

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 [HCBS] Waiver

HCBS Waiver Public Comment Period: March 30, 2016 – April 29, 2016

COMMENT 1:

Will the Department of Health and Human Services [DHHS] publish a side by side comparison to the existing waiver and the changes in the new waiver?

RESPONSE 1:

No. DHHS does not intend to publish a side by side comparison.

COMMENT 2:

Please go over the major changes in waiver document.

RESPONSE 2:

The three major changes are as follows:

- Ensuring compliance with CMS regulations governing Home and Community Based Care Services published in January 2014.
- Rate Setting Methodology
- Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers published in March 2014

COMMENT 3:

When will the rate setting framework be developed?

RESPONSE 3:

A skeleton has been developed and will require feedback from the Centers for Medicare and Medicaid Services [CMS] and stakeholders to finalize.

COMMENT 4:

Who has final authority on the allocation of unspent funds? Does the Area Agency, family, or someone else have the final say?

RESPONSE 4:

DHHS has the final authority regarding use of Medicaid Home and Community Based Services [HCBS] funds.

COMMENT 5:

Can you explain the assessments identified in the Waiver document?

RESPONSE 5:

The Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST) and Risk Assessments are examples of the types of assessments identified in the Waiver document. Individual and family preferences, along with the results of assessments, contribute to the Person Centered Planning process.

COMMENT 6:

Regarding the Rate Setting Methodology: In the market basket, how did you select Home Health Agency for this population?

RESPONSE 6:

Please be assured that we are not asking providers to be Home Health Agencies. It was the best choice in the market basket for a comparable framework. It allows the best alignment with CMS expectations.

COMMENT 7:

Can you explain the access and availability adjustment?

RESPONSE 7:

CMS is stressing that we look at regional areas to ensure access to services.

COMMENT 8:

Is it possible that you will pay more in areas where it is hard to find providers?

RESPONSE 8:

That is a consideration.

COMMENT 9:

Is it the Department's intent to do away with individual budgets as we currently understand them?

RESPONSE 9:

No. It is not the Department's intent to change the requirement for individualized budgets.

COMMENT 10:

Can you explain fair and equitable compensation?

RESPONSE 10:

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

COMMENT 11:

There are currently different rates for different services. Will the rate setting process be the same?

RESPONSE 11:

Yes.

COMMENT 12:

Is there an analysis available that compares the current reimbursement process with changes in rate setting?

RESPONSE 12:

Please see response to comment number 27.

COMMENT 13:

Do you know where we can find the market basket rates from 2007 in order to compare inflation rates since then?

RESPONSE 13:

They have moved recently. Using Google may be helpful.

The market basket the department will use to calculate July 1, 2017 rates will be for FFY17. The department will not use the market basket from each FFY since 2007 to grow the rates to July 2017.

COMMENT 14:

If you are required to go to cost reporting then it was asked that it comes 6 months after audit to minimize impact.

RESPONSE 14:

This request will be considered.

COMMENT 15:

Regarding level of care: What is meant by intermediate care facility [ICF] level required for waiver services?

RESPONSE 15:

Individuals wishing to access HCBS-DD Waiver services must meet the same level of care as individuals who wish to access care from an intermediate care facility. Information about ICF level of care can be found at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/institutional-care/intermediate-care-facilities-for-individuals-with-intellectual-disabilities-icfid.html>

COMMENT 16:

CMS has a work group on Performance Measures. The final report recommendations may have significant impact on performance. Will there be clarifications or performance related changes? Was the interim report considered in this waiver renewal? In the event that there are additional requirements or recommendations in the final report expected in September, will they be taken into consideration?

RESPONSE 16:

The Department is in regular contact with CMS regarding Waiver expectations, including those related to Waiver performance measures. Prospective changes in Waiver Performance Measure requirements are not contemplated in this Waiver renewal; however, in the event that changes in expectations are articulated by CMS, the Department will amend the Waiver accordingly. The Department is interested in hearing from stakeholders regarding additional Performance Measures that should be considered.

COMMENT 17:

Where can more information be found on the cost neutrality factor calculation?

RESPONSE 17:

Information about the cost neutrality calculation can be found in the CMS Application for a 1915c Home and Community-Based Waiver Instructions, Technical Guide and Review Criteria, Release Date: January 2015.

COMMENT 18:

Did the cost neutrality factor calculation change in January?

RESPONSE 18:

No.

COMMENT 19:

Regarding Appendix B-2: Individual Cost Limit (1 of 2).a: Historically, the radio button labeled “No Cost Limit” has been selected. In this draft “Institutional Cost Limit” has been selected.

RESPONSE 19:

This button was selected in the Waiver renewal draft posted for public review in error. This has been corrected in the DD Waiver renewal submitted to CMS to reflect that there is no cost limit.

