Updated 1.21.2018: DHHS Waiver Comparison DD, ABD, IHS, CFI and Medicaid State Plan LTSS Services					
	Home and Community Based Services for individuals with developmental disabilities (HCBS-DD)	**Home and Community Based Services for individuals with acquired brain disorders (HCBS-ABD)**	**Home and Community Based Services for children with developmental disabilities: (HCBS-IHS) In Home Supports**	**Home and Community Based Services _ Choices for Independence (HCBS-CFI)**	***State Plan Medicaid Services and supports that may be available to Medicaid Eligible Individuals with or without a waiver**
State Policy and Rules	• CHAPTER 171-A-SERVICES FOR THE DEVELOPMENTALLY DISABLED • CHAPTER He-M 500 DEVELOPMENTAL SERVICES • CHAPTER 137-K - BRAIN AND SPINAL CORD INJURIES			• PART He-E 801 CHOICES FOR INDEPENDENCE PROGRAM • CHAPTER 151-E LONG-TERM CARE	CHAPTER He-W 500 MEDICAL ASSISTANCE
Target Population:	Individuals with developmental disabilities as defined in State rule He-M 503.	Individuals with acquired brain disorders as defined in State rule He-M 522.	Children up to age 21 with developmental disabilities living at home with their families as defined in State rule He-M 524.	Adults who: meet the clinical standards for nursing facility (NF) services found in RSA 151-E: 3; meet the financial standards for community based care; and who can be cost-effectively served in the community.	Individuals who meet the technical and categorical requirements of the program.
Age Requirement	Eligible at any age for family support. May receive Residential/Personal Care Services, Supported Employment, or Day services on or after age 21.	Initial eligibility must occur between ages 22 and 60.	Children up to age 21.	Age 18 and over.	* All ages and diagnoses in the state, if eligible and with prior authorization.
HCBS Eligibility Criteria:	• Must be found by an Area Agency to have a developmental disability defined in He-M 503. • Must meet the NH Medicaid financial categorical/medical requirements of APTD, ANB, HC-CSD, OAA, MEAD or NHHPP-M standard plan (by DDU). • BDS determines HCBS eligibility based upon ICF/ID LOC.	• Must be found to have an acquired brain disorder by an Area Agency as defined in He-M 522. • Must meet the NH Medicaid financial categorical/medical requirements of APTD, ANB, HC-CSD, OAA, MEAD or NHHPP-M standard plan (by DDU). • BDS determines HCBS eligibility based upon Skilled Nursing Facility LOC.	• Must meet the NH Medicaid financial categorical/medical requirements of APTD, ANB, HC-CSD, OAA or MEAD determined by the DDU. • BDS determines HCBS eligibility based upon ICF/ID LOC • Families must be willing to self-direct.	• Must meet the NH Medicaid categorical requirements of APTD, OAA (Old Age Assistance), or ANB (Aid to the Needy Blind), MEAD, or NHHPP-M standard plan (by DDU). • Long Term Care Medical determines clinical eligibility • Must require waiver services to avoid institutional placement.	
