family home by NH DHHS.		Certified as a therapeutic foster care agency by NH DHHS.
Residential group home respite	Licensed as a group home under NH DHHS child care licensing standards	Certified as a DHHS approved residential group home.	Identified as a respite provider by NH DHHS residential certification specialist.

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
General/ treatment level foster care respite	CME will verify licensure of all homes identified as System of Care respite homes with NH DHHS.	At time of enrollment and annual thereafter.
Residential group home respite	CME will verify licensure of all homes identified as System of Care respite homes with NH DHHS.	At time of enrollment and annual thereafter.

Service Delivery Method. *(Check each that applies)*:

☐ Participant-directed	✓	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Customizable Goods and Services

Service Definition (Scope)*:*

Criteria:

1. Customizable Goods and Services are those used in support of the participant's Plan of Care (POC).
2. Services must assist the participant with inclusion, social skills, appropriate community behaviors, wellness and fitness goals related to weight or issues with self-esteem when the activity is tied to a youth's need during the Wraparound Team Meeting and is documented in the POC, e.g., a child youth's need for socialization and reentry of normalized activities, barriers to the participant's ability to participate in the HCBS and/or other related treatment services for the participant
3. Cost must be reasonable, which means that the cost , in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.
4. Cost must be necessary which means the cost has been generally determined to be one that is likely to improve outcomes or remediate a particular and specific need identified in the POC.
5. The item or service must aim to decrease the need for other Medicaid services, promote inclusion in the community, or increase the participant's safety in the home environment.
6. A participant may access the service only if the individual does not have the funds to purchase the item or service, or the item or service is not available through another source.
7. Experimental or prohibited treatments are excluded. Activities that are only recreational in nature are excluded.

Covered Services (only if the above criteria are met):

1. The state will pay only for the costs of programs in which the child/youth actively participates in accordance with the above criteria. Programs include: (a) the child/youth being on a baseball, soccer, football, basketball, gymnastics or swim team; (b) the child/youth being on a dance team or taking dance classes; (c) the child/youth taking art, theater, or martial arts classes; (d) the child/youth actively participating in any other appropriate town or private sports, recreational or community activities.
2. The state will pay for a child/youth to join a fitness club if the above criteria are met.
3. The state will pay for adaptive equipment needed in order to participate in the above.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

Categorically needy *(specify limits):*

Customizable Goods and Services should be used as the funding source of last resort - only for those costs that cannot be covered by any other source and that are vital to the implementation of the POC.

Funding shall not exceed $1,000 annually per participant. Individuals who may require services beyond the stated limit may work with their care coordinator and family wraparound team to request additional service authorization by the CME. The limit may be exceeded only by determination of need in accordance with the person- centered service plan. Individuals who may require services beyond the stated limit may work with their care coordinator and family wraparound team to request additional service authorization by the CME. The CME will review the request for demonstrated need to extend the service beyond the limit, based on criteria developed by the Department.

Medically needy *(specify limits):*

Customizable Goods and Services should be used as the funding source of last resort - only for those costs that cannot be covered by any other source and that are vital to the implementation of the POC.

Funding shall not exceed $1,000 annually per participant. Individuals who may require services beyond the stated limit may work with their care coordinator and family wraparound team to request additional service authorization by the CME. The limit may be exceeded only by determination of need in accordance with the person- centered service plan. Individuals who may require services beyond the stated limit may work with their care coordinator and family wraparound team to request additional service authorization by the CME. The CME will review the request for demonstrated need to extend the service beyond the limit, based on criteria developed by the Department.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Customizable goods and services			The CME must have a written customizable goods and services policy and procedures to ensure accountability and ensure that all customizable goods and services expenditures are verifiable. The CME shall revise its policy as needed and communicate the changes in writing to all parties. The CME shall account for all funds used and shall comply with requirements established by DHHS. The CME shall make all documentation for this service available upon request by the DHHS for quality oversight and contract management no less frequently than at each annual site review.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Customizable goods and services	CME and DHHS	CME : At time of request DHHS: During annual site review.