COMMENT 20:

Regarding Appendix C-4: Participant Services: Additional limits on amount of Waiver Services: Limits of set (s) of services: This section states “BDS has implemented service caps in certain areas including assistive technology, therapeutic recreation, e mod, consults, etc. The purpose for these service limits is to preserve the use of DD Waiver for personal care, community support services, SEP. CSNI understands and support this. However, there were only two categories, transportation and electronic devices, where there was a statement that BDS would consider additional funds. In all the other categories nothing was noted. We ask that BDS consider requests for exceeding the service caps for transportation and electronic devices as well. Does this mean if a family truly wanted to make a case, say for increased therapeutic recreation, they would appeal the ISA? The broader issue perhaps is where did the cap limits come from and are they the right caps, given the high cost of some of these categories?

RESPONSE 20:

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 21:

Regarding Appendix D-2B: Participant Services: Service Plan Development Safeguards: Monitoring Safeguards: In this section, the first option has been checked. CSNI recommends that the relevant section from HE-M503 be cited here to make clear that this provision applies only to individuals (i.e., service coordinators and not entities (i.e., area agencies).

RESPONSE 21:

This suggestion is appreciated; however, when this option is checked, the Waiver application does not allow for additional information to be entered.

COMMENT 22:

Regarding Appendix E-1B: Participant Direction of Services: Overview (1 of 13): Last sentence in top section is not complete. “Individualized budgets are created for all individuals in order that...” Please share the complete sentence.

RESPONSE 22:

This sentence has been corrected and now reads: “Individualized budgets are created for all individuals”.

COMMENT 23:

Regarding Appendix E-2: Opportunities for Participant –Direction (6 of 6): This section states: “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.” CSNI has concerns with this wording as it could have significant 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.

CSNI concurs with and supports the notion that a review is needed and a discussion needs to take place, but to stipulate that a reduction must occur does not take into account the complexity of the potential circumstances. CSNI 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 23:

This recommendation is appreciated. The wording in the section has been changed to: “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-DD 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 24:

Regarding Appendix G-3: Medication Management and Administration (1 of 2): Within this section there is no mention of NUR 404. 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 24:

A reference to delegation according to State Administrative Rule NUR 404, when appropriate, has been added in this section.

COMMENT 25:

Regarding Appendix I-2: Rates, Billing and Claims (1 of 3).a: In the current waiver this 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:

No mention is 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.

An adjustment process is described at a very high level which is intended to “provide fair and equal compensation for comparable service delivery...”

RESPONSE 25:

That is correct.

COMMENT 26:

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 26:

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 27:

We would like to review a more detailed description of the rate process. With the current high level description the impact to current service delivery cannot be determined. Would you please make public your analysis of the impact of the rate methodology change? We cannot endorse this draft until such information is provided to help us better understand and analyze the proposal. We would also request 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 will occur upon implementation of the new methodology.”

RESPONSE 27:

Rate Setting Methodology –

- It is a method used to set rates for services provided by the department under the NH Developmental Disabled Waiver to individuals who meet the relevant institutional Level of Care, specifically, ICF/ID: Intermediate Care Facility for the Intellectually Disabled.
- The new rate setting methodology which now includes an opportunity to consider regional impact has been designed to hopefully better support the 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 so 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 (individually or in combination as is applicable and necessary):

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 Developmental Disabled 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 28:

Please describe the basis for “comparable service delivery,” i.e. to what will the rates be compared?

RESPONSE 28:

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

COMMENT 29:

The public comments are due by April 29 and waiver application is due by August. Will there be additional dialogue between DHHS and stakeholders before submission?

RESPONSE 29:

Final submission of the DD Waiver renewal is due to CMS no later than May 31, 2017. All comments and questions received during the public input process will be addressed in writing and included in the waiver application to CMS. Changes based on public comment will be made as appropriate. Comments can be submitted via a dedicated email address: BKSQualityCouncil@dhhs.state.nh.us or US Postal Service to Maureen DiTomaso at NH DHHS.

COMMENT 30:

Regarding State Transition Plan Assessment of Service Environments: State funding guidelines regarding individual budgets and caps in which provider agencies must operate should be analyzed and considered as part of the waiver review process.

RESPONSE 30:

Thank you for this recommendation.

COMMENT 31:

Regarding CMS Regulations and Opportunities: The definition for each existing service area should be revisited and amended best practice. The definition for each existing service area should be amended to ensure best practice. For example, Supported Employment should be changed or expanded to include Customized Employment consistent with industry best practice and New Hampshire's Interdepartmental MOU related to WIOA.

New services should be considered under existing services. Supported Living Models should be included as one of these new services offered to individuals that require this type of support. Transportation services should be added as to increase opportunity and success in other service areas (e.g. Employment).

