

He-E 801 Subcommittee
New Hampshire Medical Care Advisory Committee
March 14, 2011

At its January meeting, the Medical Care Advisory Committee (MCAC) empanelled a subcommittee on He-E 801, a rule governing the Choices for Independence home and community-based long-term care program. Subcommittee members reviewed the proposed 27-page rule, catalogued member findings, and over 100 comments and questions were submitted to the New Hampshire Department of Health and Human Services (DHHS). Two meetings were held with the Department. The Department was in agreement with some recommendations and, in turn, provided revisions to the rule, the latest revision dated March 1, 2011. The He-E 801 Subcommittee expresses its appreciation to the Department, particularly Susan Lombard and Michael Holt, for their assistance and patience. We also respectfully submit the following findings and recommendations to the Medical Care Advisory Committee, relative to those issues upon which the Department and the Subcommittee did not agree.

Finding 1: Process for person-centered care plan development not clear.

Recommend: The Department amend the rule to clearly describe care plan development, as well as the relationship between each “plan” in the process, from the “long term care service plan” developed by a BEAS nurse to the “comprehensive care plan” developed by a case manager (in accordance with He-E 805) to an individual provider care plan.

The relationship between the long term care service plan and the comprehensive care plan is especially not clear. The Department defines the “long term care service plan” as follows:

A list of health and supportive care services which:

- (1) Is determined by the registered nurse employed or designated by the bureau;
- (2) Is based on the participant’s needs as identified in the medical assessment process;
- (3) Specifies the services and their frequency, duration and scope of the CFI services to be provided to the participant; and
- (4) Authorizes reimbursement to service providers.

Problematically, the term is then not used anywhere in the rule, nor is it used in the case management rule, He-E 805.

Moreover, the participant’s access to a “person-centered” planning process is vague, at best. NH RSA 151-E gives each CFI participant the right to a “person-centered” support planning process. This means that the CFI participant is at the core of the planning process and identifies his or her preferences, strengths, capacities, needs, and desired outcomes or goals. The Department explained that the person-centered process occurs during the development of the comprehensive care plan, with the case manager. However, as the rule is written now, it can only be concluded that the BEAS nurse, who may never even meet the participant, identifies the participant’s needs and outcomes, specifying the services the participant will receive, including frequency, duration and scope. The Subcommittee would like to believe this is not the intent and asks for clarification; the transition to and the relationship between all three plans should be clear, including the person-centered process.

The Subcommittee recommends that the development of a care plan always be done in a face-to-face meeting with the participant and through a person-centered process. This should include an opportunity for the participant to express his choice of services, while still giving the BEAS nurse or case manager the opportunity to ensure a cost-effective plan and sufficient risk management. Further, it

would seem that if the person-centered process occurs via the case management process, there is no need for the process to be duplicated by the BEAS nurse.

Finding 2: Fair hearing rights inconsistent within CFI rules and between Medicaid rules Department-wide.

The Subcommittee recommends that the Department adopt uniform rules on fair hearing rights under Medicaid. The rules should include all applicable elements of federal Medicaid law. Any element unique to the service coverage or eligibility determination could be added, as needed.

Notice Requirements

BEAS initially proposed adoption of fair hearing notice and appeal rights that the Subcommittee believed were not clearly consistent with federal law. Through the revision process those provisions were improved. However, while fair hearing standards are clearly articulated relative to *eligibility* in the CFI rules, they are not and should be relative to CFI *service* denials.

The Subcommittee would also note that this is not an issue unique to BEAS. A cursory review of the He-W 500 rules shows a consistent inconsistency in establishing fair hearing rules, including, for example, at least ten different versions of the provision describing the notice. (See Attachment A.) One rule goes so far as to offer only an opportunity for reconsideration by the Department, rather than a fair hearing. It would seem easiest to adopt a uniform standard Department-wide that clearly implements the federal language.

