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State/Territory Name: NH

State Plan Amendment (SPA) #: 22-0038

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

June 23, 2023

Lori A. Weaver, Interim Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

RE: New Hampshire's 1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal 22-0038, Home and Community-Based Care for High-Risk Children with Serious Emotional Disturbance (SED)

Dear Commissioner Weaver:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's §1915(i) HCBS State Plan Amendment (SPA) with transmittal number NH 22-0038. The purpose of this amendment is to renew New Hampshire's current 1915(i) State Plan HCBS benefit. New Hampshire's current 1915(i) HCBS benefit (NH 18-0002) for High-Risk Children with SED, serves children with a minimum age of 5, along with youth and young adults with a maximum age of 21. With this renewal, the state adds the target group of 0 through age 5 and clarifies needs-based criteria language. The effective date for this renewal is July 1, 2023. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring June 30, 2028, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS approval of this 1915(i) HCBS State Plan benefit renewal 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 you have any questions concerning this information, please contact me at (206) 615-3814. You may also contact Christopher Semidey at Christopher.Semidey@cms.hhs.gov or (212) 616-2328.

Sincerely,

Wendy Hill Petras, Acting Director
Division of HCBS Operations and Oversight

Enclosure

cc: Christopher Semidey, CMS
Deanna Clark, CMS
Cynthia Nanes, CMS
Patricia McKnight, CMS
George P. Failla, Jr., CMS
Joyce Butterworth, CMS
Deborah Benson, CMS
Dawn Tierney, NH-DHHS
Henry Lipman, NH DHHS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0038

2. STATE: NH

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Section 1915(i) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 478,397
b. FFY 2024 $ 1,913,590

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, pages 1-53
Attachment 4.19-B, pages 1-3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, Pages 1-51 (TN 18-0002)
Attachment 4.19-B of 1915(i), 3 pages (TN 21-0021)

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

10. 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:

11. SIG

12. TYPED NAME
Christine L. Santaniello

13. TITLE
Associate Commissioner

14. DATE SUBMITTED
December 29, 2022

15. RETURN TO
Dawn I. Tierney
Division of Medicaid Services - Brown Building
129 Pleasant Street
Concord, NH 03301

FOR CMS USE ONLY

16. DATE RECEIVED
December 29, 2022

17. DATE APPROVED
June 23, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19

20. TYPED NAME OF APPROVING OFFICIAL
Wendy Hill Petras

21. TITLE OF APPROVING OFFICIAL
Acting Director, DHCBSO

22. REMARKS

Instructions on Back

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

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):*

Wraparound/Enhance 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*:**

X	**Not applicable**	
O	**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)*:

X	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)*:	
	X	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.

X (*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. X **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):*

6. X **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. X **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. X **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	7/1/23	6/30/24	750
Year 2			
Year 3			
Year 4			
Year 5			

2. X **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. X **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.

X 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.

X 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*):

X	D rectly by the Medicaid agency
O	B Other (*specify State agency or tity 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 of 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.

At the initial evaluation, the state reviews the results of the Child and Adolescent Needs and Strengths (CANS) assessment tool to determine whether a child meets the 1915(i) needs-based eligibility criteria under #5 in the SPA (below). Subsequently, the treating practitioner (i.e. Care Management Entity (CME) completes the CANS at least quarterly and the results are shared with the state, which the state uses to determine whether a child meets the needs-based eligibility criteria. At the time of Redetermination/Reevaluation, the state reviews the results of the CANS, which is completed by the treating practitioner, to re-evaluate continued eligibility.

The CANS assessment tool is used 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 demonstrates: (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.

Explanation of ratings:

0 - No assistance needed

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.

Specific eligibility criteria are outlined in #5 below.

The CME will submit for review the most recent plan of care (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. X **Reevaluation Schedule**. *(By checking this box, the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. X 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 are used to determine that the child has support needs that exceed that of the current services he/she may be receiving and requires assistance with;

- Reducing symptomology or increasing symptom management; or increasing resiliency; or stabilizing behaviors that are placing the child/youth at risk for placement outside of home, a new hospitalization or repeated hospitalizations, juvenile justice involvement, and/or school or education disruptions. OR
- 1 or more of 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.

