CHAPTER He-E 800 MEDICAL ASSISTANCE

PART He-E 801 CHOICES FOR INDEPENDENCE PROGRAM

REVISION NOTE:

Document #9969, effective 8-8-11, adopted, readopted with amendments and renumbered, and repealed the rules in Part He-E 801, formerly entitled "Home and Community-Based Care for the Elderly and Chronically Ill", and now entitled "Choices for Independence Program."

Document #9969 replaces all prior filings for rules in the former He-E 801. The filings affecting the former He-E 801 include the following documents:

#7488, eff 5-8-01
#7655, eff 2-28-02
#7823, eff 2-8-03
#9326, eff 11-21-08
#9858, INTERIM, eff 2-8-11

He-E 801.01 Purpose. The purpose of the rules contained in He-E 801 is to describe the requirements for eligibility and the services provided through the Choices for Independence (CFI) Medicaid waiver program, which provides Medicaid coverage of services that are clinically necessary as determined following a clinical assessment.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.02 Definitions.

(a) "Activities of daily living (ADLs)" means activities such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, and monitoring and supervision of medications.

(b) "Annual aggregate Medicaid cost" means the total Medicaid costs for nursing facility residents, combining both the initial Medicaid payments and quarterly supplemental payments.

(c) "Average aggregate payment" means the value of the annual aggregate Medicaid cost of nursing facility services divided by the number of paid Medicaid bed days in nursing facilities.

(d) "Bureau" means the department's bureau of elderly and adult services (BEAS).

(e) "Care plan" means a written guide that:

(1) Is developed and maintained by the service provider in consultation with the participant, his or her legal representative, if any, or both;

(2) Is developed as a result of an assessment process which includes communication with the participant's case manager;

(3) Is consistent with and addresses the applicable service needs identified in the participant's comprehensive care plan; and

(4) Contains specific instructions on providing a defined service to the participant.

(f) "Case management agency" means an agency that is enrolled as a New Hampshire Medicaid provider to provide targeted case management services to CFI participants in accordance with He-E 805.

(g) "Case manager" means a person providing services in accordance with He-E 805, who has the primary responsibility for assessing the participant's needs, developing a comprehensive care plan, and coordinating and monitoring the services described in the comprehensive care plan.

(h) "Choices for Independence (CFI)" means a system of long-term care services provided under Section 1915(c) of the Social Security Act to participants who meet the eligibility requirements in He-E 801. This term is also known as home and community-based care for the elderly and chronically ill (HCBC-ECI).

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

(j) "Comprehensive care plan" means an individualized plan described in He-E 805.05(c) that is the result of a person-centered process that identifies the strengths, capacities, preferences, and desired outcomes of the participant.

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

(l) "Home-based services" means long term care services provided to an individual either in a private home setting or in a mid-level residential facility, including:

(1) CFI services;

(2) Case management services; and

(3) The following Medicaid State Plan services:

a. Personal care attendant;

b. Home health aide;

c. Home health nursing;

d. Physical therapy;

e. Occupational therapy;

f. Speech therapy;

g. Adult medical day; and

h. Private duty nursing.

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

(1) An attorney;

(2) A guardian or conservator;

(3) An agent acting under a power of attorney;

(4) An authorized representative acting on behalf of an applicant in some or all of the aspects of initial and continuing eligibility in accordance with He-W 603.01; or

(5) A representative acting on behalf of another individual pursuant to RSA 161-I, Personal Care Services.

(n) "Legally responsible relative" means "legally responsible relative" as defined in RSA 161-I:2, VIII. In this rule, the only applicable legally responsible relative is the participant's spouse.

(o) "Licensed practitioner" means:

(1) Medical doctor;

(2) Physician's assistant;

(3) Advanced practice registered nurse;

(4) Doctor of osteopathy;

(5) Doctor of naturopathic medicine; or

(6) Anyone else with diagnostic and prescriptive powers licensed by the appropriate New Hampshire licensing board.

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

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

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.03 Eligibility.

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

(1) Submits a signed and dated application, as defined in He-W 601.17, to the department;

(2) Is at least 18 years of age;

(3) Has been determined financially eligible as either categorically needy or medically needy;

(4) Meets the clinical eligibility requirements for nursing facility care in RSA 151-E:3, I(a), namely, the person requires 24-hour care for one or more of the following purposes, as determined by registered nurses appropriately trained to use an assessment instrument and employed by the department, or a designee acting on behalf of the department:

a. Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;

b. Restorative nursing or rehabilitative care with patient-specific goals;

c. Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or

d. Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence;

(5) Requires the provision of at least one CFI waiver service, as documented in the identified needs list, and receives at least one CFI waiver service at least monthly;

(6) Is determined by a registered nurse employed or designated by the department to require CFI waiver services that can be provided at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services; and

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

(b) Pursuant to 42 CFR 441.301 (b)(1)(iii) and (b)(6), eligibility shall be restricted to individuals who meet the target population criteria approved by CMS for this program and who, without the services provided by the program, would otherwise require institutional placement in a long term care nursing facility as described in He-E 802, and not services provided in a hospital, an institution for mental diseases (IMD) as defined in 42 CFR 435.1010, or an intermediate care facility for the mentally retarded (ICF/MR) as defined in 42 CFR 440.150.