Disability Definition	• The individual must have a disability due to an intellectual disability, cerebral palsy, epilepsy, autism, or learning disability closely related to an intellectual disability, which has its onset prior to age 22. • Individual must be found to have a developmental disability by an Area Agency. • Individual would require ICF/ID services, needing daily assistance for: ➢ Activities of daily living; ➢ Intellectual, physical, sensorimotor, psychological, emotional development and well-being; ➢ Medication administration, medical monitoring, nursing care; or	• Between the ages of 22 and 60, an individual must have a non-congenital brain or nervous system disorder presenting severe and life-long disabling condition due to: physical trauma; infectious disease (meningitis); brain tumor, intracranial surgery, or cerebral vascular disease (stroke); demyelinating or inflammatory disease (multiple sclerosis); toxic metabolic disorder (anoxia); or other related neurological disorder (Huntington's disease). • Individuals must be found to have an acquired brain disorder by an Area Agency. Individuals would require Skilled Nursing Facility (SNF) or Specialized Rehabilitative Services, needing daily assistance for:	• The individual must have a disability due to an intellectual disability, cerebral palsy, epilepsy, autism, or learning disability closely related to an intellectual disability, which has its onset prior to age 22. • Individual must be found to have a developmental disability by the Area Agency. • Individual would require ICF/ID services, needing daily assistance for: ➢ Activities of daily living; ➢ Intellectual, physical, sensorimotor, psychological, emotional development and well-being; or ➢ Medication administration, medical monitoring, nursing care; or	Registered nurses appropriately trained and employed by DHHS, or a designee acting on behalf of DHHS determine clinical eligibility for NF care. The clinical standard is that the person requires 24-hour care for one or more of the following purposes: (1) Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services; (2) Restorative nursing or rehabilitative care with patient-specific goals;	

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Disability Definition (cont)	➢ Services on a less than daily basis as part of a planned transition or to prevent circumstances that could necessitate more intrusive and costly services; and has a combination of 2 or more individual factors or a combination of one individual factor and one parent factor which complicate care of the individual or impede the ability of the care giving parent to provide care.	➢ Activities of daily living; ➢ Intellectual, physical, sensorimotor, psychological, emotional rehabilitation and well-being; ➢ Medication administration, ➢ Medical monitoring, ➢ Nursing care; or ➢ Special dietary needs.	➢ Services on a less than daily basis as part of a planned transition or to prevent circumstances that could necessitate more intrusive and costly services; and has a combination of 2 or more individual factors or a combination of one individual factor and one parent factor which complicate care of the individual or impede the ability of the care giving parent to provide care.	(3) 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 (4) Both: • Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence; and • For whom appropriate community services are available within the cost control requirements of RSA 151-E: 11.	
NH Medicaid Financial Eligibility:	**See DHHS, Division of Family Assistance (DFA) Program Fact Sheet for detailed information. Go to link and find the document under Policy/Guidelines: http://www.dhhs.nh.gov/dfa/publications.htm** **Link to: NH Medicaid State Plan Brochure**				

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Standard of Need (SON)	• $764/month for individuals in independent living. • $826/ for an individual living in a He-M 1001 Certified Staffed Residence, or He-M 521 Certified Family Setting, or He-M 525 Family Setting with a residential service. • $944/month for an individual living in a He-M 1001 Certified Enhanced Family Care Residence or He-M 525 Certified Enhanced Family Care Residence.	For ABD the SON applies for those who reside in homes owned and/or operated by providers unrelated to the individual by ancestry, marriage, or other legal arrangement; 300% of SSI, or $2,250/month	$2,250/month for individuals in family homes.	$2,250 maintenance allowance	
Payments required by waiver participants for their Room & Board	• $678/month for individuals in a He-M 1001 Certified Staffed Residences, He-M 521 Certified Family Setting, or He-M 525 Family Setting with a residential service. • $796/month for individuals in He-M 1001 Certified Enhanced Family Care Residences or He-M 525 Certified Enhanced Family Care Residences	• $678/month for individuals in a He-M 1001 Certified Staffed Residences, He-M 521 Certified Family Setting, or He-M 525 Family Setting with a residential service. • $796/month for individuals in He-M 1001 Certified Enhanced Family Care Residences or He-M 525 Certified Enhanced Family Care Residences	• N/A	Participants who live in residential care settings certified under He-P 804 retain $70/month and are responsible to pay room and board in accordance with the established rate of the setting.	
Personal Needs Allowance (PNA)	$148/month for individuals receiving BDS HCBS Waiver Services.	$148/month for individuals receiving BDS HCBS Waiver Services.	• N/A	$70/month for participants living in settings licensed under He-P 804.	