The State should consider a waiver -funded housing plan service for families interested in developing non-traditional affordable housing plan for their family member while they are still living at home. This would be in the State's best interest to partner with families to ensure that any such housing meets the HCBS regulatory requirements thereby protecting the State's ability to fund future services using Waiver dollars. Further, by linking this service to the Case Management system, conflicts of interest would be avoided and efficiencies would be achieved.

To the best of our knowledge, no crosswalk was conducted nor was public input requested or provided related to the new service opportunities that exist given the new CMS regulations.

Measures are now required on "choice of waiver services and providers" verses "institutional and community". How does the State intend to monitor and report on choice?

Presently the State requires the Area Agencies to be the provider of last resort. This occurs when the Area Agency is unable to obtain proposals from vendor or provider agencies. Unfortunately this occurs on an ever increasing basis for a variety of reasons. Likewise, the current system fails to ensure Free Choice of Provider as outlined on page 7 item E.

RESPONSE 31:

The Department appreciates these observations. A reference to Customized Employment as well as the development of integrated microenterprises has been added to the service definition for Supported Employment. Likewise, transportation is incorporated in relevant service definitions to ensure that individuals have the transportation necessary to access the service[s] they are receiving.

With regard to housing supports, the Department appreciates the challenges faced by individuals with regard to affordable housing and is currently actively participating in Technical Assistance supported by CMS in this area.

Regarding freedom of choice, each Waiver participant is afforded choice of service provider(s). An individual/guardian may choose any willing, qualified provider and new providers may be added at the request of an individual/guardian so long as that provider is qualified. The Department will monitor compliance with this performance measure through on-site service review/record review audits.

COMMENT 32:

Regarding System Capacity:

- Fiscal guidelines such as DSP wages and the current Room and Board issues pose considerable barriers to service delivery. BDS budgeting guidelines have not increased since SFY 2009 when the legislature provided a 2% increase. This update should include recognition of the CMS Market Baskets which could be used as a standard for annual COLA's to ensure they do not become so outdated again.
- The quality of services has suffered due to high turnover rates and the inability to recruit new employees due to low wages. With the current unemployment rate in NH being at 2.6%, there are increased opportunities in other fields with greater pay and benefits.
- An overall workforce development plan is needed to ensure stability, capability and service quality. The State needs to ensure that the various fiscal guidelines, such as those contained in this Waiver Renewal Application provide appropriate pay in recognition of the duties and responsibilities along with the skills and abilities required to ensure quality services.
- Recognize DSP's professional credentials in the funding guidelines. If a person has completed one of the higher education professional education programs provide, allow for an adjustment in their pay. Some people want to remain DSPs throughout their career. The fiscal guidelines should allow for when an agency is able to assign a staff member with greater credentials and experience. A 2014/2015 survey of 355 DSPs found 60% are over the age of 40 and 45% are dependent upon a second job income and their greatest challenge was inadequate pay.
- System capacity issues are not addressed or spoken to as part of this waiver application.

RESPONSE 32:

The Department appreciates these observations. The importance of adequate Direct Support Professional wages will be considered when the Department makes its request for funding for the upcoming biennium. While the Department recognizes the difficulty of securing affordable housing for individuals, the issue of allowing Room and Board expenses in HCBS budgets, not appropriately offset, is a federal HCBS expectation. As noted previously, the Department is currently actively participating in Technical Assistance supported by CMS in this area.

COMMENT 33:

I would like to see the waiver embrace and fund opportunities for individuals on the waiver to participate in researched based physical fitness activities to improve their health outcomes. Given the mortality rate of the population and the associative personal costs and fiscal impact of poor health outcomes, more activity needs to be focused on how to change that dynamic. Attached is a proposal that outlines our current thinking to impact our client base and to create an evidence based model implement within the system. Thank you for your consideration.

RESPONSE 33:

Thank you for this recommendation. In response to this suggestion a service category of “Wellness Coaching” has been added to the menu of HCBS-DD Waiver services.

COMMENT 34:

Rather than renewal, an extension should be requested and granted to provide time to address and complete a variety of core service systems plans to ensure that a clear vision exists for the 5 year span of the waiver.

RESPONSE 34:

The Department is committed to working with its stakeholders to address core service system issues and welcomes the opportunity to participate in the development of a formal vision statement for the next five years.

COMMENT 35:

Regarding State Transition Plan assessment of service environments:

While the State Transition Plan (STP) has been published, the findings of the environmental assessments have not. As such, a variety of considerations have not been made, nor do we know the scope of the corrective action. For example, if corrective action requires major housing renovations the Consolidated State Housing Plan does not recognize a housing need for people with developmental disabilities. As such, no federal housing funds could be accessed to assist in this effort thereby requiring the use of pure state dollars for financing.