6. X 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 are used to determine that the child has support needs that exceed that of the current services he/she may be receiving and requires assistance with; • Reducing symptomology or increasing symptom management; or increasing resiliency; or stabilizing behaviors that are placing the child/youth at risk for placement outside of home, a new hospitalization or repeated hospitalizations, juvenile justice involvement, and/or school or education disruptions. OR • 1 or more of his/her	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	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	A child's acute psychiatric needs require intensive and/or immediate action to address the need or risk behavior. 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.

activities of daily living that are age appropriate and that are identified as problematic due to symptomology associated with his/her behavioral health condition.	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 • Assistance with 2 or more ADL's. • A need for medical monitoring • Intellectual disability or behavioral concerns	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 • Assistance with 2 or more ADL's. • A need for medical monitoring • Intellectual disability or behavioral concerns.	

*Long Term Care/Chronic Care Hospital
**LOC= level of care

7. X **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: 6-up to 21 years of age. Have a qualifying Axis 1 disorder with the exception of substance use disorders;
- Ages 0 up through age 5. May have an Axis 1 disorder, but it is not required.

☐ **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. [X] **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):	
	X	**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. [X] **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, foster care home (adoptive parents, relative and non-relative guardian, etc., and not in a residential treatment setting or any other institutional setting).

The state assures that the foster care parent, guardian or designated caregiver (related or unrelated) does not provide HCBS and are not licensed providers. In efforts to avoid duplication of services under other authorities, the state attests the settings where youths reside and receive HCB Services cannot be settings where the foster parent, guardian or unrelated/related caregiver provide HCBS.

- As part initial evaluation process, the state also uses a tool that includes all of the settings criteria to determine if the settings where the youth will reside and receive services meets the settings requirements.
- The provider (CME) provides ongoing monitoring for compliance to the settings rule. This monitoring includes meeting directly with the individual in the approved home setting. Direct (face to face) contacts occur frequently (from 2-3 times weekly to at least every 30 days). The CME uses a tool that includes all of the settings criteria when performing ongoing monitoring in the approved home setting. If it is determined that the setting in which the youth resides is being paid to provide HCBS, the setting will no longer be eligible to provide housing for the youth. In this scenario, the provider (CME) will work with the individual to relocate to a setting that does not provide HCBS so that they can continue to receive the services under this SPA.
- The state reviews eligibility of the individual annually, which includes reviewing the setting of which the individual resides.

The state reviews internal Medicaid databases, consults with the provider, and reviews Plans of Care to help confirm the setting criteria.

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 HCBS.
2. Attestation that the foster care parent, guardian or designated caregiver (related or unrelated) does not provide HCBS and are not licensed providers. Furthermore, in efforts to avoid duplication of services under other authorities, the state attests the settings where youths reside and receive HCBS cannot be settings where a foster parent, guardian or unrelated/related caregiver provide HCBS.
3. Attestation that assessments have been completed for foster care regulations/licensing to ensure AND are compliant with the settings rule, as well as the setting meets the foster care regulations and licensing.
4. Attestation that the youth has the same experiences as a child not receiving Medicaid HCBS in the setting.
5. 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.
6. 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. X 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. X 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. X 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/Enhanced Care Coordinators will be responsible for conducting a face-to-face assessment of an individual's support needs and capabilities. Wraparound/Enhanced Care Coordinators are employed by the Care Management Entity (CMEs) and have met all the requirements of being a wraparound/enhanced care coordinator.

Wraparound/Enhanced 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/Enhanced 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

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/Enhanced Care Coordinators will be responsible for helping and guiding the wraparound/enhanced care coordination team in developing the person centered (individual/family driven) Plan of Care (POC) or Service Plan. 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/Enhanced Care Coordinators are employed by the Care Management Entity (CMEs) and have met all the requirements of being a wraparound/enhanced care coordinator;

Wraparound/Enhanced 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, the Wraparound/Enhanced 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.