(c) While receiving care as a resident in a nursing facility, an individual shall not be eligible for coverage of CFI services listed in He-E 801.12(b).

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

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

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

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.04 Eligibility Determination.

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

(1) A registered nurse employed or designated by the department shall:

a. Conduct an on-site, face-to-face visit with the applicant;

b. Perform a clinical assessment of the applicant; and

c. Develop a list of identified needs with the applicant;

(2) The applicant shall sign the following:

a. The identified needs section of the assessment, indicating his or her agreement or disagreement with the identified needs;

b. A consent for participation in the CFI program, including whether or not he or she has a preference of a case management agency;

c. An authorization for release of information; and

d. An authorization for release of protected health information;

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

(4) Within the 30 day period in (3) above, if the requested information is not received, the department shall send a second notice to the applicable licensed practitioner(s), with a copy to the applicant, as a reminder to provide the requested information by the original deadline;

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

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

(b) For each applicant who meets the clinical eligibility requirements, a registered nurse employed or designated by the department shall estimate the costs of the provision of home-based services by identifying medical and other services, including units, frequencies, and costs, that would meet the needs identified in the assessment in (a)(1) above in order to determine if services that meet the applicant's needs can be provided at a cost that is the same as, or lower than, the Medicaid cost of nursing facility services, pursuant to He-E 801.03(a)(6), and does not exceed the cost limits described in He-E 801.09.

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

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

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

(2) The eligibility start date.

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

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

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

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.05 Development of the Comprehensive Care Plan.

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

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.06 Service Authorization.

(a) Upon review of the information provided in He-E 801.05(b), the department shall authorize services that are consistent with services that meet the needs identified in the clinical assessment in He-E 801.04(a) and other verified long-term care needs not previously identified through the assessment.

(b) Service authorizations shall consist of specific types, units, and frequencies of medical and other services.

(c) Service authorizations shall be issued to specific service providers identified by the participant's case manager as a result of person centered planning.

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

(1) The requested service;

(2) The authorized service;

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

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

(e) An applicant or participant who disagrees with a service authorization may request a reconsideration of the service authorization, as follows:

(1) The applicant or participant, or his or her representative, shall submit a written request to the bureau within 30 days of the service authorization; and

(2) The written request shall include an explanation of the reason why a specific service authorization should be changed, including any supporting documentation.

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

(g) Requesting a service authorization reconsideration shall not:

(1) Preclude in any way an applicant's or participant's right to appeal a disputed service authorization in accordance with He-C 200; and

(2) Change the timeframes established for filing an appeal.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.07 Redetermination of Eligibility and Service Authorization.

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

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

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

(d) Upon a redetermination of eligibility, the identified needs list and service authorizations shall be updated as necessary by the department.

(e) If a participant is determined ineligible, or if services are identified as no longer being clinically necessary, the department shall either terminate CFI eligibility or reduce or terminate the services authorized, respectively, as follows:

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

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

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

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

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

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

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.08 Request for Clinical Redetermination After Clinical Denial.

(a) Within one year of a determination of clinical ineligibility per He-E 801.04(f) or a reduction or termination of service after redetermination per He-E 801.07(d), an individual may request clinical reconsideration for CFI services by submitting to the department supporting documentation, completed by the applicant's medical doctor, doctor of osteopathy, or advanced practice registered nurse (APRN), that indicates new evidence of clinical eligibility not submitted with the original request for services.

(b) After one year of an initial denial per He-E 801.04(f) or a termination of service after redetermination per He-E 801.07(d), an individual may reapply to the CFI program without meeting the requirement in (a) above.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.09 Cost Control Methodology.

(a) For each applicant or participant, the department shall conduct a cost comparison between the cost of the individual's home-based services and the average annual cost of the provision of services to a person in a nursing facility, per RSA 151-E:11.

(b) The cost comparison in (a) above shall be conducted as part of the initial eligibility determination and redetermination, and at any other time when a participant's comprehensive care plan is adjusted or the services received by the participant change.

(c) The total cost of an individual's home-based services shall include the costs of all home-based services.

(d) Costs associated with services rendered for acute care needs shall not be included in the calculation in (c) above.

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

(1) The basic Medicaid cost, determined by dividing the total annual Medicaid cost stated in the nursing facility budget line by the number of paid Medicaid bed days for that budget year; and

(2) The average aggregate payment made under the Medicaid Quality Incentive Program, through the Nursing Facility Trust Fund as described in RSA 151-E:14 and 151-E:15, divided by the number of paid Medicaid bed days.