Prior Authorization Process (PA)	• All services and payments must be prior authorized by BDS. • **Initial authorization - A**rea Agencies submit to BDS: ♦ BDS Functional Screen Form ♦ Service Agreement/ISP (Individualized Service Plan) or IFSP ♦ Individualized Budget; ♦ Assessments (e.g., psychological) • **Reauthorization -** Area Agencies submit to BDS: ♦ BDS Functional Screen Form ♦ Service Agreement/ISP or IFSP	• All services and payments must be prior authorized by BDS. • **Initial authorization -** Area Agencies submit to BDS: ♦ BDS Functional Screen Form ♦ Service Agreement/ISP ♦ Individualized Budget; ♦ Assessments (e.g., psychological) • **Reauthorization -** Area Agencies submit to BDS: ♦ BDS Functional Screen Form ♦ Service Agreement/ISP	• All services and payments must be prior authorized by BDS. • **Initial authorization -** Area Agencies submit to BDS: ♦ BDS Functional Screen Form ♦ Service Agreement/ISP; ♦ Individualized Budget; ♦ Assessments (e.g., psychological) • **Reauthorization -** Area Agencies submit to BDS: • BDS Functional Screen Form • Service Agreement/ISP; • Individualized Budget	• Upon Acceptance, a skilled medical professional employed or contracted by DHHS approves a set of preliminary services that address the participant's identified needs. • Case managers and participants identify service needs & sends request to Long Term Care Medical, who authorizes all services. • For special medical equipment or home modification, estimates are required from two potential registered providers of the service. These are sent to long Term Care Medical, who	

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				reviews and determines appropriate request to meet the participant's needs.	

Covered Services	• Assistive Technology Support Services;
	• Case Management/Service Coordination
	• Community Participation Services (Day Services), Levels 1 –6;
	• Community Support Services;
	• Crisis Response;
	• Environmental and Vehicle Modifications;
	• Medical/Behavioral Respite Care;
	• Participant Directed and Managed Services (PDMS)
	• Personal Care Services/Residential, Levels 1-7;
	• Respite Care Services;
	• Specialty Services, Levels 1 & 2 Assessments/Consults; HRST;
	• START Services, Levels 1&2; Assessment/Consults; Center Stays;
	• Supported Employment Services, Levels 1-3; and
	• Wellness Coaching
		• Assistive Technology Support Services;
		• Case Management/Service Coordination
		• Community Participation Services (Day Services), Levels 1 –6;
		• Community Support Services
		• Crisis Response;
		• Environmental and Vehicle Modifications;
		• Medical/Behavioral Respite Care;
		• Participant Directed and Managed Services (PDMS)
		• Personal Care Services/Residential, Levels 1-7;
		• Respite Care Services;
		• Specialty Services, Levels 1 & 2 Assessments/Consults; HRST;
		• START Services, Levels 1&2; Assessment/Consults; Center Stays; and
		• Supported Employment Services, Levels 1-3
			• Participant Directed and Managed Services (exclusively Participant Directed) may include any or all of the following:
			  • Consultative Services;
			  • Environmental and Vehicle Modifications;
			  • Family Support Service Coordination;
			  • Enhanced Personal Care; and
			  • Respite
				• Adult Medical Day Services
				• Home Health Aide
				• Homemaker
				• Personal Care
				• Respite
				• Supported Employment
				• Financial Management Services
				• Adult Family Care
				• Adult In-Home Services
				• Community transition services
				• Environmental accessibility services
				• Home-Delivered Meals
				• Non-Medical Transportation
				• Participant Directed and Managed Services
				• Personal Emergency Response System
				• Residential Care Facility Services
				• Residential Care Facility Services Skilled Nursing
				• Specialized Medical Equipment Services
				• Supportive Housing Services
					Link to:
					NH Medicaid State Plan Brochure
					• Adult Medical Day;
					• Durable Medical Equipment.