Service Delivery Method. *(Check each that applies)*:		
☐ Participant-directed	✓	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Family Peer Support

Service Definition (Scope)*:*

Family Peer Support is delivered on an individualized basis by a Family Peer Support Partner who will do some or all of the following, depending on the support need identified in the participant's Plan of Care. Family Peer Support is offered to all youth who are served within the State Plan HCBC program in order to enhance the primary caregiver's ability to set goals for the child/youth participant, reduce caregiver strain in order to improve the quality of life and resilience for each participant The primary concern and goal of this service is to increase the caregiver's ability and skill to assist the child/youth in reducing symptomology or increase symptom management, increasing resiliency, stabilize behaviors that are placing the child/youth at risk for placement outside of home, repeated hospitalizations, and juvenile justice involvement, school and education disruptions. Assist the child/youth with his/her activities of daily living that are age appropriate and that are identified as problematic due to symptomology associated with his /her behavioral health condition. This is achieved by connecting the parent with a trained peer supporter who, first and foremost has lived experience in caring for a child with a mental health condition, who can offer expertise in skill development for managing the child's behaviors and symptomology, assistance with setting goals and advocacy issues and instill a sense of hope that things can improve.

- Explain role and function of the Family Peer Support Partner to the newly enrolled families
- Work with family members to identify and articulate their concerns, needs, and vision for the future of their child/youth, which will then be used to craft the goals of the Plan of Care for the participant.
- Ensure family members' opinions and perspectives are incorporated into Youth Family Team process and Plan of Care through communication with the Care Coordinator and team members, so that the child/youth's plan of care is realistic and can be easily carried out within the home setting with the assistance of the child/youth's caregivers.
- Attend team meetings with family members to support family and youth decision making and choice of options
- Listen to family members express needs and concerns from peer perspective and offer suggestions for engagement in the wraparound approach and helping the child/youth achieve the goals of the Plan of Care.
- Provide ongoing emotional support, modeling, and mentoring during all phases of the family team process to ensure that the caregiver can continue to help support the child/youth in achieving the goals of the plan of care and continue to live safely at home.
- Help family members identify, engage, and strengthen its own natural and community support system to support the child/youth.
- Facilitate family members attending peer support groups and other family organization activities
- Work with family members to organize and prepare for meetings in order to maximize the family and child/youths participation in meetings
- Inform families about options and possible outcomes in selecting services and support so they are able to make informed decisions on behalf of their child and family
- Support family members in meetings at school and other locations in the community to assist the child/youth's participation, inclusion and competence in all settings in the community.
- Empower family members to make choices to achieve desired outcomes for their youth.
- Help family members acquire the skills and knowledge needed to attain greater self-sufficiency and maximum autonomy in order to assist the child/youth in achieving the goals

within the Plan of Care.
- Assist family members to develop the skills to identify and access resources that will assist managing the youth's behavioral health needs as identified in the child/youth's Plan of Care.
- Educate family members on how to navigate systems of care for their child
- Assist family members in organizing and completing paperwork to secure needed resources on behalf of the child and youth.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

Categorically needy *(specify limits):*

Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Family Peer Support Provider			Meets qualifications for a Family Peer Support Provider. Must demonstrate the following: Education: H.S. diploma or equivalency AND lived experience as the parent or primary caregiver of a child or youth with emotional or behavioral challenges, who has received supports through the public child and family serving systems a) b) meets the training and certification requirements for position Experience: a)Lived experience as a parent or primary caregiver of a child or youth with emotional or behavioral challenges who has received supports through the public child and family serving systems b)Valid state driver's license and/or access transportation with liability coverage as required by state laws

			Upon hire, FPSP's must complete the required training, including but not limited to: a) Orientation b) Pre-Service Assignments per Curriculum c) Day 1 and Day 2 per curriculum d) Skill Builder Booster training, minimum of 1 each 3 months for first 24 months

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Family Peer Support	Provider of Family Peer Supports and Care Management Entity and DHHS	At time of hire and during annual site reviews.