(f) If the cost of an applicant's or a participant's home-based services exceeds 80% of the average annual cost for the provision of services to a person in a nursing facility, participation in the CFI program shall not be approved without the prior approval of the commissioner in accordance with He-E 801.10.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.10 Commissioner Prior Approval Process.

(a) In accordance with RSA 151-E:11, II, no applicant or participant whose home-based services costs would be in excess of 80% of the average annual cost for the provision of services to a person in a nursing facility shall be approved for CFI participation without the prior approval of the commissioner.

(b) The commissioner's prior approval process shall include the following:

(1) A review of the costs of the home-based services identified to meet the applicant's or the participant's needs;

(2) A review of the costs of nursing facility services at a nursing facility qualified to provide services, including any specialized services, that would be necessary for the proper care and treatment of the applicant or participant;

(3) A comparison of the amounts in (1) and (2) above; and

(4) The approval of those cases which do not exceed the individual cost limit specified in the HCBC-CFI waiver approved by the Centers for Medicare and Medicaid Services.

(c) If the commissioner approves the applicant's or the participant's participation in the CFI program, the bureau shall:

(1) Inform the applicant or participant in writing that services through the CFI program shall be provided or continued; and

(2) Inform the applicant or participant in writing that if the approval for services is discontinued in the future due to a determination that the services exceed what is allowed in RSA 151-E:11, the participant shall be informed in writing of the decision and the right to appeal the decision in accordance with He-E 801.04(f).

(d) If the commissioner does not approve the applicant's or the participant's participation in the CFI program, the bureau shall:

(1) Inform the applicant or participant in writing that services through the CFI program shall not be provided or continued, including the reason and legal basis for the determination; and

(2) Inform the applicant or participant in writing of the right to appeal the decision and the process to file an appeal in accordance with He-E 801.04(f) or 801.07(e).

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.11 Post-Eligibility Computation of Cost of Care for CFI Services.

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

(1) The amount of the applicant or recipient's gross earned income as defined in He-W 601.81 shall be determined;

(2) The employment expense disregard, as specified in He-W 654.18 for OAA or ANB recipients or the earned income disregard, as specified in He-W 654.15 for APTD recipients, shall be subtracted from the individual's gross earned income to obtain the individual's net earned income;

(3) The total amount of the individual's unearned income, as defined in He-W 601.176, shall be added to the net earned income to determine the individual's net income;

(4) The allowable deductions, as defined in He-W 654.20 and He-W 654.21, shall be subtracted from the individual's net income;

(5) For the maintenance needs of the individual, 300% of the maximum SSI benefit for an eligible individual as determined in accordance with 20 CFR 416.410, adjusted by cost of living increases pursuant to 20 CFR 416.405 shall be subtracted from the amount in (4) above;

(6) The cost of the following medical expenses incurred by the recipient that are not subject to third-party payment shall be subtracted from the amount in (5) above:

a. Health insurance premiums, including Medicare Part A, Part B, Part C, and Part D, coinsurance payments, and deductibles;

b. Necessary and remedial care that would be covered by medical assistance except that allowable payment limits have been exceeded;

c. Necessary and remedial care that is recognized by state law, but not covered by medical assistance; and

d. Currently obligated, unpaid prior medical debt;

(7) The amount of any continuing SSI benefits, under section 1611 (e) (1) (E) and (G) of the Social Security Act, shall be subtracted from the amount in (6) above;

(8) The veterans affairs aid and attendance allowance shall be added to the amount in (6) or (7) above as required by 42 CFR 435.733 (c); and

(9) The result in (8) above shall be the amount of income for which the individual is liable to remit as payment toward the cost of his or her CFI services.

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

(1) The amount of the applicant or recipient's gross earned income as defined in He-W 601.81 shall be determined;

(2) The employment expense disregard, as specified in He-W 654.18 for OAA or ANB recipients or the earned income disregard, as specified in He-W 654.15 for APTD recipients, shall be subtracted from the individual's gross earned income to obtain the individual's net earned income;

(3) The total amount of the individual's unearned income, as defined in He-W 601.176, shall be added to the net earned income to determine the individual's net income;

(4) The allowable deductions, as defined in He-W 654.20 and He-W 654.21, shall be subtracted from the individual's net income;

(5) The personal needs allowance as defined in He-W 654.17(b) shall be subtracted from the amount in (4) above;

(6) The cost of the following medical expenses incurred by the recipient that are not subject to third-party payment shall be subtracted from the amount in (5) above:

a. Health insurance premiums, including Medicare Part A, Part B, Part C, and Part D, coinsurance payments, and deductibles;

b. Necessary and remedial care that would be covered by medical assistance except that allowable payment limits have been exceeded;

c. Necessary and remedial care that is recognized by state law, but not covered by medical assistance; and

d. Currently obligated, unpaid prior medical debt;

(7) The amount of any continuing SSI benefits, under section 1611 (e) (1) (E) and (G) of the Social Security Act, shall be subtracted from the amount in (6) above;

(8) The veterans affairs aid and attendance allowance shall be added to the amount in (6) or (7) above as required by 42 CFR 435.733 (c); and

(9) The result in (8) above shall be the amount of income for which the individual is liable to remit as payment toward the cost of his or her CFI services.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.12 Covered Services and Requirements of Service Provision.