Measuring the Response Request Time

BEAS proposes the recipient respond to service or eligibility denials within 10 or 30 days of the date of the notice. Unfortunately, CFI recipients report the Department mailing the fair hearing notices several days after the date on the notice, leaving the respondent a challengingly short response time, especially when only given a 10 day response period. The Subcommittee initially recommended adoption of commercial standards, the time period beginning at receipt of the notice. The Department rejected that recommendation. The Subcommittee now recommends adoption of the language of federal law, the time period beginning at the date of the mailing.

Length of Response Request Time

Currently, if a participant's CFI eligibility is terminated the participant is given 60 days before service coverage ends. The rule now before the MCAC allocates only 30 days. Given the challenge of establishing long-term care services or of moving to a new setting, the Subcommittee recommends maintaining the 60-day window and to do so from the date of the *final* decision, if the termination is appealed.

Finding 3. Inappropriate use of acute care standards for long-term care eligibility or service coverage. Significant Change in Condition

The Subcommittee recommends that the term "significant change in condition" be redefined or left undefined.

In the proposed rule He-E 801.06, an applicant may request reconsideration of an eligibility denial if there is new evidence not submitted in the application process or if there is a "significant change in condition." The latter standard is defined this way:

He-E 801.06(b): "Significant change in condition" means a decline in an applicant's condition that would not normally resolve itself without ongoing

intervention by licensed medical providers and that impacts more than one area of the applicant’s physical functioning or structure.

The Department explained the origin of the standard as a Medicare standard. While the Subcommittee attempted to better understand the term in context, it could not readily locate the definition in Medicare statute or regulation. The Subcommittee concludes that the standard is not clear, not related to the eligibility standards in RSA 151-E:3, and an acute-care standard calling for a condition that may be “resolved” rather than a long-term care standard wherein many conditions are never resolved.

Seat Lift Coverage

The Subcommittee recommends the Department include the coverage of a chair with the coverage of the seat lift described in He-E 801.25. While the Subcommittee is appreciative of the Department accepting the subcommittee recommendation to include coverage of lift, the standard (below) would likely be of little value to the average CFI participant.

As shown in the table below, the proposed He-E 801 standard is effectively a Medicare standard, although the Department adds that the person must be “*completely* incapable of standing up from a regular armchair or any chair in their home” and “once standing, the participant is able to walk.” First, it is unlikely that the proposed acute care standard is appropriate to many long-term care recipients. For the frail elder, for example, arthritis or neuromuscular disease may not be the cause of the frailty. It is also likely that a physician may not view the seat lift as a mechanism “to effect improvement or arrest or retard deterioration;” instead, it provides support for a condition not likely to improve and a condition that may worsen. Second, the Medicaid-eligible individual is at a poverty level that makes a seat lift mechanism without the seat (chair) essentially useless.

Coverage Standards, Seat Lift: Proposed He-E 801.25 (rev. Feb. 18, 2011) and Medicare.

Proposed He-E 801.25	Medicare
<p>(b) Covered specialized medical equipment services shall include the following durable and non-durable medical equipment items:</p> <p>(6) Lift chairs as follows:</p> <ol style="list-style-type: none"> a. Coverage shall be limited to the seat lift mechanism and its installation, and not the chair itself; and b. All of the following criteria shall be met: <ol style="list-style-type: none"> 1. The participant has severe arthritis of the hip or knee, or a severe neuromuscular disease; 2. The seat lift mechanism is a part of the physician’s course of treatment to effect improvement or arrest or retard deterioration in the participant’s condition, and shall be prescribed by the attending physician or a consulting physician for the disease or condition resulting in the need for a seat lift; 3. The participant is completely incapable of standing up from a regular armchair or any chair in their home; and 4. Once standing, the participant is able to walk; 	<p>Reimbursement may be made for the rental or purchase of a medically necessary seat lift when prescribed by a physician for a patient: with severe arthritis of the hip or knee and patients with muscular dystrophy or other neuromuscular disease when it has been determined the patient can benefit therapeutically from use of the device. In establishing medical necessity for the seat lift, the evidence must show that the item is included in the physician’s course of treatment, that it is likely to effect improvement, or arrest or retard deterioration in the patient’s condition, and that the severity of the condition is such that the alternative would be chair or bed confinement.</p> <p>Coverage of seat lifts is limited to those types which operate smoothly, can be controlled by the patient, and effectively assist a patient in standing up and sitting down without other assistance. Excluded from coverage is the type of lift which operates by a spring release mechanism with a sudden, catapult-like motion and jolts the patient from a seated to a standing position. Limit the payment for units which incorporate a recliner feature along with the seat lift to the amount payable for a seat lift without this feature.</p>