Service Delivery Method. *(Check each that applies)*:

☐ Participant-directed	✓	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Youth Peer Support

Service Definition (Scope)*:*

Youth Peer Support is offered to all youth who are served within the State Plan HCBC program in order to enhance their ability to set goals for quality of life and transition to adulthood, achieve greater independence in advocating for themselves and managing/achieving their own wellness goals while increasing resilience. Youth Peer Support services include:

- Strategic sharing of own lived experience to decrease peer isolation
- Support youth to safely share their own experiences in order to self-advocate and drive their own goals and planning
- Uses Futures Planning mapping strategies and tools to assist youth to pre-plan for maximum participation in team meetings
- Support youth to identify triggers and barriers and to develop their own wellness plans
- Support youth to employ conflict resolution strategies and to make informed decisions about choices for treatment/Wraparound planning as well as accessing ancillary community resources.

- Support youth to participate in crisis prevention planning activities and to understand their own crisis plans
- Orients youth to team processes and expectations
- Orients youth to a Hope, Strengths, and Resilience framework for planning
- Supports youth in forming or maintaining community connections and informs youth of opportunities for leadership trainings or systems level engagement, such as wellness groups, work on advisory groups, focus groups, regional planning activities.
- Supports youth to navigate and understand public and community resources and how to access them.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

Categorically needy *(specify limits):*

Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other standards (*Specify*)
Youth Peer Support Partner			Meets the following qualifications for a Youth Peer Support Partner: 1.Experience: a. Young Adult with Lived experience of a child/youth with emotional or behavioral health challenges and b. Who has received supports though the public child and family serving systems. c. Valid state driver's license and/or access to transportation with liability coverage as required by state laws. 2.Education: A. A High School diploma or equivalency

			B. Completes the training requirements which includes: 1. Orientation: o System of Care overview o NH Children's Behavioral Health Collaborative overview o Agency Policy and Procedures • Mandated reporting • Confidentiality and HIPPA • Personal Safety • Ethics and boundaries • Supervision structure: ongoing coaching. 2.Pre-Service training o Youth engagement and leadership module o Person centered planning module o Wraparound/ RENEW overview module o Cultural and Linguistic competencies foundational module o Language in the youth movement Youth Voice in Policy-Portland/Federation/YMN publication.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Youth Peer Support	Provider of Family Peer Supports and Care Management Entity and DHHS.	At time of hire and during annual site review.

Service Delivery Method. *(Check each that applies)*:

☐ Participant-directed	✓	Provider managed

2. ☒**Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified

legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

The only services with in this State Plan HCBC that can be furnished by relatives of the participant are in home respite care. Since respite services are difficult to fulfill, it is the intent of DHHS to allow respite services to be provided by natural supports, including family members. The intent is to provide both the participant and the family a respite so that the specifications of using natural supports will not include family members who reside in the household with the participant or who may be legally responsible for the participant.

The choice of individuals providing this service and the specifications of service delivery is vetted through the family team meeting, including the participant and his/her caregivers and the person identified by the team to provide the service will be vetted by the Care Management Entity.

Because this HCBC service is being delivered mostly to children and youth residing in a home with either a parent(s) or legal guardian or foster care provider, the relative that is being paid cannot reside in the same home as the participant, cannot be a person who is legally responsible for the participant and is only paid for respite delivered. Respite payments are made to the individual providing the service agreed upon and documented in the Plan of Care and in the manner described in the Plan of Care, including frequency and duration.

The Care Management Entity will be responsible for ensuring the above and DHHS will review cases that utilize this natural support respite option during annual site reviews.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

●	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement		**1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**
Discovery		
	Discovery Evidence *(Performance Measure)*	**1-1** Percentage of plans of care that identify needs and the strategies in which the needs will be met. • Numerator: Number of plans of care in the denominator that identify needs and the strategies by which they will be met. • Denominator: Number of plans of care reviewed during the CME site