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 practice model and enhanced care coordination 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 (when developmentally appropriate) and family members are the primary decision makers in the care of their family and the treatment and services the participant receives.

The Wraparound/Enhanced 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/Enhanced Care Coordinator contacts the participant and family to schedule a face-to-face meeting. The Wraparound/Enhanced Care Coordinator is responsible for ensuring fidelity to the system of core values of family and youth driven, community-based culturally and linguistically competent, and trauma informed. The family and participant identify their wraparound team members.

The process for wraparound, the family/participant roles, wraparound team and wraparound/enhanced care coordinator's roles and responsibility within the process are:
At the first meeting between the Wraparound/Enhanced Care Coordinator, participant, and family after enrollment, the Wraparound/Enhanced Care Coordinator will:

- Administer the CANS assessment, 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/enhanced care process; and
- Review Front-End Stabilization services with family and assess whether the family and participant require that level of need.

The Wraparound/Enhanced Care Coordinator will facilitate the family sharing their story by using a "Timeline" tool template. The Wraparound/Enhanced 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/coordination 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 ensures that the Care Management Entity (CME) will have access to and maintain resources directory available to the CME and the family from which to choose providers to implement the plan of care. Providers are selected by the family with the support of the child/family 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 provide ongoing adequacy reviews 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 region within the state. Examples of these groups include but is not limited to: The NH's Behavioral Health Clearinghouse, Regional Integrated Delivery Network groups, Children's System of Care Advisory Council, System of Care Implementation Team, and the Care Management Entity Workgroup.

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. The evaluator (state) will use 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 as the output of the needs-based intake and eligibility process, conducted by the state, at the time of initial evaluation and subsequently by the treating practitioner (i.e. CME), in collaboration with the state every 12 months thereafter to re-evaluate continued eligibility.
2. Upon state approval (eligibility), the initial Plan of Care is developed by the provider (CME) in conjunction with the child and family team.
3. Plans of Care are updated frequently (each child and family team meeting). Updated Plans of Care are shared with the state, along with the updated CANS results at re-eligibility.
4. 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
X	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/Enhanced Care Coordination
Service Definition (Scope):	

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

The wraparound/enhanced 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/enhanced care coordination services include:

- Assessment/evaluation of service needs;
- Identifying crisis safety risks and address within crisis safety plan and POC;
- Identifying team members involved with the child/youth;
- Supporting family and youth to identify team members;
- Planning meetings;
- Facilitating High Fidelity Wraparound/Enhanced Care Coordination meetings in accordance with the NH Wraparound/Enhanced care model and/or Enhance Care Coordination curriculum;
- Supporting 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;
- Obtaining 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/enhanced care 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/Enhanced care coordination services are provided through face-to-face, telephonic and/or telehealth contact with the wraparound child/youth and family team, including significant family supports/providers involved with the Plan of Care. Wraparound team planning may be conducted anywhere in the community. In addition to the care coordination, identification of child/youth and family's needs and assisting the family in the implementation of their crisis plan, may be part of team planning.

Wraparound/Enhanced care coordination services are provided through face-to-face, telephonic and/or telehealth contact with the wraparound 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/enhanced care coordinator is responsible for guiding the family and the Wraparound/Enhanced care family wraparound/enhanced care team through the wraparound/enhanced care process and its phases. This includes working directly with the family using and completing all applicable tools, identifying and coordinating family wraparound/enhanced care team members, educating those team members on their roles and the wraparound/enhanced care process and facilitating the family's wraparound/enhanced care 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/ Enhanced Care Coordinator		The NH Wraparound/ Enhanced Care Coordinator	Meets qualifications for a Care Coordinator. Care Coordinators employed by the CME must demonstrate the following: **Education:**