Item 4. Services not covered as personal care services.

Personal Care Services Provided the Same Day as Adult In Home Care or Homemaker Services

The Subcommittee recommends clarification of the provisions prohibiting personal care coverage the same day as adult in home care or homemaker service coverage is provided, and vice versa. This recommendation is made to ensure the safety of the CFI participant.

He-E 801.20(c) provides:

- (c) Personal care services shall not be covered: . . . On the same day that adult in home care or homemaker services are provided;

The Department explains that the intention is to prevent duplication of services or inefficiency. The table below demonstrates that the three services are similar. However, they are not the same. With some assumptions relative to laundering and cleaning, the personal care service appears the broadest, but does not include “errands for necessary tasks.”

The Subcommittee raises the concern that a participant may require and receive adult in home care or homemaker services in the morning and still need the personal care service at night to transfer from wheelchair to bed. The rule plainly prohibits this service arrangement. Clarification is needed.

Tasks covered under the adult in home care, homemaker and personal care services.

Covered Task	Adult In Home Care	Homemaker	Personal Care
(1) Hands-on assistance with the activities of daily living or cuing a participant to perform a task.	X		X
(2) Meal or snack preparation and assisting the participant with eating, as specified in the care plan.	X	X	X
(3) Cleaning the food preparation area after the food is served.	X	X	
(4) Under the direction of the participant, assistance with self-administration of oral or topical medication as prescribed, to include: <ul style="list-style-type: none"> 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. 			X
(5) Accompanying the participant when 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 the need for re-direction and/or direct assistance is documented in the clinical assessment, due to one or more of the following conditions: <ul style="list-style-type: none"> a. A cognitive impairment; b. A mobility impairment; c. A problem behavior; or d. The need for oxygen or other equipment during the course of the trip that the participant cannot manage independently. 			X
(6) When non-medical transportation service is authorized, hands-on assistance at the authorized destination for a maximum period of 3 hours per week when the comprehensive care plan documents that this assistance is required at the destination.			X

(7) General household tasks.			X
(8) Laundering the participant’s personal clothing items, towels, and bedding.	X	X	X*
(9) Light cleaning limited to the individual’s bedroom, bathroom, and mobility devices	X	X	X*
(10) When the participant lives alone, light cleaning of the kitchen and entry way areas, in order to maintain a safe environment		X	X*
(11) Errands for necessary tasks identified in the comprehensive care plan		X	

*Assume that “general household tasks” include light cleaning of the bedroom, bathroom, kitchen, entry and mobility devices, as well as laundering the participant’s personal clothing, towels, and bedding.

Personal Care Services Provided by an Agent under a Power of Attorney

The Subcommittee recommends allowing a person who is named as agent under a power of attorney to act as the principle’s personal care worker until the power is activated.

He-E 801.20(c) provides:

(c) Personal care services shall not be covered: . . . When provided by any of the following individuals: . . . c. The participant’s designated power of attorney, regardless of whether the power of attorney has been activated

NH RSA 161-I:2 prohibits provision of personal care services by “a person granted power of attorney by the eligible consumer.” (Emphasis added.) To “grant” is to transfer or convey. The authority is not “granted” until the power of attorney is activated. The Department prohibits the named agent from providing services before the authority is granted; the Subcommittee believes that do so is not reasonable.