		review • Performance Standard: 100%.[1] **1-2** Percentage of cases in which the most recent plan of care has been updated within the 12 months. • Numerator: Number of cases in the denominator in which the most recent plan of care has been updated within the past 12 months. • Denominator: Number of plans of care reviewed during the CME site review • Performance Standard: 100% **1-3** Percentage of plans of care signed by parents attesting to choice of service and provider. • Numerator: Number of plans of care in the denominator, signed by parents attesting to choice of a service and provider. • Denominator: Number of plans of care reviewed during the CME site review • Performance Standard: 100%. **1-4** Percentage of cases being re-evaluated in which the most current plan of care identifies needs and the strategies in which the needs will be met. • Numerator: Number of cases in the denominator in which the most current plan of care identifies needs and the strategies in which the needs will be met. • Denominator: Number of cases being re-evaluated. • Performance Standard: 100%. **1-5** Percentage of cases being re-evaluated in which the most recent plan of care has been updated within the past 12 months. • Numerator: Number of cases in the denominator in which the most recent plan of care has been updated within the past year. • Denominator: Number of cases being re-evaluated. • Performance Standard: 100%. **1-6** Percentage of cases being re-evaluated in which the plans of care is signed by the parents attesting to choice of service and provider. • Numerator: Number of cases in the denominator in which the plan of care is signed by the parents attesting to choice of a service and provider. • Denominator: Number of cases being re-evaluated. • Performance Standard: 100%.
	Discovery Activity	Measure 1-1 through Measure 1-3 • Data Source: File review: CME on-sight audit. • Sample Size: 8/30 file methodology[2]

[1] When applicable performance standards are listed. DHHS reserves the right to reset standards after initial baseline data is collected.

	(Source of Data & sample size)	Measure 1-4 through Measure 1-6 • Data Source: Administrative data: Eligibility data manually tracked. • Sample Size: All members with an annual re-evaluation.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Measure 1-1 through Measure 1-3 DHHS is monitoring CME performance. Measure 1-4 through Measure 1-6 DHHS is monitoring internal DHHS performance.
	Frequency	Annually.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHHS is responsible analyzing and aggregating performance measures associated with this requirement. Performance issues that require remediation will result in corrective action plans developed by the CME within 30 days of being informed about the finding. DHHS will approve all corrective action plans created by the CME and will continuously monitor CME performance until the issue is resolved. Performance issues related to internal DHHS process will result in the development of an internal action plan. Action plans will be developed and acted upon within 30 days of the identification of the issue.
	Frequency *(of Analysis and Aggregation)*	CME program improvements will be reported by the provider and assessed every 90 days until improvement is achieved. DHHS program improvements will be reassessed every 90 days until improvement is achieved.

Requirement	***Eligibility Requirements***
Discovery	
Discovery Evidence *(Performance Measure)*	**2-1** Percentage of referrals to the DHHS for 1915(i) services in which DHHS completes an eligibility determination. • Numerator: Number of referrals in the denominator with a completed eligibility determination. • Denominator: Number of referrals to DHHS for 1915(i) services. • Performance Standard: 100% **2-2** Percentage of eligible members who in the past year had a re-evaluation.

[2] 8/30 file review methodology is used by the National Committee for Quality Assurance (NCQA) of health plans in evaluating health plan accreditation. Through this methodology a random sample of 30 files are selected. 8 files are reviewed for the particular standard. If all 8 files meet the standard, then the standard has passed. If less than 8 meet the standard, an additional 22 files are reviewed to evaluate the standard.
https://www.ncqa.org/Portals/0/Programs/Accreditation/8_30%20Methodology.pdf?ver=2018-01-10-154243-267

		• Numerator: Number of eligible participants in the denominator with a completed annual re-evaluation. • Denominator: Number of eligible participants who have been eligible for more than 12 months at the time of review. • Performance Standard: 100% **2-3** Percentage of new cases with an eligibility determination that included a review of all eligibility criteria. • Numerator: Number of cases in the denominator that included a review of all eligibility criteria. • Denominator: Number of new cases reviewed. • Performance Standard: 90% **2-4** Percentage of re-evaluated cases that included a review of all eligibility criteria. • Numerator: Number of cases in the denominator that included a review of all eligibility criteria. • Denominator: Number of re-evaluated cases reviewed. • Performance Standard: 90% Criteria to be included in eligibility determination and re-evaluation include but is not limited to: • Information in referral forms were complete; • Current CANS tool or psychosocial assessment was reviewed and met requirements; • That those tools and the information within them were applied in accordance with the eligibility criteria; and • Eligibility determinations are made within the standards outlined in the NH DHHS CME rule.
	Discovery Activity *(Source of Data & sample size)*	Measure 2-1 • Data Source: Administrative data: Referral and eligibility data manually tracked. • Sample Size: All referrals. Measure 2-2 • Data Source: Administrative data: Eligibility data manually tracked. • Sample Size: All members who have been eligible for more than 12 months at the time of review. Measure 2-3 through Measure 2-4 • Data Source: File review: DHHS internal eligibility file review. • Sample Size: 8/30 file methodology.
	Monitoring Responsibilities *(Agency or entity*	DHHS is monitoring internal DHHS performance.