		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/ Enhanced Care Coordinator Initial Certification Requirement	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 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/Enhanced Care Coordinators must complete the required trainings, including, but not limited to: v. Orientation vi. High Fidelity Wraparound/enhanced care Training vii. Enhanced Care Coordination viii. Mental Health (Adult and/or Youth) First Aid

		s: Is hired to be a NH Wraparound/enhanced care Coordinator by a DHHS-approved entity. Completed the 3 days of NH Wraparound/enhanced care Facilitator core training, including the pre-training module. Completed an in-person DHHS-approved Cultural and Linguistic Competency training (such as the Diversity and Cultural Competency Workshop). Completed the following modules: -a DHHS-approved worker safety and mandated reporting module Modules on NH4youth.org website -Special Education module -NH CHINS Law -Overview of Multi-Tiered Systems of Support	

		-Stress, Trauma, and the Brain Completed a minimum of 13 hours of shadowing, which must include 5 hours shadowing family team meetings, 3 hours shadowing initial meetings, and 5 hours shadowing in-between meetings, with an endorsed or certified NH Wraparound/enhanced care Coordinator (i.e. a Coordinator who has been recommended by the Coach) or Wraparound/enhanced care Coach. Received 1:1 coaching at least twice a month (the majority of which is in person) from an individual who has been certified as a NH Wraparound/enhanced care Coach, which adds up to at least 36 hours of coaching per year. Completed a minimum of 12 hours of active	

		coaching with Wraparound/enhanced care Coach which must be in person (some these hours can be counted as coaching hours). Obtained CANS certification (only for Medicaid-funded projects such as Fast Forward at NFI). Completed Mental Health First Aid (Youth or Adult) training. Provided at least 50 hours of Wraparound/enhanced care Facilitation to at least 3 families/youth within the last 12 months. Participated in monthly group coaching meetings. Completed a 1-day Initial Training on Addiction and Recovery and a 1/2-day Families and Addiction training. Observed by a Wraparound/enhanced care Coach in at least one Wraparound/enhanced care Team	

		meeting for at least 2 families each and received a score of 80% or higher on the NH Wraparound/enhanced care Coordinator Observation Tool and Plan of Care Coaching Tool for each family. Submitted 2 Plans of Care including the Crisis Plans. Assembled a portfolio and application for NH Wraparound/enhanced care Coordinator Certification, with a letter of recommendation from the Wraparound/enhanced care Coach. The portfolio includes: -2 Plans of Care including the Crisis Plans. - Observations and Plan of Care review tools from 2 families. Schedule of completed coaching (individual and group). -Schedule of shadowing.	

		-Verification of facilitating Wraparound/enhanced care with families. -Verification that core training and modules have been completed. Coach's letter of recommendation. Completed NH Wraparound/Enhanced Care Coordinator online application form.	

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/ Enhanced 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	X	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 caregiving. 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 Care is available for caregivers to receive short periods of relief. In-Home Respite Care 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 Care 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/enhanced care 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):

X	Categorically needy *(specify limits):*
	In-Home Respite Care services are available to all enrolled participants. In-Home Respite Care should be provided at a minimum of 1 hour to bill. In-Home Respite Care 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/enhanced care team to request additional service authorization by the CME. The CME will review the 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.
X	Medically needy *(specify limits):*
	In-Home Respite Care services are available to all enrolled participants. In-Home Respite Care is billed at a minimum of 1 hour to bill. In-Home Respite Care 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/enhanced care team to request additional service authorization by the CME. The CME will review the 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 Care-Natural Support	N/A	N/A	Family identified. Requires a criminal record check and any applicable registry checks.

In-Home Respite Care-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 Care-Natural Support	Family and CME via Wraparound/Enhanced Care Coordinator.	At time of support identification.
In-Home Respite Care-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	X	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: Out-of-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 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 Care options are:

- General level foster care: Foster homes that are licensed 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. 1915(i) funds are not available to pay for maintenance (including room and board) and supervision of children who are under the state's

custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The cost associated with maintenance and supervision of these children are considered a state obligation.	
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):*	
X	Categorically needy *(specify limits):*
	Out-of-Home respite care services only are available to children receiving the HCBS benefit. Out-of-home respite care services do not include on-going child care or before or after school programs. The levels of Out-of-Home Respite Care 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 Care 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/enhanced care 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.
X	Medically needy *(specify limits):*

Out-of-Home respite care services only are available to children receiving the HCBS benefit.

