

New Hampshire Department of Health and Human Services [DHHS]

Bureau of Developmental Services [BDS]

Responses to Public Comments on New Hampshire Draft Developmental Disabilities Home and Community Based Services [ABD] Waiver

HCBS Waiver Public Comment Period: May 31, 2016 – July 12, 2016

COMMENT 1:

One commenter noted that there are a number of changes in Appendix B and requested information about the reasons for and implications of the changes.

RESPONSE 1:

Changes in Appendix B relate to the eligibility groups covered under NH's Medicaid State Plan, inclusion of the NH Health Protection Program new adult group and information regarding post eligibility treatment of income to comply with requirements of the Affordable Care Act. In addition, this section includes information regarding application of the spousal impoverishment rules to married applicants seeking home and community based services under 1915c Waivers.

COMMENT 2:

One commenter noted information in Appendix C-1/C-3 regarding Day Habilitation appears to relate to Personal Care Services.

RESPONSE 2:

Thank you for this observation; this has been corrected.

COMMENT 3:

One commenter noted that the service definition for Assistive Technology did not appear Appendix C and asked if this service was being eliminated.

RESPONSE 3:

Thank you for this observation; Assistive Technology is not being eliminated and will continue to be offered in the ABD Waiver.

COMMENT 4:

A commenter noted that in the Service Definition section for Specialty Services, there appears to be information about PDMS.

RESPONSE 4:

Thank you for this observation.

COMMENT 5:

A commenter indicated that under the Service Definition section for Wellness Coaching, the first sentence reads: “Wellness Coaching: Plan, direct, coach and mentor individuals with disabilities in integrated exercise activities based on a licensed healthcare practitioner’s recommendation.” The commenter asked for a definition for “integrated exercise activities”. Specifically, clarification is requested for the word ‘integrated.’ Should the wording be more akin to “exercise activities in an integrated setting?” Please clarify.

RESPONSE 5:

All services provided under the ABD waiver are subject to the requirements of the CMS 1915 C regulations which require that individuals receive integrated services in the community to the same degree of access as individuals not receiving Medicaid home and community based services.

COMMENT 6:

One commenter asked the Department to add flexibility to the caps identified in the section on additional limits on amount of Waiver Services.

RESPONSE 6:

The Department appreciates this input and has added qualifying language for a number of capped services indicating that the BDS will consider increasing certain caps based on the recommendation of a licensed professional, the recommendation of the Area Agency and the availability of funds.

COMMENT 7:

One commenter observed that under the section on Service Plan Implementation and Monitoring, the first radio button was meant to be selected: “Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.”

RESPONSE 7:

The selection “Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant” has been selected.

COMMENT 8:

A commenter noted that the last sentence in Appendix E: Participant Direction of Services: E-1: Overview (1 of 13) is not complete. “Individualized budgets are created for all individuals in order that...”

RESPONSE 8:

The sentence should read “Individualized budgets are created for all individuals.” This has been corrected

COMMENT 9:

A commenter expressed concerns over the wording under “Opportunities for Participant” where in one section it is stated that “If a participant has not fully utilized the allocated funding for two consecutive years, the Area Agency must discuss and initiate with the participant and family, a reduction to the total allocated budget.” The concerns with this wording are related to potential adverse impact on individuals. For example, if a family lost a staff person in the last 2 months of the year and then they are unable to hire someone until the third month of the following year, both years would have an unspent portion of the budget that is needed in full in the following year. The commenter recommends having a threshold that would automatically trigger a discussion, for example, 6% underspend for 2 consecutive years and where a reduction is warranted by circumstance that will occur. It’s also very important to keep in mind that historically, some degree of unspent budgets has been critical to how the system is structured and enabled to manage temporary crises that don’t rise to the level of being able to receive advanced annualized crisis funding.

RESPONSE 9:

Your concern is appreciated and this section has been reworded and now reads:

The Area Agency ensures that the funds budgeted for an individual are appropriately and fully utilized by the individual. The area agency, in collaboration with its Board of Directors and Family Support Council, will develop policies and procedures that articulate how the funding allocated to each individual will be monitored to ensure that funds are appropriately and fully utilized in order to avoid waste in HCBS-ABD services. These policies and procedures must articulate how the area agency will work with the individual and family to make budgetary adjustments if a participant has not fully utilized the allocated funding.