	that conducts discovery activities)	
	Frequency	Annually.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHHS is responsible analyzing and aggregating performance measures associated with this requirement. Performance issues related to internal DHHS process will result in the development of an internal action plan. Action plans will be developed and acted upon within 30 days of the identification of the issue.
	Frequency *(of Analysis and Aggregation)*	DHHS program improvements will be reassessed every 90 days until improvement is achieved.

Requirement	***Providers meet qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	**3-1** Percent of claims paid to a provider with a DHHS approved application.[3] • Numerator: Number of paid claims in the denominator administered by providers with a DHHS approved application • Denominator: Number of 1915(i) claims paid in the sample. • Performance Standard: 100% **3-2** Percent of plans of care in which services are designated and received by the member from qualified providers. • Numerator: Number of plans of care in the denominator in which the member received services from a qualified provider. • Denominator: Number of plans of care reviewed with designated services. • Performance Standard: 90%
Discovery Activity *(Source of Data & sample size)*	Measure 3-1 • Data Source: Claims data and File review (Provider applications) • Sample Size: 8/30 file methodology for file review. Measure 3-2 • Data Source: File review: CME on-sight audit. • Sample Size: 8/30 file methodology

[3] Provider applications for 1915(i) services are reviewed and approved by the DHHS Office of Improvement and Integrity. Once applications are electronically approved in the DHHS Medicaid Management Information System, the provider is eligible to bill and receive payment for authorized Medicaid services.

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Measure 3-1 DHHS is monitoring internal DHHS performance. Measure 3-2 DHHS is monitoring CME performance.
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHHS is responsible analyzing and aggregating performance measures associated with this requirement. Performance issues that require remediation will result in corrective action plans developed by the CME within 30 days of being informed about the finding. DHHS will approve all corrective action plans created by the CME and will continuously monitor CME performance until the issue is resolved. Performance issues related to internal DHHS process will result in the development of an internal action plan. Action plans will be developed and acted upon within 30 days of the identification of the issue.
	Frequency *(of Analysis and Aggregation)*	CME program improvements will be reported by the provider and assessed every 90 days until improvement is achieved. DHHS program improvements will be reassessed every 90 days until improvement is achieved.

Requirement	Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	**4-1** Percentage of members who were initially determined eligible in the past 12 months that have a participant/family attestation that meets settings requirements in the member's file. • Numerator: Number of files in the denominator with participant/family attestations that meet setting requirements. • Denominator: Number of files reviewed. • Performance Standard: 100% **4-2** Percentage of eligible members who had a recertification in the past 12 months that have an updated participant/family attestation that meets settings requirements in the member's file. • Numerator: Number of files with participant/family attestations that meet setting requirements. • Denominator: Number of files reviewed. • Performance Standard: 100%
Discovery Activity *(Source of Data & sample size)*	Measure 4-1 • Data Source: Administrative data: Eligibility data manually tracked. • Sample Size: All members with an eligibility determination. Measure 4-2 • Data Source: Administrative data: Eligibility data manually tracked. • Sample Size: All members with a re-evaluation.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DHHS is monitoring internal DHHS performance.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHHS is responsible analyzing and aggregating performance measures associated with this requirement. Performance issues related to internal DHHS process will result in the development of an internal action plan. Action plans will be developed and acted upon within 30 days of the identification of the issue.
Frequency *(of Analysis and Aggregation)*	DHHS program improvements will be reassessed every 90 days until improvement is achieved.

