

Waiver Comparison Category	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 (HCBC-CFI)
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.
Age Requirement	Eligible at any age. May receive Residential/Personal Care Services 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.
HCBC Eligibility Criteria:	<ul style="list-style-type: none"> • Must be found by an Area Agency to be developmentally disabled. • Must meet the NH Medicaid financial categorical/medical requirements of APTD, ANB, HC-CSD, OAA or MEAD (by DDU). • BDS determines ICF/MR LOC 	<ul style="list-style-type: none"> • Must be found to have an acquired brain disorder by an Area Agency. • Must meet the NH Medicaid financial categorical/medical requirements of APTD, ANB, HC-CSD, OAA or MEAD (by DDU). • BDS determines ICF/MR LOC. 	<ul style="list-style-type: none"> • Must meet the NH Medicaid financial categorical/medical requirements of APTD, ANB, HC-CSD, OAA or MEAD determined by the DDU. • BDS determines ICF/MR LOC. 	<ul style="list-style-type: none"> • Must meet the NH Medicaid categorical requirements of APTD, OAA (Old Age Assistance), or ANB (Aid to the Needy Blind), MEAD. • Long Term Care Medical determines clinical eligibility • Must require waiver services to avoid institutional placement.
Disability Definition	<ul style="list-style-type: none"> • The individual must have a disability due to mental retardation, cerebral palsy, epilepsy, autism, or learning disability closely related to mental retardation 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/MR services, needing daily assistance for: <ul style="list-style-type: none"> ➢ activities of daily living; ➢ intellectual, physical, sensorimotor, psychological, emotional development and well-being; ➢ medication administration, medical monitoring, nursing care; or ➢ special dietary needs. 	<ul style="list-style-type: none"> • 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: 	<ul style="list-style-type: none"> • Prior to age 22, individual must have disability due to mental retardation, cerebral palsy, epilepsy, autism, or learning disability closely related to mental retardation. • Individual must be found to have a developmental disability by the Area Agency. • Individual would require ICF/MR services, needing daily assistance for: <ul style="list-style-type: none"> ➢ activities of daily living; ➢ intellectual, physical, sensorimotor, psychological, emotional development and well-being; or ➢ medication administration, medical monitoring, nursing care; or 	<p>Clinical eligibility for NF care is determined by registered nurses appropriately trained and employed by DHHS, or a designee acting on behalf of DHHS. The clinical standard is that the person requires 24-hour care for one or more of the following purposes:</p> <ol style="list-style-type: none"> (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)		<ul style="list-style-type: none"> ➤ activities of daily living; ➤ intellectual, physical, sensorimotor, psychological, emotional rehabilitation and well-being; ➤ medication administration, ➤ medical monitoring, ➤ nursing care; or ➤ special dietary needs. 	<ul style="list-style-type: none"> ➤ 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. 	<p>(3) Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding treatment of recent or unstable conditions requiring medical or nursing intervention; or</p> <p>(4) Both:</p> <ul style="list-style-type: none"> • Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence; <u>and</u> • For whom appropriate community services are available within the cost control requirements of RSA 151-E:11.
NH Medicaid Financial Eligibility:	<ul style="list-style-type: none"> • <u>Medical Assistance-Categorically Needy with Financial Assistance (State Supplement):</u> <ul style="list-style-type: none"> • Resources \$1,500 or less. • Monthly income less than the Standard of Need (SON). • <u>Medical Assistance-Categorically Needy:</u> <ul style="list-style-type: none"> • Resources \$1,500 or less. • Max gross income/mo \$2,2,199 • Cost of Care payment when net income exceeds monthly Standard of Need (SON). • <u>Medical Assistance---Medically Needy:</u> <ul style="list-style-type: none"> • Resource limit: \$2,500 • Net income compared to Protected Income Limit (PIL) \$591.00 	<ul style="list-style-type: none"> • <u>Medical Assistance-Categorically Needy with Financial Assistance (State Supplement):</u> <ul style="list-style-type: none"> • Resources \$1,500 or less. • Monthly income less than the Standard of Need (SON). • <u>Medical Assistance-Categorically Needy:</u> <ul style="list-style-type: none"> • Resources \$1,500 or less. • Max gross income/mo \$2,199. • Cost of Care payment when net income exceeds monthly Standard of Need (SON). • <u>Medical Assistance---Medically Needy:</u> <ul style="list-style-type: none"> • Resource limit: \$2,500 • Net income compared to PIL \$591.00 	<ul style="list-style-type: none"> • <u>Medical Assistance-Categorically Needy with Financial Assistance (State Supplement):</u> <ul style="list-style-type: none"> • Resources \$1,500 or less. • Monthly income less than the Standard of Need (SON). • <u>Medical Assistance-Categorically Needy:</u> <ul style="list-style-type: none"> • Resources \$1,500 or less. • Max gross income/mo \$2,199 • Cost of Care payment when net income exceeds monthly Standard of Need (SON). • <u>Medical Assistance---Medically Needy:</u> <ul style="list-style-type: none"> • Resource limit: \$2,500 minus • Net income compared to PIL \$591.00 	<ul style="list-style-type: none"> • <u>Medical Assistance-Categorically Needy:</u> <ul style="list-style-type: none"> • Resource limits \$1,500. • Max gross income/mo \$2,199. • <u>Medical Assistance Medically Needy:</u> <ul style="list-style-type: none"> • Resource limit: \$2,500 • Net income compared to PIL \$591.00. • Person spends down to \$591 before Medicaid eligibility starts.