The rush to publish and submit the Waiver Renewal Application rather than requesting an extension in order to consider all the factors and findings related to the STP assessment leaves gaps in the overall planning and review process.

STP Assessment findings related to Choice, Individual Rights and Quality will need to be considered as part of each provider’s corrective action plan. Absent this information it is unclear as to the impact in numerous areas and how these may influence areas that should be considered as a part of this waiver renewal.

Likewise, state funding guidelines in which providers must operate may prove to be a factor. Given the service providers' repeated concerns expressed about the state guidelines and caps in the related individual budget categories these finding should be analyzed and considered as part of the State's Waiver review and submission.

Quality of environment and relationships between new quality indicators and those contained in the Waiver may generate the need to consider added issues which the State may choose to monitor through the quality council.

RESPONSE 35:

Thank you for these observations. With regard to the Statewide Transition Plan, The Statewide Transition Plan will work in concert with each of New Hampshire's 1915(c) waivers. The opportunity to amend a 1915(c) as needed, for whatever reason, remains available to the state, should that need arise pending new information that may become available at future dates. The ultimate date for compliance with the settings regulations is 2019, providing more than enough time to collect and respond to any new information that comes to light.

COMMENT 36:

Community Inclusion and Choice are cornerstones for the new CMS HCBS regulations and historically NH has been known for being progressive in these areas. As such, it would have been useful to have provided the opportunity to have open discussions to explore and consider new innovations within the service industry, best practices, and various existing systems/service challenges to facilitate the intended maturation/evolution of New Hampshire's service system.

Such an effort would provide the opportunity to consider these issues in the light of day with other systemic changes such as those related to the implementation of WIOA, HUD Policies and funding changes(and the need for affordable housing) and the ABLE Act just to name a few.

RESPONSE 36:

As noted previously, the Department welcomes the opportunity to collaborate in the development of a formal vision statement for the next five years.

COMMENT 37:

Regarding The State of New Hampshire Health and Human Services Bureau of Developmental Services LBA Audit and the need for IT infrastructure improvements, February, 2016. Corrective action effort is currently underway and will require a focused effort to properly complete. The technology infrastructure is inadequate to properly support current operations. There is no fully integrated IT system which results in the use of segregated systems with some submissions still being submitted via mail. This slows the process as well as impacting upon service provision. As such, the waiver application should be accompanied with an IT Plan that facilitates the operation of an efficient, person-centered, data driven, timely, quality service system.

The only efficient manner in which the various Waiver Assurances and Sub-Assurance can be met and facilitate a person centered driven system is to establish an appropriate technology infrastructure which supports all the partners in the service process.

The State should access the funding available through CMS to create such a system. This could be accomplished through a phased in process utilizing the Area Agency system to pilot the system prior to full implementation.

RESPONSE 37:

Thank you for these observations. The Department recently initiated an in depth assessment of BDS/Area Agency IT systems. The Department is also finalizing work on a web-based, assessment informed Service Agreement [Person Centered Planning] template and electronic individualized budget template, both of which have been piloted by Area Agencies. In addition, the BDS is engaged in a Lean analysis in collaboration with the 10 Area Agencies of all prior authorization and budget tracking processes to ensure the most effective and efficient approaches.

COMMENT 38:

Regarding Managed Care Plans:

A Plan does not exist to phase in the legislatively enacted managed care system. As such, the method by which the State would plan to meet various assurances and sub-assurances may (and most certainly would) drastically change.

Years ago New Hampshire passed legislation related to converting DHHS BDS services including those funded through this Waiver Application to a Managed Care service delivery system; as of yet the roles and vision for this MCO service system have not yet been defined. Nor has it been determined, or communicated, who is responsible for the various sub-assurances contained within this Waiver Application. In fact, the vision for Area Agencies is unclear at best. When such a major void in vision of a service system exists, roles become confused, quality suffers and chaos ensues.

The waiver application places responsibilities to parties under the current system but fails to identify who will assume the responsibility to the monitoring and reporting of these sub-assurances under a managed care system which could be implemented within 6 months after this waiver takes effect.

Once again, the rate setting system should be examined to ensure that quality standards and the intent of the waiver can be achieved under the goals set for New Hampshire's' MCOs. Area Agencies that met with representatives of the MCOs were advised that the fiscal goal was to cut 17%. This was unrealistic at best and demonstrated that MCOs had failed to complete their due diligence to ensure rates were adequate to meet the specified goal.

RESPONSE 38:

The state of New Hampshire will ensure that all of the legal instruments governing Medicaid managed care and its 1915(c) waivers will comply with federal requirements related to any health care initiatives it undertakes.