COMMENT 10:

A commenter pointed out that within the Medication Management and Administration there is no mention of NUR 404. The commenter explained that currently, He-M 525 allows for the use of NUR 404 or NUR1201 to oversee medication management and administration. For clarity purposes, please include a reference to NUR404 and indicate that this option will be available in situations where it is appropriate.

RESPONSE 10:

This section now reads, in part, “Area Agencies and vendor agencies through their State designated nurse trainers in conjunction with State Administrative Rule He-M 1201: Administration of Medications or under certain circumstances, State Administrative Rule NUR 404, Delegation of Medication Administration.”

COMMENT 11:

A commenter pointed out that in the current waiver the billing and claims section describes in detail the process by which highly individualized funding/budget arrangements drive the cost determination of services delivered to waiver participants. In the proposed draft, there is no mention made of individual budgets. It suggests that the rates which have been in effect since 2007 will continue to be used as the baseline going forward and an adjustment process is described at a

very high level in which adjustments will be made to a base rate “using a combination of... indices and factors as applicable & necessary.’ The outcome is intended to “provide fair and equal compensation for comparable service delivery...”

RESPONSE 11:

That is correct.

COMMENT 12:

Does the state intend to eliminate individual budgets as we currently have in place?

RESPONSE 12:

It is not designed to change the current service delivery system.

COMMENT 13:

Given that the 2007 waiver service rates is stated to be the baseline moving forward is it the intent of the State to continue not to increase this baseline and, if so, CSNI would like to highlight the impact of having sub-market rates moving forward on the ability to secure workforce needed to implement services.

RESPONSE 13:

2007 will be the baseline for the July 1, 2017 rate setting. These July 1, 2017 rates set will be the baseline for the next biennium’s rate setting process.

COMMENT 14:

Commenters requested a more detailed description of the rate process. With the current high level description that references the application of indices and factors “as necessary,” the impact to current rates and, subsequently, service delivery cannot be determined. It was requested that the analysis of the impact of the rate methodology change on rates as well as a more detailed description of specifically how indices and factors will be applied to the base rate be made public. It was also requested that to protect the individuals currently in our system, the following wording be added: “In order to protect the current level of service delivery received by individuals, no loss to revenue to individual budgets will occur upon implementation of the new methodology.” Additionally, it was suggested that a staged transition roll-out could be utilized to mitigate any unintended consequences with the new methodology. A transparent and fair process for designing the rate methodology process into which the providers have input was recommended.

RESPONSE 14:

Rate Setting Methodology –

- It is a method used to set rates for services provided by the department under the NH Acquired Brain Disorder (ABD) Waiver to individuals who meet the relevant institutional Level of Care, specifically, Specialized Nursing Home.
- It is not designed to change the current service delivery system.

Baseline Rates - Those in effect on July 1, 2017 (which are the ones that have been in effect since 2007)

- The market basket used will be for FFY17
- The department will not use the market basket from each FFY since 2007 and grow it to July 2017.

Rate Setting Frequency – once a biennium at the beginning of the biennium. For the upcoming SFY18-19 biennium rate setting will be for July 1, 2017. The next rate setting will take place July 1, 2019.

Indices & Factors:

Market Basket - CMS Home Health Agency PPS Market Basket Update. This is the market basket category closest to the home and community based services that are provided under the Acquired Brain Disorder Waiver.

“Health Risk Screening Tool (HRST)” [See He-M 503.02] means the 2015 edition of the Health Risk Screening tool, which is a web-based rating instrument used for performing health risk screenings on individuals in order to:

- (1) Determine an individual’s vulnerability regarding potential health risks; and
- (2) Enable the early identification of health issues and monitoring of health needs.

“Supports Intensity Scale (SIS)” [See He-M 503.02] means the 2004 edition of the Supports Intensity Scale, which is an assessment tool intended to assist in service planning by measuring the individual’s support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The tool uses a formal rating scale to identify the type of supports needed, frequency of supports needed, and daily support time.