Requirement	The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	**5-1** Percentage of CME quarterly reports submitted to DHHS • Numerator: Number of quarterly reports in the denominator that were received by DHHS from the CME. • Denominator: Number of quarterly reports required from the CME. • Performance Standard: 100% **5-2** Percentage of CME enrollment census updates submitted to DHHS • Numerator: Number of enrollment census updates in the denominator that were received by DHHS from the CME. • Denominator: Number of enrollment census updates due from the CME. • Performance Standard: 95% **5-3** Percentage of CME standards that are met during the annual contract compliance review. • Numerator: Number of standards in the denominator that are met. • Denominator: Number of CME standards evaluated during the annual contract compliance review. • Performance Standard: 90% Criteria to be included in the CME audit will include but not be limited to: • Member has an updated CANS that identifies areas of need; and • Member has evidence of a wraparound team meeting at least every 45 days.
Discovery Activity *(Source of Data & sample size)*	Measure 5-1 through Measure 5-2 • Data Source: Administrative data. Manually tracked. • Sample Size: All reports. Measure 5-3 • Data Source: Mixed Data (e.g. File review, Desk audit, Staff Interviews): CME on-sight audit. • Sample Size: 8/30 file methodology for file review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DHHS is monitoring CME performance.
Frequency	Measure 5-1 and 5-2: Quarterly. Measure 5-3: Annually.
Remediation	
Remediation	DHHS is responsible analyzing and aggregating performance measures associated

	Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	with this requirement. DHHS will work with CME to identify areas needing improvement based on findings from site review, develop a plan that outlines the activities for improvement no more than 30 days after the site review, and will work with the CME on implementing and monitoring the activities in the plan until evidence of completion is achieved.
	Frequency *(of Analysis and Aggregation)*	Depending on the severity of the improvements, Technical assistance visits will occur. Progress on program improvements will be reported by the provider and assessed every 90 days until improvement plan is achieved.

Requirement	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence *(Performance Measure)*	**6-1** Percent of claims paid to a provider with a DHHS approved application. • Numerator: Number paid claims in the denominator administered by a provider with a DHHS approved application • Denominator: Number of 1915(i) claims paid in the sample. • Performance Standard: 100% **6-2** Percent of internal DHHS process standards that meet audit criteria • Numerator: Number of standards in the denominator that meet audit criteria. • Denominator: Number of process standards reviewed. • Performance Standard: 100% Audit criteria includes: • NH Medicaid Management Information System (MMIS): o Pays 1915(i) claims; o Has edits to ensure that only authorized services are covered, provided by properly enrolled providers and rendered to individuals who were eligible on dates of service; o Has the ability to input authorizations; and o Reviews pended provider claims. • Office of Improvement and Integrity within DHHS includes 1915(i) claims in: o Approves provider applications using criteria outlined in federal and state regulations; o Monitoring of financial claims; o Reviews of provider claims for fraud, waste, or abuse; o Overpayment recoveries; o Post-payment reviews; o Monitoring provider sanctions received by medical and licensing boards; and o Member Explanation of Benefit verifications.
Discovery Activity *(Source of Data & sample size)*	Measure 6-1 • Data Source: Claims data and File review (e.g. provider applications) • Sample Size: 8/30 file methodology for file review. Measure 6-2 • Data Source: Administrative Data: Internal desk audit and staff interviews. • Sample Size: N/A
Monitoring Responsibilities *(Agency or entity that conducts*	DHHS is monitoring internal DHHS performance.

	discovery activities)	
	Frequency	Annually.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHHS is responsible analyzing and aggregating performance measures associated with this requirement. Performance issues related to internal DHHS process will result in the development of an internal action plan. Action plans will be developed and acted upon within 30 days of the identification of the issue.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		The state identifies addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery		
	Discovery Evidence *(Performance Measure)*	**7-1** Percent of reportable events including incidents of abuse, neglect and exploitation that are reported to DHHS and evaluated according to policy and NH State law associated with cases receiving 1915(i) services. • Numerator: Number of events in the denominator that are reviewed by DHHS for appropriate resolution, according to policy and NH state law. • Denominator: Number of reportable events reported to DHHS.
	Discovery Activity *(Source of Data & sample size)*	Measure 7-1 • Data Source: Administrative data. Manually tracked. • Sample Size: All reported events.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DHHS is monitoring internal DHHS performance.
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHHS is responsible for analyzing and aggregating performance measures associated with this requirement. Performance issues related to internal DHHS process will result in the development of an internal action plan. Action plans will be developed and acted upon within 30 days of the identification of the issue.
	Frequency *(of Analysis and Aggregation)*	DHHS program improvements will be reassessed every 90 days until improvement is achieved.