For example— A 25-year old with traumatic paraplegia establishes a power of attorney for health care. He and his physician have every expectation that he will live a normal life span. Yet, as a result of his accident, he knows well how quickly life may change and for that reason is careful to establish advance directives. He names a person who knows him well and who has helped care for him since his injury as his agent under a power of attorney for health care. This person who has long cared for him cannot now care for him, even though the power of attorney may never be activated.

Even a power of attorney for a frail elder may never be activated.

The Department provides that it is not practical or reasonable to expect that a person would have to find a new personal care worker once a power of attorney is activated. They further point out that it is not practical or reasonable that a case manager or the Department would know when a power of attorney was activated.

The Subcommittee respectfully disagrees with the Department. One of the greatest benefits of the personal care service is the ability to hire people that you know and trust; that may include someone you would also trust as a power of attorney, if needed. As it often becomes apparent that someone is declining and may soon need a power of attorney activated, preparations can be made to find a new caregiver or change the named agent. If there is a sudden change in health, such a situation often involves hospitalization or temporary nursing home care, again giving time to make new care arrangements. Also, the named agent could decline the agency, requiring an alternate to fill the role. Ultimately, it is the participant that takes the risk and not the Department.

Furthermore, given that the case manager or the Department should be aware when a power of attorney is activated, a process should be in place to ensure this.

Item 6. Impact on eligibility resulting from the inclusion of allied therapy costs within the CFI cost cap. The Subcommittee recommends careful scrutiny of cases in which allied therapy costs impact CFI eligibility, so as to ensure each situation is in fact comparable to costs incurred by residents of nursing facilities.

Some Subcommittee members express concern that including the cost of allied therapies (physical therapy, occupational, and speech therapies) within the CFI cost cap will result in participants unreasonably being found ineligible from a cost perspective. Strikingly, several members did not know of the recent State law change that requires this. Therefore, the Subcommittee recommends careful scrutiny of cases in which these costs negatively impact eligibility, ensuring that disqualifying community costs would have been born by a nursing facility resident within the facility's standard rate. The Subcommittee also respectfully requests updates over the next year as to how this provision is impacting eligibility.

ATTACHMENT A: FAIR HEARING PROVISIONS IN NEW HAMPSHIRE MEDICAID RULES

He-W 501 (General Medical Eligibility)

Rule expired, including fair hearing rule.

He-W 502 (Aid to the Needy Blind - 2007)

No rule on notice/appeal.

He-W 503 (APTD)

Rule expired.

He-W 504 (MEAD - 2005)

No rule on notice/appeal.

He-W 507.03 & 507.05 (Children with Severe Disabilities - 2003)

Continued Eligibility

(d) If an adverse eligibility determination is made, the written notice to the recipient shall include the following information:

- (1) The recipient's identifying information;
- (2) A listing of the medical and non-medical reports considered during the disability determination process;
- (3) A statement of the department's action;
- (4) The reasons for the department's action;
- (5) Citations from federal and state statutes and regulations supporting the department's actions; and
- (6) An explanation of the individual's rights to appeal the department's disability determination and to reapply for medical assistance.

Appeals

(a) Individuals may appeal an adverse disability determination, pursuant to RSA 541-A:31, III and He-C 200.

He-W 508.08 & 508.09 (HC-CSD - 2009)

Cost Reduction Plans

(d) The recipient shall receive a written notice of termination of medical eligibility on department Form 272hc, "Termination of Medical Eligibility for HC-CSD," including:

- (1) The reason for, and legal basis of, the termination;
- (2) Information that a fair hearing on the termination may be requested within 30 calendar days of the date on the notice of termination, in accordance with He-C 200.