					• Home Health Aide acute only);
					• Hospice;
					• Incontinence products;
					• Medical Transportation;
					• Medications; and
					• Nursing (acute only);
					• Personal Care Attendant Services (PCA);
					• Private Duty Nursing;
					• PT/OT/Speech/Respirator;
					• Targeted Case Management

Examples of Covered and Non-Covered Services	• Social, recreation, and employment related transportation and supports **are covered** when approved in the support plan. • Provider Networks and provider reimbursement may be different across the waivers. • Family members can provide some services but not all. • Case Management/Service Coordination is a waiver service. • Participant Directed and Managed, individual or family budgets are allowed.			• Case management and medical transportation are state plan services. • Non-medical transportation is specific to identified tasks/accompaniment needs; Transportation to social, education, recreation, and employment activities is non-covered. Services are not intended to provide 24/7 support.	• Medical Transportation is covered • Pers Emerg Response coverage is a **non-covered** service .

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Provider Qualifications:	• Area Agency must be an enrolled provider with NH Medicaid. • Residential (He-M 1001, He-M 521, and He-M 525) and Community Participation/Day (He-M 507) service settings require annual state certification and or licensing. • Individual providers must meet the requirements specified for each of the service components described appropriate rules such as: He-M 506, 507, 517, 521, 522, 525 and 1001.	• Area Agency must be an enrolled provider with NH Medicaid. • Residential (He-M 1001, He-M 521, and He-M 525) and Community Participation/Day (He-M 507) service settings require annual state certification and or licensing. • Individual providers must meet the requirements specified for each of the service components described appropriate rules such as: He-M 506, 507, 517, 521, 522, 525 and 1001.	• Area Agency must be an enrolled provider with NH Medicaid. • Individual providers must meet the requirements specified for each of the service components as described in He-M 506, 510, 513, and 517.	• Must be enrolled Medicaid HCBS/CFI provider. • Licensed and certified as required by State Plan or approved waiver.	
Service Plan:	• An annual Service Agreement/Individual Service Plan (ISP) is developed by the service coordinator, individual, guardian and other members of the individual's team. • The Service Agreement specifies types, amount, frequency, and duration of services and identifies the service provider(s). • The Service Agreement is signed/approved by the individual and or guardian and the Area Agency Executive Director or designee.	• An annual Service Agreement/Individual Service Plan (ISP) is developed by the service coordinator, individual, guardian and other members of the individual's team. • The Service Agreement specifies types, amount, frequency, and duration of services and identifies the service provider(s). • The Service Agreement is signed/approved by the individual and or guardian and the Area Agency Executive Director or designee.	• An annual Service Agreement/Individual Service Plan (ISP) is developed by the service coordinator, individual, guardian and other members of the individual's team. • The Service Agreement specifies types, amount, frequency, and duration of services and identifies the service provider(s). • The Service Agreement is signed/approved by the individual and or guardian and the Area Agency Executive Director or designee.	• The Comprehensive Care Plan (CCP) is developed collaboratively by the participant and case manager, based on needs identified during the clinical assessment. • The CCP specifies types of service, and their amount, & the provider(s). • The participant or guardian signs the CCP. • The case manager enters information about the selected services and providers into the Options information system for RN approval. Once approved, Options sends authorizations to the MMIS, which notifies providers and pays accordingly.	