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

When data, annual reviews or fidelity measures indicate the need for a program improvement plan. The need for a program improvement plan is assessed by;
1. The data indicates noncompliance with a 10% measure by not meeting the percentage required.
2. Documentation indicates the practice model or program requirements are not being met.
3. Wraparound and System of Care fidelity tools indicate an unacceptable deviation from practice by falling shy of the national benchmark by 10% or more.

2. Roles and Responsibilities

CME and DHHS

3. Frequency

- Biannually from biannual reports for service utilization and enrollment, disenrollment.
- Annually
- Team meeting and rating scales are completed after every team meeting and every family check in.
- Wraparound fidelity index-EZ and Wraparound inventory are completed annually.

4. Method for Evaluating Effectiveness of System Changes

- Review of data submitted by CME to DHH for compliance measures.
- DRM tool for documentation and record reviews.
- CANS tool for progress and needs identification.

Wraparound fidelity measures:
Wraparound fidelity Index-EZ
Team meeting rating scale (TMR)
Progress Rating scale
Community Supports for Wraparound inventory (system fidelity)

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
✓	HCBS Respite Care

In-Home Respite Care (Natural Support or Agency Based)

Payment for in-home respite care shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2018, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. The per diem rate was established based on rates paid for these same services by the Division of Children, Youth, and Families (DCYF). All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

Out-of-Home Respite

Payment for out-of-home respite shall be made at per diem rates established by the Department based on recipient age and location of service. Rates were set as of July 1, 2018, and are effective for services provided on or after that date. The per diem rates were established based on rates paid for these same services by the Division of Children, Youth, and Families (DCYF) and/or rates which were established under the grant which was in effect prior to planning for sustainability of the services as Title XIX state plan services. The cost data varies based on the age related clinical needs of the recipients, as well as the location of service as described below:

	a) Of the four services, the out-of-home respite in non-therapeutic foster care for children ages 6-11 was priced at the lowest rate of $18 per diem based on DCYF established rates. b) Out-of-home respite in non-therapeutic foster care for children ages 12 and over was priced at $21.41 per diem to account for the higher clinical needs of adolescents, and was also based on DCYF established rates. c) Out-of-home respite in therapeutic foster care for children was priced at a higher rate to take into account the clinical services being offered and matches the pricing established under the grant. This rate is set at $70 per diem. d) Out-of-home respite in a group home was priced at $110 per diem. This rate is based on pricing established under the grant and has been compared to the DCYF group home rates to ensure that it is reasonable and comparable. The levels and rates of out of home respite are intended to meet the unique behavioral and clinical needs of each participant. The level of respite utilized for each participant will be based on that participant's clinical and behavioral needs. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers. •
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
✓	Other Services (specify below) See attached Rate schedule
	Wraparound Facilitation/Care Coordination Payment for wraparound facilitation/care coordination shall be made at a per diem rate established by the Department. Rates were set as of July 1, 2018, and are effective for services provided on or after that date. The per diem rate was established based on the rate paid on a contract basis for the same service which was covered under a departmental grant prior to planning for its sustainability as a Title XIX state plan service. The grant rate was set based on cost data provided by the provider on a budget worksheet that took into account the salaries, fringe benefits, indirect costs, and transportation costs required to deliver the service. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public

	and private providers.
	Family Peer Support Payment for family peer support shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2018, and are effective for services provided on or after that date. The rate was set based on cost data provided by the provider on a budget worksheet that took into account the salaries, fringe benefits, indirect costs, and transportation costs required to deliver the service. No provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.
	Youth Peer Support Payment for youth peer support shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2018, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider's usual and customary charge. The rate was set based on cost data provided by the provider on a budget worksheet that took into account the salaries, fringe benefits, indirect costs, and transportation costs required to deliver the service. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.
	Customizable Goods and Services For customizable goods and services which are prior authorized, the approved payment amount is based on the actual cost of the good or service with the approved amount being provided on the prior authorization notice which is sent to the provider. The limit on this service is $1,000/recipient/per year. The limit established was based upon a review of utilization by participants receiving this service during a grant period and used the maximum billed amount in one year per participant to ensure that all participant's needs in this area are covered.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*