(a) CFI services shall be covered for eligible participants when:

(1) The services are provided as specified in the participant's comprehensive care plan;

(2) The services are provided in accordance with the service descriptions in He-E 801.14 through He-E 801.28; and

(3) Authorized by BEAS.

(b) CFI services shall include one or more of the following services:

(1) Adult family care services;

(2) Adult in-home care services;

(3) Adult medical day services;

(4) Environmental accessibility adaptations;

(5) Home-delivered meals services;

(6) Home health aide services;

(7) Homemaker services;

(8) Non-medical transportation services;

(9) Personal care services;

(10) Personal emergency response system services;

(11) Residential care service;

(12) Respite services;

(13) Skilled nursing services;

(14) Specialized medical equipment services; and

(15) Supportive housing services.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.13 Non-Covered Services.

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

(1) Is covered through the Medicaid State Plan and the participant is eligible for that coverage;

(2) Is covered through Medicare or any other insurance and the participant is eligible for that service;

(3) Is provided as a component of any other covered service;

(4) Duplicates another service being provided to the participant;

(5) Addresses needs being met by another paid or unpaid service;

(6) Is provided by a legally responsible relative; or

(7) Is primarily for the purpose of recreation.

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.14 Adult Family Care.

(a) Adult family care shall be covered:

(1) When provided at a private residence in the community that is either:

a. Certified in accordance with RSA 151 and He-P 813; or

b. Not required to be licensed pursuant to RSA 151:2, II(b); and

(2) When the services are organized and managed by an adult family care oversight agency as authorized by BEAS.

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

(c) The home provider of a residence in (a)(1)b. above shall:

(1) Be at least 21 years of age;

(2) Possess and maintain a NH driver's license and current automobile liability insurance;

(3) Have personal injury liability insurance for the residence and maintain certificates of insurance on file at the premises;

(4) Have a written agreement with an oversight agency;

(5) Receive orientation and training by the oversight agency regarding the program, policies and procedures, as well as training on the participant's specific care needs and other aspects related to providing support in the home;

(6) Provide care in accordance with the participant's care plan, the fire safety plan, and the personal safety plan;

(7) During a planned absence or in the event of an emergency, collaborate with the oversight agency and the participant's case manager to arrange for a substitute caregiver in accordance with the participant's care plan;

(8) Allow other service providers into the home to provide medical care and support for the participant's other needs if identified in the participant's comprehensive care plan;

(9) Obtain a life safety inspection by the local fire department prior to the commencement of service provision and remain in compliance with the requirements of the life safety inspection as mandated by the local fire department;

(10) Comply with the oversight agency in obtaining a criminal record check, motor vehicle records check, and BEAS state registry check, per RSA 161-F:49, for all household members age 17 years or older; and

(11) Not have, and ensure that no one else in the household has had, a felony conviction or a misdemeanor conviction that involves physical or sexual assault, violence or exploitation, theft, or any other conduct that represents evidence of behavior that could endanger the well being of a participant.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.15 Adult In-Home Care Services.

(a) Adult in-home care services shall be covered when provided by an agency licensed in accordance with RSA 151:2 and either He-P 809 or He-P 822.

(b) Covered services shall include:

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

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

(3) Preparing non-communal meals and snacks, unless for multiple CFI participants, including cleaning the food preparation area after the food is served;

(4) Hands-on assistance with activities of daily living or cuing a participant to perform a task; and

(5) Medication administration as allowed in He-P 809 and He-P 822.

(c) Adult in-home care shall not be covered:

(1) For the purposes of food preparation for meals and snacks provided to both the participant and non-participants; or

(2) When provided to a participant receiving residential care services.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-P 801.16 Adult Medical Day Services.

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

(b) Covered adult medical day services shall be those services that are provided in accordance with He-E 803, except that the requirement contained in He-E 803.03(a)(6), which requires attendance for a minimum of 4 hours in a day, shall not apply.

(c) Adult medical day services shall not be a covered service when:

(1) Provided for non-medical reasons;

(2) Provided to a participant receiving residential care services; or

(3) Provided to a participant receiving adult family care services.