Out-of-home respite care services do not include on-going child care or before or after school programs.

The levels of Out-of-Home Respite Care 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 Care 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/enhanced care 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 Care: General/level foster care respite	Licensed family foster home by NH DHHS.		Identified as a respite provider by NH DHHS.
Out-of-Home Respite Care: 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.

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):*
General/	CME will verify licensure of all homes identified as System of Care respite homes with NH DHHS.	At time of enrollment and annual thereafter.

treatment level foster care respite		
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	X	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: Customizable Goods and Services

Service Definition (Scope):

Criteria for youth ages 6 – up to 21:

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/enhanced care 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):

8. 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.
9. The state will pay for a child/youth to join a fitness club if the above criteria are met.
10. The state will pay for adaptive equipment needed in order to participate in the above.

Criteria for youth ages 0 – up through 5:

11. All of the above is applicable, but includes;
12. Appropriate specialized nutritional needs as identified in the Plan of Care/Service Plan. Specialized nutritional needs must not constitute a "full nutritional regime (3 meals per day).

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):

X	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/enhanced care 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/enhanced care 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.

X	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/enhanced care 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/enhanced care 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	X	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: Family Peer Support

Service Definition (Scope):

Family Peer Support is delivered on an individualized basis by a Family Peer Support Specialist 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 Home and Community-Based Care (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, assist 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 Specialist 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/enhanced care 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/youth's 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/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 Specialist		Is hired to be a Family Peer Support Specialist by a DHHS-approved entity. Completion of all Trainings associated with NAMI NH's Family Peer Support Specialist Practice Profile. Completed the 3 days of NH Wraparound/enhanced care Facilitator training Completed a DHHS-approved Cultural and Linguistic Competency training. Completed a minimum of 10 hours shadowing in family meetings, (2 hours orientation meetings, 4 hours of family meetings, and 4 hours of family team meetings) with an endorsed NH Family Peer Support Specialist. Receives 1:1 supervision	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 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: Orientation Pre-Service Assignments per Curriculum Day 1 and Day 2 per curriculum Skill Builder Booster training, minimum of 1 each 3 months for first 24 months

		and/or mentoring from an endorsed supervisor with lived experience and/or Family Peer Support Specialist weekly during first 3 months and at least 2X/mo. thereafter for at least an hour (in person or via distance). Participates in monthly group Wraparound/enhanced care meetings Assembles a portfolio and application for NH Wraparound/enhanced care Family Peer Support Specialist Certification, with a letter of recommendation from his or her Family & Community Peer Support Mentor to be reviewed by a representative from NAMI NH, DHHS approved CME, and UNH/IOD. The portfolio shall include:	

		1. Completion of NAMI NH's Family Peer Support Specialist Curriculum. 2. Shadowing Certificated Family Peer Support Specialist(s) for a minimum of 10 hours. 3. Completion of all 3 Wraparound/enhanced care Training Days. 4. Completion of a minimum of 50 hours of direct Family Peer Support. 5. Mentor/Supervisor's recommendations	

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	X	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:	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, and 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 Standard *(Specify):*
Youth Peer Support Partner		Is hired to be a NH Youth Peer Support Specialist by a DHHS-approved entity. -Completion of online modules from Washington State Manual: Modules 1-10	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.