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Updated 1.21.18 NON-MEDICAID SOCIAL SERVICES: CHAPTER He-E 500		
Program	**Older Americans Act Title III Services**	**Social Services Block Grant (Title XX (SSBG))**
Overview	Enacted in 1965, the Older Americans Act (OAA) provides essential services to our most vulnerable seniors. OAA is Federal funding for range of home and community services that primarily assist people age 60 and older in their homes. Services are considered "safety net"; to promote and support independent living and prevent/delay nursing home placement. No income eligibility requirements but services must be targeted to individuals most economically and socially disadvantaged. Many individuals served are just above financial eligibility for Medicaid. Individuals accessing these services cannot already be receiving the same or duplicate services from another program such as a Medicaid waiver program or certain Veteran Benefits.	The Social Services Block Grant (SSBG) is funded under Title XX of the Social Security Act and provides home and community-based services targeting elderly (age 60 and older) and younger adults between age 18 and 60 who have a chronic illness or disability. SSBG services, also known as Title XX services, are provided to promote independence, prevent unnecessary institutionalization and protect individuals from abuse, neglect and exploitation. Individuals accessing these services cannot already be receiving the same or duplicate services from another program such as a Medicaid waiver program or certain Veteran Benefits.
Target Popul ation:	Individuals who are age 60 and older in accordance with Rule He-E 502	Adults with disabilities and Older adults in accordance with Rule He-E 501.05
Eligibility	• Be 60 years of age or older, except as specified in He-E 502.29(c)(1)-(4) Nutrition Services: Congregate Meals and He-E 502.30(c)(1)-(3) Nutrition Services: Home Delivered Meals; • Adult day program services shall not be available to anyone: ○ Who resides in a nursing facility or other licensed or certified facility; ○ Who receives adult family care services pursuant to He-E 801.14; ○ Whose needs cannot be met by the adult day program; or ○ Who is primarily seeking services to support needs related to a diagnosis of mental illness or developmental disability. • Eligible individuals seeking Transportation for the following: ○ Title III services, except home delivered meals; ○ Medical appointments; ○ Shopping for groceries and other basic needs; and ○ Services provided by community settings and agencies that increase participation in programs, and otherwise promote independent living as specified in the individual's person-centered plan. • Reside in an independent living situation, or be expected to transition to an independent living situation prior to the initiation of services, with the exception of legal services; and • **Not already be receiving the same or duplicate services from another program such as a Medicaid waiver program.**	• Elderly (age 60 and older) and younger adults between age 18 and 60 who have a chronic illness or disability. • Reside in or be expected to reside in an independent living situation, as defined by He-E • 501.02(v); • As determined by the assessment described in He-E 501.05(b), be in need of the requested SSBG service in order to maintain the health and safety of an individual. • **Not already be receiving the same or duplicate services from another program such as a Medicaid waiver program.** • Have a monthly income which does not exceed $1218* per month, based on the sources of income specified in He-E 501.06, and: ○ The income of each individual, including spouses, is considered separately; and ○ SSBG services shall be provided without regard to income if the service(s) are provided during or after a protective investigation conducted by BEAS in accordance with RSA 161-F: 42-57. **In accordance with state law, the SSBG income limit increases in January of each calendar year, concurrent with the annual Social Security cost of living increase (COLA). Before each annual increase becomes effective, BEAS provides written notification on the increase to BEAS staff, SSBG providers and ServiceLink staff.*
Covered Services	• Adult Day Non-Medical Services; • Adult Day Program Services; • Congregate Meals; • Family Caregiver Support • Home Health Aide; • Home-Delivered Meals; • In-Home Services: homemaker, home health aide and nursing; • Prevention/Wellness Programs • Transportation;	• Adult Day Non-Medical Services; • Adult Day Program Services; • Adult In-Home Care; • Essential Services (Chore, Emergency Support, Respite); • Home-Delivered Meals; and • Homemaker Services.
HOW ARE THESE SERVICES ACCESSED: DHHS contracts with local agencies to provide 1 or more of the services listed under Title III and Title XX. You can visit the ServiceLink website at: servicelink.nh.gov and go to the Search for Services Page http://www.referweb.net/nhsl/. (Ex.search for Title XX under agency or program name) or you can contact a local ServiceLink who has access to the listing of local providers contracted to provide title III services. Call ServiceLink at 1-866-634-9412 or find a local ServiceLink: http://www.servicelink.nh.gov/locator/index.htm		

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