(d) Adult medical day service providers shall comply with the provider and documentation requirements specified in He-E 803 and He-P 818, in addition to the requirements in He-E 801.30.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.17 Environmental Accessibility Adaptations.

(a) Environmental accessibility adaptations (EAA) shall be a covered service when:

(1) A NH Medicaid-enrolled licensed practitioner or physical or occupational therapist has determined the need for one or more of the services in (b) below;

(2) The participant's case manager has requested prior authorization for the service in accordance with (d) below;

(3) BEAS has provided the prior authorization for the service; and

(4) The service is completed by a provider or contractor enrolled with the department in accordance with (e) below.

(b) The following environmental accessibility adaptations shall be covered:

(1) Installation of ramps;

(2) Installation of grab bars;

(3) Widening of doorways to accommodate the participant's wheelchair or other mobility access equipment; and

(4) Other adaptations authorized by BEAS that are necessary for the health and safety of a participant that are not otherwise covered under the Medicaid State Plan.

(c) The following environmental accessibility adaptations shall not be covered:

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

(2) Adaptations which add to the square footage of the home;

(3) Purchase of or modifications to a motor vehicle;

(4) Electrical or plumbing work that is beyond what is required to support the authorized adaptation;

(5) Electrical or plumbing work for which the proposed contractor is unable to state, in writing, that the proposed adaptation can be done within the current electrical or plumbing capacity of the home; and

(6) Adaptations to a residential care facility or other licensed facility, except for adaptations in an adult family care home when approved for a specific participant.

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

(1) A completed Form 3715, "Choices for Independence Prior Authorization Request Form" (4/2011);

(2) A copy of the evaluation in (a)(1) above that describes:

a. The medical or functional need for the adaptation;

b. The description and measurements required for the adaptation; and

c. The proposed training plan for the client and caregiver to ensure safe use of the adaptation;

(3) Proposals from at least 2 registered providers or contractors, except that one proposal may be submitted with a written explanation of why only one proposal is available or appropriate, including the following, as applicable to the project:

a. A list of supplies and materials;

b. Blueprints or scaled drawings;

c. The name(s) of any subcontractors that will be involved;

d. Written confirmation of whether or not a building permit is required;

e. If electrical or plumbing work is required to support the adaptation, then:

1. A statement signed by the provider or contractor stating that the requested adaptation can be done within the current electrical or plumbing capacity of the residence; and

2. A copy of the electrician or plumber's license;

f. A statement signed by the provider or contractor affirming knowledge of all applicable building codes and permitting requirements and affirming that any subcontractors involved in the work are appropriately licensed; and

g. An agreement signed by the provider or contractor stating that reimbursement for the authorized service through CFI will be payment in full;

(4) If a participant prefers one bid over the other(s), then an explanation of the preference shall be submitted; and

(5) A notarized written statement from the property owner granting permission to complete the project if the participant is not the owner of the residence.

(e) Providers or contractors shall meet the following requirements in order to be enrolled to perform EAAs:

(1) Licensed if the work to be completed requires licensure, such as plumbing or electrical work;

(2) Registered with the NH secretary of state to do business in the state of NH;

(3) Insured with general liability insurance for person and property for a minimum amount of $50,000; and

(4) Have submitted documentation of (1)-(3) above to the department's fiscal agent.

(f) Payment for EAAs shall not be made until the department receives the following:

(1) A copy of any required building permit and written confirmation from the building inspector that the work was completed as allowed by the permit;

(2) A signed statement from the participant stating that the work has been completed according to the approved bid and plans and to the satisfaction of the participant; and

(3) A signed confirmation from the case manager stating that the work was completed.

(g) Payment for environmental accessibility adaptations shall not exceed the participant lifetime limit specified in the HCBC-CFI waiver approved by the Centers for Medicare and Medicaid Services.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.18 Home-Delivered Meals Services.

(a) Covered home-delivered meals services include:

(1) The delivery of nutritionally balanced meals to the participant's home; and

(2) The monitoring of the participant and the reporting of emergencies, crises, or potentially harmful situations to emergency personnel or the participant's case manager, as appropriate.

(b) All home-delivered meals shall be nutritionally balanced and contain at least one-third of the current Recommended Dietary Allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.

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

(1) Have a current contract with DHHS to provide home-delivered nutrition services to adults;

(2) Ensure that meals are prepared and delivered in compliance with the comprehensive care plan and with any applicable state or local requirements;

(3) Provide meals that accommodate diabetic or salt restricted diets, or both, if such are requested by the case manager;

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

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

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.19 Home Health Aide Services.

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

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

(1) Those services allowed within the LNA scope of practice, pursuant to Nur 700; and

(2) Personal care services, as described in He-E 801.22, when the participant's care plan contains documentation that his or her medical condition necessitates the performance of such tasks by an LNA and not an unlicensed provider.

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.20 Homemaker Services.