		(excluding module #4 which is specific to Washington state). -Completed Cultural Linguistic Competence online module. -Completed Family Driven and Youth-Guided Practice online module. -Completed System of Care in Children's BH online module. -Stress, Trauma, and the Brain online module. - NHCBHC Core Competencies online module. - Completed 6 hr Initial Training on Addictions & Recovery and 3.5 hr Families and Addiction training (NH DHHS). - Completed Strategic Sharing Module - Completed a NH mandated reporting training. - Completed the 1-day Diversity and Cultural Competence in	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: ○ System of Care overview ○ NH Children's Behavioral Health Collaborative overview ○ Agency Policy and Procedures • Mandated reporting • Confidentiality and HIPPA • Personal Safety • Ethics and boundaries • Supervision structure: ongoing coaching. 2.Pre-Service training ○ Youth engagement and leadership module ○ Person centered planning module ○ Wraparound/RENEW overview module ○ Cultural and Linguistic competencies foundational module ○ Language in the youth movement Youth Voice in Policy-Portland/Federation/YMN publication.

		the Workplace training. - Completed a minimum of 15 hours observing youth peer supporter specialists with lived experience as they work with youth or young adults. - Receives & tracks at least 2 hours/month of coaching from a trained Youth Peer Support Specialist Coach to ensure fidelity to the model. - Regularly attends & tracks monthly group coaching with trained Youth Peer Support Specialist coach and other Youth Peer support Specialist staff. - Assembles and submits a portfolio to apply for Youth Peer Support Specialist Certification to be reviewed by the NH Wraparound Certification Panel.	

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	X	Provider managed

2. X **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 within this State Plan HCBC that can be furnished by relatives of the participant is 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 HCBS 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 the 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):*

X	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 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 which the most recent plan of care has been updated within the past 12 months.

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

	• 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, 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 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 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 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 *(Source of Data & sample size)*	Measure 1-1 through Measure 1-3 • Data Source: File review: CME on-sight audit. • Sample Size: 8/30 file methodology[2] Measure 1-4 through Measure 1-6 • Data Source: Administrative data: Eligibility data manually tracked. • Sample Size: All members with an annual 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

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	***2. 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 with a completed eligibility determination. • Denominator: Total 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. • Numerator: Number of eligible participants with a completed annual re-evaluation. • Denominator: Total 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 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 re-evaluated cases 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 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	***3. 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 administered by providers with a DHHS approved application • Denominator: Total number of 1915(i) claims paid. • 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 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
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*	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.

[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.

remediation activities; required timeframes for remediation)	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	***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).
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 with participant/family attestations that meet setting requirements. • Denominator: Total 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: Total 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 that were received by DHHS from the CME. • Denominator: Total 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 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 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 Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHHS is responsible analyzing and aggregating performance measures associated 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 of paid claims in the administered by a provider with a DHHS approved application • Denominator: Total number of 1915(i) claims paid. • Performance Standard: 100% **6-2** Percent of internal DHHS process standards that meet audit criteria • Numerator: Number of standards that meet audit criteria. • Denominator: Total number of process standards reviewed. • Performance Standard: 100% Audit criteria includes: • NH Medicaid Management Information System (MMIS): ○ Pays 1915(i) claims;

	○ 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; ○ Has the ability to input authorizations; and ○ Reviews pended provider claims. • Office of Improvement and Integrity within DHHS includes 1915(i) claims in: ○ Approves provider applications using criteria outlined in federal and state regulations; ○ Monitoring of financial claims; ○ Reviews of provider claims for fraud, waste, or abuse; ○ Overpayment recoveries; ○ Post-payment reviews; ○ Monitoring provider sanctions received by medical and licensing boards; and ○ 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 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)*	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 that are reviewed by DHHS for appropriate resolution, according to policy and NH state law. • Denominator: Total 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.

4. Method for Evaluating Effectiveness of System Changes

- Review of data submitted by CME to DHHS for compliance measures.
- Document Review Measure (DRM) tool for documentation and record reviews.
- CANS tool for progress and needs identification.

Wraparound fidelity measures:
CANS
Team meeting rating scale (TMR)
Progress Rating scale

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
X	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, 2023, 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 is 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, 2023, and are effective for services provided on or after that date. The per diem rates are 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) Out-of-home respite in non-therapeutic foster care was based on DCYF established rates. b) 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 $74.41 per diem. c) Out-of-home respite in a group home was priced at $116.93 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 Care 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)
X		Other Services (specify below)
		Wraparound Facilitation/Enhanced 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, 2023, 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, 2023, 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, 2023, 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.