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Standard of Need (SON)	<ul style="list-style-type: none"> • \$747/month for individuals in independent living situations. • \$797/month for individuals in certified staffed residences (He-M 1001) or family homes (He-M 521). • \$927/month for individuals in He-M 1001 cert Enhanced Family Care (EFC). 	<ul style="list-style-type: none"> • \$747/month for individuals in independent living situations. • \$797/month for individuals in cert'd staffed residences (He-M 1001) or fam. homes (He-M 521). • \$927/month for individuals in He-M 1001 cert Enhanced Family Care (EFC). • \$2,199/month for individuals who live independently or with their family. 	<ul style="list-style-type: none"> • \$2,199/month for individuals in family homes. 	<ul style="list-style-type: none"> • \$2,199 maintenance allowance
Payments required by waiver participants for their Room & Board	<ul style="list-style-type: none"> • \$649/month for individuals in staffed, He-M 521, or He-M 525 residences. • \$767/month for individuals in EFC. 	<ul style="list-style-type: none"> • \$649/month for individuals in staffed, He-M 521, or He-M 525 residences. • \$767/month for individuals in EFC. 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • Participants who live in residential care facilities retain \$70/month and pay the remainder of their income to the providers for room and board.
Personal Needs Allowance (PNA)	<ul style="list-style-type: none"> • \$148/month for individuals living in certified residences. 	<ul style="list-style-type: none"> • \$148/month for individuals living in certified residences. 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • \$70/month for participants living in licensed facilities.
Prior Authorization Process (PA)	<ul style="list-style-type: none"> • All services and payments must be prior authorized by BDS. • Initial authorization - Area Agencies submit to BDS: <ul style="list-style-type: none"> ◆ BDS Functional Screen Form ◆ Service Agreement/ISP (Individualized Service Plan) or IFSP ◆ Individualized Budget; ◆ Assessments (e.g., psychological) • Reauthorization - Area Agencies submit to BDS: <ul style="list-style-type: none"> ◆ BDS Functional Screen Form ◆ Service Agreement/ISP or IFSP 	<ul style="list-style-type: none"> • All services and payments must be prior authorized by BDS. • Initial authorization - Area Agencies submit to BDS: <ul style="list-style-type: none"> ◆ BDS Functional Screen Form ◆ Service Agreement/ISP ◆ Individualized Budget; ◆ Assessments (e.g., psychological) • Reauthorization - Area Agencies submit to BDS: <ul style="list-style-type: none"> ◆ BDS Functional Screen Form ◆ Service Agreement/ISP 	<ul style="list-style-type: none"> • All services and payments must be prior authorized by BDS. • Initial authorization - Area Agencies submit to BDS: <ul style="list-style-type: none"> ◆ BDS Functional Screen Form ◆ Service Agreement/ISP; ◆ Individualized Budget; ◆ Assessments (e.g., psychological) • Reauthorization - Area Agencies submit to BDS: <ul style="list-style-type: none"> ◆ BDS Functional Screen Form ◆ Service Agreement/ISP; ◆ Individualized Budget 	<ul style="list-style-type: none"> • 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 reviews and determines appropriate request to meet the participant's needs.