(a) Homemaker services shall be covered when provided by employees of:

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

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

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

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

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

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

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

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

(c) Homemaker services shall not be covered:

(1) For the purposes of food preparation for meals and snacks that include both the participant and non-participants; or

(3) Separately when provided at a residential care facility.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.21 Non-Medical Transportation Services.

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

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

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

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

(4) Agencies under contract with BEAS to provide services, which include the provision of transportation, funded by the Older Americans' Act or the Social Services Block Grant.

(b) Vehicles used for providing non-medical transportation services shall have a current inspection sticker.

(c) Drivers providing non-medical transportation services shall:

(1) Have a current and valid driver's license;

(2) Provide documentation of having car insurance that

a. Includes uninsured motorist coverage; and

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

(3) Be 18 years of age or older.

(d) When requesting authorization for non-medical transportation services, the participant's case manager shall:

(1) Document the following in the participant's record:

a. What public transportation resources were investigated by the case manager and why they do not meet the participant's needs;

b. What private transportation resources were investigated by the case manager, such as friends or family members, including who was contacted and when that person denied transportation; and

c. How the non-medical transportation requested will implement the comprehensive care plan; and

(2) Send the following information with the request for non-medical transportation to BEAS:

a. The specific destination(s) of the requested transportation;

b. How the participant has previously been transported to that destination(s), if applicable;

c. The name of the person or provider that will provide the transportation;

d. If more than one trip to the same destination is being requested, identify the frequency requested;

e. A copy of the section of the comprehensive care plan that documents that the requested transportation is necessary for it to be implemented; and

f. Which specific public and private resources were investigated, as described above in (1)a. and b., and why they are not available to the participant.

(e) Non-medical transportation services shall be covered:

(1) When it is authorized by BEAS to access a waiver service or other destination to implement the participant's comprehensive care plan; and

(2) The documentation requirements in (d) above are met.

(f) Non-medical transportation trips shall include transportation to and from the authorized destination.

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

(1) Assistance with tasks at a destination;

(2) Transportation to or from medical appointments or services; and

(3) Transportation provided to a participant receiving residential care or adult family care services.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.22 Personal Care Services.

(a) Personal care services shall be covered when provided by employees of:

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

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

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

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

(1) Hands-on assistance with the activities of daily living or cuing a participant to perform a task;

(2) Assisting the participant with eating, as specified in the care plan;

(3) Under the direction of the participant, assistance with self-administration of oral or topical medication as prescribed, to include:

a. Reminding the participant regarding the timing and dosage of the medication, and to take his or her medication as written on the medication container;

b. Placing the medication container within reach of the participant;

c. Assisting the participant with opening the medication container;

d. Assisting the participant by steadying shaking hands; and

e. Observing the participant take the medication and recording the same in the participant's record;

(4) Accompanying the participant when:

a. The assistance of the personal care worker is required for the participant to access necessary services that are documented in the comprehensive care plan; and

b. The need for re-direction or direct assistance, or both, is documented in the clinical assessment, or, if the participant needs oxygen or other equipment during the course of the trip that he or she cannot manage independently, is documented in the comprehensive care plan;

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

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

a. Laundering the participant's personal clothing items, towels, and bedding;

b. Light cleaning limited to the participant's bedroom, bathroom, and mobility and medical devices;

c. When the participant lives alone, light cleaning of the kitchen and entry way areas, in order to maintain a safe environment;

d. Errands for necessary tasks identified in the comprehensive care plan; and

e. Preparing non-communal meals and snacks, unless for multiple CFI participants, including cleaning the food preparation area after the food is served.

(c) Personal care services shall not be covered:

(1) For the purpose of transportation;

(2) For the purposes of food preparation for meals and snacks provided to both the participant and non-participants;

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

a. A residential care facility;

b. A hospital;

c. A nursing facility;

d. A rehabilitation facility;

e. An adult family care home; and

f. An adult medical day program; and

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

a. The participant's personal care services representative, designated in accordance with (d) and (e) below;

b. The participant's designated power of attorney, regardless of whether the power of attorney has been activated; or

c. The participant's legal guardian.

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

(1) To direct the personal care services being provided; and

(2) Under the following conditions:

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

1. The personal care worker providing services;

2. The participant's case manager; and

3. Anyone having a financial relationship with any agency providing personal care services or intermediary services, as defined in RSA 161-I: VII, to the participant;

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

1. The PCS representative's role applies only to decisions made regarding the personal care services described in this section;

2. The appointment of a PCS representative may be revoked by the participant at any time; and

3. The responsibilities of the PCS representative shall be to:

(i) At a minimum, have weekly face-to-face contact with the participant and the personal care worker;

(ii) At a minimum, have monthly contact with the participant's case manager concerning personal care services;

(iii) Ensure that the personal care worker is taking the participant's care preferences into consideration; and

(iv) Communicate concerns or satisfaction to the provider agency that employs that personal care worker; and

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

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

(1) Notify the provider agency in writing of the PCS representative's name and scope of authority; and

(2) Notify the provider agency in writing of any changes in representation within 30 days of the date that the change occurs.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.23 Personal Emergency Response Systems Services.