Access and Availability Adjustment – Could include, but not limited to, national/regional/statewide consumer price index statistics.

COMMENT 15:

Please describe what the criteria are for fair and equitable compensation?

RESPONSE 15:

Rates are based on access to care and services provided. The rates are related to services not specific providers.

COMMENT 16:

A commenter requested clarification on the basis for “comparable service delivery,” specifically; to what will the rates be compared?

RESPONSE 16:

There are many things we will consider when deciding on a “comparable service delivery” which could include, but not limited to national/regional/statewide consumer price index statistics.

COMMENT 17:

A commenter noted in the current waiver the costs for Factor D from year 1 through year 5 are:

1. \$98,723.70
2. \$98,839.00
3. \$99,233.80
4. \$99,648.83
5. \$99,854.26

RESPONSE 17:

That is correct.

COMMENT 18:

The commenter pointed to the new waiver draft, and indicated the costs for Factor D from year 1 through year 5 (listed below). The commenter requested clarification on why the numbers from the previous waiver differ from the numbers in the waiver renewal.

1. \$85,083.44
2. \$85,176.67
3. \$85,266.76
4. \$85,353.87
5. \$85,389.98

RESPONSE 18:

Per request at the public hearing on July 8, 2016, the Department has reviewed the methodology used to produce the above ABD Waiver draft Factor D for year 1 through year 5. In addition, the Department reviewed the methodology used to develop the current ABD Waiver. During this review, the Department developed a methodology, to project expenditures and unduplicated clients, using actual federal claiming and budgeted state fiscal year (SFY) date. This new methodology updated the costs for Factor D to be \$84,942.00 for year 1 through year 5. The methodology is described below:

1. The historical data used is actual federal claiming for ABD Waiver expenditures and unduplicated participants as reported on the Federal 372 report for years 2012, 2013, 2014 & 2015.
2. An average percent growth of the percent growths per year, for the four (4) years listed in #1 above, on unduplicated participants was calculated.
3. The base year for unduplicated participants and cost per person is state fiscal year (SFY) 2017 as developed during the SFY2016-2017 biennium budget.
4. The cost per person is projected to be unchanged for the ABD Waiver years 1 through 5.
5. The unduplicated participants from #3 above are 292. This number is grown by 4% each year. How this percentage was derived is described in #2 above.
6. The cost per person is then multiplied by the calculated number of unduplicated participants to determine the projected total expenditures for the ABD Waiver year 1 through year 5.

COMMENT 19:

A commenter noted that year 1 of the new waiver draft relative to year 5 of the current waiver represents a **14.8% DECREASE** in costs once this waiver draft takes effect. Additionally, the numbers for years 1-5 for Factor D', Factor G and Factor G' are the exact same as the current waiver. Year 1 of the new waiver draft relative to year 5 of the current waiver represents a **9.4% DECREASE** in costs once this waiver draft takes effect. Additionally, in **J-2: Derivation of Estimates (3 of 9)** it states that the Factors D, D' and G' were obtained from MMIS for the period ending June 30, 2015. Given acknowledged cost trends the above decreases would not be possible. The commenter asked that the Department explain the basis for and intent behind the dramatic reduction in costs for this waiver submission.

RESPONSE 19:

In the Department's review, as explained in Response 8 above, there was an estimated average 13% less actual services provided and claimed vs. current ABD Waiver projected costs per person for years 2012 through 2015.

The base or budgeted SFY17 cost per person represents an increase of 1% over actual 2015 cost per person. The methodology used to determine the ABD Waiver draft Factor D for year 1 through year 5 is explained in Response 8 above.

COMMENT 20:

The Brain Injury Association strongly supports the Departments recommendations in the 2016 ABD Waiver renewal dealing with spousal impoverishment being taken into account in considering ABD Waiver eligibility and the allowance for spouses to be paid as caregivers.

The New Hampshire brain injury community looks forward to the approval of the ABD Waiver renewal by CMS. The ABD Waiver continues to be one of the best resources available in our state to help survivors of brain injury live in their own home and community settings.

RESPONSE 20:

The Department thanks you for this feedback and support.