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Covered Services	<ul style="list-style-type: none"> • Case Management/Service Coordination • Case Management and Advocacy; • Day Habilitation Srvc, Lvl 1 –4; • Supported Employment Services, Levels 1 & 2; • Personal Care Services/Residential, Levels 1-6; • Respite Care Services; • Medical/Behavioral Respite Care; • Crisis Response; • Community Support Services; • Assistive Technology Support Services; • Environmental Modifications; • Specialty Services, Levels 1 & 2; • Consolidated DD Services (Consumer Directed Services). 	<ul style="list-style-type: none"> • Case Management/Service Coordination • Case Management and Advocacy; • Day Habilitation Srvc, Lvl 1 –4; • Supported Employment Services, Levels 1 & 2; • Personal Care Services/Residential, Levels 1-6; • Respite Care Services; • Medical/Behavioral Respite Care; • Crisis Response; • Community Support Services; • Assistive Technology Support Services; • Environmental Modifications; • Specialty Services, Levels 1 & 2; • Consolidated ABD Services (Consumer Directed Services). 	<ul style="list-style-type: none"> • Consolidated Developmental Service (exclusively Consumer Directed) may include any or all of the following: <ul style="list-style-type: none"> • Family Support Service Coordination; • Personal Care; • Consultative Services; • Respite; • Home and Vehicle Modifications; and • Fiscal Intermediary Services. 	<ul style="list-style-type: none"> • Home Health Aide; • Homemaker; • Adult Medical Day; • Respite Care; • Pers Emerg Response Syst; • Nursing (non-acute); • Personal Care Service Provider consumer or agency directed; • Environmental Modification; • Special Medical Equipment • Residential Care; • Adult Family Care; • Kinship Care • Home Delivered Meals; • Medication Delivery systems; <p>Case Management is provided to every participant as a State Plan service.</p>
Provider Qualifications:	<ul style="list-style-type: none"> • Area Agency must be an enrolled provider with NH Medicaid. • Residential (He-M 1001, He-M 521) and 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, and 1001. 	<ul style="list-style-type: none"> • Area Agency must be an enrolled provider with NH Medicaid. • Residential (He-M 1001, He-M 521) and 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, and 1001. 	<ul style="list-style-type: none"> • 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, 513, and 517. 	<ul style="list-style-type: none"> • Must be enrolled Medicaid HCBC/CFI provider. • Licensed and certified as required by State Plan or approved waiver.

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Service Planning Process:	<ul style="list-style-type: none"> • 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, 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. 	<ul style="list-style-type: none"> • 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, 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 	<ul style="list-style-type: none"> • 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, 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 staff designee 	<ul style="list-style-type: none"> • 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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Quality Reviews:	<ul style="list-style-type: none"> • Monthly contacts with the individual, guardian and providers by the service coordinator to ensure satisfaction with service provision. • On at least a quarterly basis documentation identifying whether the services match the interests and needs of the individual; meet with the individual’s satisfaction; and meet the terms of the service agreement of IFSP. • Annual certification reviews. • Annual Adult Outcome reviews of 10% of waiver service recipients is conducted by BDS in collaboration with the Area Agencies. • The BDS evaluates the Area Agencies’ performance regarding their compliance with program rules. 	<ul style="list-style-type: none"> • Monthly contacts with the individual, guardian and providers by the service coordinator to ensure satisfaction with service provision. • Annual certification reviews. • Annual Adult Outcome reviews of 10% of waiver recipients is conducted by BDS in collaboration with the Area Agencies. • The BDS evaluates the Area Agencies’ performance regarding their compliance with program rules. 	<ul style="list-style-type: none"> • On monthly basis the Area Agency visits or has verbal contact with the individual and family or providers responsible for direct provision of services and documents the visit or contact; provides the family with a report indicating: <ul style="list-style-type: none"> ◆ Budget approved for the authorization period; ◆ Expenditures; and ◆ Amount remaining in the budget; and ◆ Provides the family with a feedback form that the family can complete and return to the Area Agency, indicating its level of satisfaction and concerns, if any, regarding the in-home services. • At least quarterly, the designated Area Agency staff visits the individual and his/her family at home, to determine and document whether the services: match the interests, needs, competencies of the individual; meet the individual’s environmental and personal safety needs; are being provided in accordance with the terms of the service agreement and established contracts; and whether the individual/family are satisfied. • The BDS conducts annual family satisfaction and consumer outcome surveys to determine the level of quality and individual and family satisfaction with supports provided. • The BDS evaluates the Area Agencies’ performance regarding compliance with program rules. 	<ul style="list-style-type: none"> • 100% annual review of needs by Long Term Care Medical RN. • Comprehensive Care Plan is reviewed monthly and as needed by case manger and participant.
<p>* All HCBS waivers are mutually exclusive.</p>				