(a) "Personal emergency response system" means a communication service providing socially isolated participants with 24-hour direct access to a medical control center through an electronic device which allows the participant to alert the control center in the case of an emergency.

(b) Personal emergency response systems shall be a covered service for participants who:

(1) Live alone, live only with someone in poor or failing health, or who are alone at home for greater than 4 hours each day;

(2) Are one of the following:

a. Are ambulatory and have been identified as being at risk of falls after an assessment of fall risk by a registered nurse or occupational or physical therapist; or

b. Have been identified as being at risk of having a medical emergency in the clinical eligibility determination or by a primary care practitioner, registered nurse, or occupational therapist; and

(3) Would require ongoing supervision if the personal emergency response system were not provided.

(c) Personal emergency response systems shall not be covered separately when provided to a participant receiving residential care services or adult family care services.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.24 Residential Care Services.

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

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

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

(2) Twenty-four hour per day supervision; and

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

a. Emergency transportation;

b. Transportation more than once per week; or

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

(c) The services described in (b) above shall be included in a per diem rate, established by the department in accordance with RSA 161:4, VI(a), and shall not be reimbursed as a separately covered service when provided in a residential care setting.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.25 Respite Care Services.

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

(1) A Medicaid-enrolled nursing facility, licensed in accordance with RSA 151:2 and He-P 803;

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

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

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

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

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

(b) Respite care services shall be:

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

(2) Limited to a maximum number of units not to exceed 20 24-hour days per state fiscal year.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.26 Skilled Nursing Services.

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

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

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

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

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

(3) At a residential care facility.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.27 Specialized Medical Equipment Services.

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

(1) A NH Medicaid-enrolled licensed practitioner or physical or occupational therapist has determined the clinical need for one or more of the items in (b) below;

(2) The participant's case manager has requested prior authorization for the item in accordance with (c) below;

(3) BEAS has provided the prior authorization for the item; and

(4) The service is completed by a NH enrolled Medicaid provider.

(b) Covered specialized medical equipment services shall include the following durable medical equipment items:

(1) Raised toilet seats;

(2) Shower/tub seats and benches;

(3) Tub lifts;

(4) Transfer benches;

(5) Bedside commodes;

(6) Dressing aids and grabbers;

(7) Non-slip grippers to pick up and reach items;

(8) Adaptive utensils;

(9) Transport wheelchairs;

(10) Wheelchair cushions;

(11) Walkers;

(12) Hoyer lifts;

(13) Slings;

(14) Semi-electric beds;

(15) Bed rails;

(16) Mattress overlay pads;

(17) Seat lifts, including the chair, or seat lift mechanisms when the following criteria are met:

a. The participant meets the following criteria:

1. Has a severe condition that causes the participant to require assistance to come to a standing position; and

2. Is completely incapable of standing up from a regular armchair or any chair in their home; and

b. The participant's attending physician, or a consulting physician treating the participant for the disease or condition resulting in the need for a seat lift, documents that the seat lift mechanism is a part of the physician's course of treatment to provide support for a condition that is not likely to improve and that may worsen; and

(18) Medication dispensing devices, including training on their use, when the following conditions are met:

a. The participant or caregiver is able to use the device;

b. The participant does not live in a licensed facility;

c. When the use of this service is documented to either:

1. Replace another service of equal or greater cost; or

2. Avoid the addition of another service; and

d. The type of device is determined by the BEAS nurse to be the least costly device that is appropriate for the participant.

(c) The participant's case manager shall submit the following when requesting prior authorization for specialized medical equipment:

(1) A completed Form 3715, “Choices for Independence Prior Authorization Request Form” (4/2011);

(2) A copy of the evaluation in (a)(1) above that describes:

a. The medical or functional need for the equipment;

b. The description and any measurements required for the equipment; and

c. The proposed training plan for the client and caregiver to ensure safe use of the equipment;

(3) Proposals from at least 2 enrolled providers, except that one proposal may be submitted with a written explanation of why only one proposal is available or appropriate, including the following, as applicable to the equipment:

a. A list of supplies and materials; and

b. A description, including measurements, of the equipment; and

(4) If a participant prefers one bid over the other(s), then an explanation of the preference.

(d) Specialized medical equipment services shall not be covered separately for participants receiving residential care services.

(e) Payment for specialized medical equipment shall:

(1) Be for the most cost-effective item, as identified by the department, that would effectively meet the participant’s needs; and

(2) Not exceed the participant lifetime limit specified in the HCBC-CFI waiver approved by the Centers for Medicare and Medicaid Services.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.28 Supportive Housing Services.

(a) Supportive housing services shall be covered when provided by a home health care providers licensed in accordance with RSA 151:2 and He-P 809 and when provided to participants who live in federally subsidized individual apartments.

(b) The following supportive housing services shall be covered:

(1) Personal care services, as described in He-E 801.22;

(2) Assistance with activities of daily living;

(3) Assistance with the following activities:

a. Making telephone calls; and

b. Obtaining and keeping appointments;

(4) Home health aide services;

(5) Homemaker services, as described in He-E 801.20;

(6) Personal emergency response services; and

(7) Medication reminders and other supportive activities as specified in the comprehensive care plan or which promote and support health and wellness, dignity and autonomy within a community setting.

(c) The services described in (b) above shall be included in a per diem rate, established by the department in accordance with RSA 161:4, VI(a), and shall not be reimbursed as a separately covered service when provided in a supportive housing setting.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.29 Provider Participation.

(a) Each participating provider shall:

(1) Be enrolled in NH Medicaid as a CFI provider; and

(2) Meet the applicable licensing, certification, or other requirements of the specific service they provide, such as a contract with the bureau.

(b) Each participating provider shall:

(1) Create and maintain an individual care plan for each participant served in accordance with He-E 801.30(a);

(2) Create and maintain other documentation in accordance with He-E 801.30;

(3) Submit claims for payment in accordance with He-E 801.31;

(4) Provide services in accordance with He-E 801.12 through He-E 801.28, as applicable; and

(5) Be subject to monitoring by the department.

(c) Each participating provider shall comply with the provisions of RSA 161-F:49 with regard to checking the names of prospective or current employees, volunteers or subcontractors against the BEAS state registry.

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.30 Required Documentation.

(a) Each participating provider, with exceptions noted in (b) below, shall develop, maintain, and implement a written care plan as follows:

(1) The care plan shall be developed in consultation with the participant and the participant's legal representative, if any;

(2) The provider shall communicate with the participant's case manager in order to ensure the care plan is consistent with and addresses the applicable service needs identified in the comprehensive care plan;

(3) The care plan shall contain, at a minimum:

a. A description of the participant's needs and the scope of services to be provided;

b. The dates upon which services will begin and end;

c. The frequency of the services;

d. The total number of service units authorized and the number that will be provided on each date of service;

e. Information on the participant's health condition, medications, allergies, and special dietary needs as it relates to the provision of the service; and

f. The anticipated goals and outcomes of service provision;

(4) The care plan shall be updated at least annually and as necessary; and

(5) The provider shall communicate the elements of the care plan to the participant's case manager, upon the completion or revision of the plan, and document the date it was communicated.

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

(1) Environmental accessibility adaptations;

(2) Home-delivered meals services;

(3) Non-medical transportation services;

(4) Personal emergency response system services;

(5) Specialized medical equipment services; and

(c) Each participating provider shall:

(1) Maintain documentation in accordance with applicable licensure, certification or other requirements;

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

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

(d) In addition to (c) above, documentation of personal care services shall include verification of the personal care services worker's time, including, when paper timesheets are used, the signature of the participant or PCS representative indicating that the service was provided in accordance with the care plan and to the participant's satisfaction.

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

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.31 Payment for Services.

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

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

(c) Providers shall not bill the participant if Medicaid does not pay due to billing practices of the provider which result in non-payment for a Medicaid item, supply, or service.

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.32 Utilization Review and Control. The department shall monitor utilization of CFI services in accordance with 42 CFR 455, 42 CFR 456, He-W 520, and He-E 801.

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.33 Third Party Liability.

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

(b) Providers shall determine if third party liability exists and file a claim with the third party before billing Medicaid.

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

Source. (See Revision Note at part heading for He-E 801) #9969, eff 8-8-11

He-E 801.34 Waivers

(a) An applicant, case manager, provider agency, individual, or guardian, may request a waiver of specific procedures outlined in He-E 801 using the form titled “NH Bureau of Elderly and Adult Services Waiver Request.” (August 2018) The case management agency or provider agency shall submit the request in writing to (c) below.

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

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

(2) The case manager and provider agency executive director or designee recommending approval of the waiver.

(c) A waiver request shall be submitted to:

Bureau of Elderly and Adult Services
Hugh J. Gallen State Office Park
105 Pleasant Street, Main Building
Concord, NH 03301

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

(e) The request for a waiver shall be granted by the commissioner within 30 calendar days if the alternative proposed by the requesting entity meets the objective or intent of the rule, and it:

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

(2) Does not affect the quality of services provided to individuals; and

(3) All required criminal records checks have been completed no earlier than a year before the date of the waiver request; and

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

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

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

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

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

Source. #12610, eff 8-23-18