Continued Medical Eligibility for HC-CSD

(d) The written notice in (c) above shall include:

- (1) The recipient's identifying information;
- (2) A listing of the medical and non-medical reports used for consideration during the medical eligibility review process;
- (3) A description of the impairments used for consideration during the medical eligibility review process;
- (4) The reasons for the department's decision;
- (5) The legal basis supporting the department's decision(s);
- (6) Information that a fair hearing on the denial of continued medical eligibility may be requested within 30 calendar days of the date on the notice of denial, in accordance with He-C 200; and
- (7) Information on how to reapply for medical assistance.

He-W 529.03 (Independent Coverage Review - 2008)

(e) If the requested service or item is determined to be non-covered during the department's independent coverage review, the department shall forward a notice of non-coverage to the recipient and the ordering provider on Form 272nc, "Non-Covered Based Upon Independent Coverage Review" including:

- (1) The reason that the request did not meet the criteria in (c) above; and
- (2) Instructions that a fair hearing may be requested, in accordance with He-C 200, by the recipient within 30 calendar days of the date of the non-coverage notice.

He-W 540.07 (Private Duty Nursing - 2004)

(m) If a request for authorization is denied by OHPM or DEAS, notice of denial shall be forwarded to the recipient on the "MA Program Denial for Prior Authorized Services" form.

(n) The denial form described in (m) above shall include:

- (1) A detailed explanation of factors contributing to the denial of the request;
- (2) That a fair hearing may be requested within 30 calendar days from the date of the notice; and
- (3) Information to the recipient that if the hearings officer reverses the denial, the recipient's services shall start or continue and the need for services shall be reviewed at the next scheduled interval but, if the hearings officer upholds the OHPM or DEAS denial, then the recipient's request for initial or continuation of services will be denied.

He-W 543.04 (Hospital Services - 2008)

(g) If the department denies the prior authorization request, the department shall forward a notice of denial to the recipient and the ordering provider on the department Form 272a, "Medical Assistance Program Denial for Prior Authorized Services," including the following:

- (1) The reason for, and legal basis of, the denial;
- (2) Information that a request for an independent coverage review on the denial may be requested in accordance with He-W 529.03 within 30 calendar days of the date on the notice of denial; and
- (3) Information that a fair hearing on the denial may be requested within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

He-W 546.06 (EPSDT - 2007)

(g) If the requested service is denied by the department, the department shall forward a notice of denial to the recipient and the provider on Form 272a, "Medical Assistance Denial for Prior Authorized Services."

(h) Form 272A shall include the following information:

- (1) The reason for, and the legal basis of, the denial; and
- (2) Instructions that a fair hearing on the denial may be requested by the recipient within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

He-W 569.06 (Radiological Services - 2006)

(d) When a prior authorization request is denied, the PA imaging agent shall forward a written notice of denial to the recipient and the ordering practitioner to include the following:

- (1) Reason for the denial and a copy of the approved clinical guidelines used to make the decision;
- (2) Information on how the recipient can file an appeal in accordance with He-C 204 [motion for reconsideration, to request reconsideration of a decision of the department prior to or in lieu of appealing the decision]; and
- (3) That a denial may be appealed by the recipient within 30 calendar days from the date the denial was issued

He-W 570.06 (Pharmaceutical Services - 2009)

(i) When a prior authorization request is denied, the PBM shall forward a written notice of denial to the recipient and the prescribing practitioner that states the following:

- (1) The medication being denied;
- (2) The reason for the denial;
- (3) The legal basis for the denial;
- (4) Information on how the recipient can file an appeal in accordance with He-C 204; and

(5) That a denial may be appealed by the recipient within 30 calendar days from the date the denial was issued.

He-W 571.07 (Durable Medical Equipment, Prosthetic and Orthotic Devices, and Medical Supplies - 2010)

(m) If the department denies the PA request, the department shall forward a notice of denial to the recipient and the ordering provider on the department Form 272a, "Medical Assistance Program Denial for Prior Authorized Services" including the following:

- (1) The reason for, and legal basis of, the denial;
- (2) Information that a request for an independent coverage review on the denial may be requested in accordance with He-W 529.03 within 30 calendar days of the date on the notice of the denial; and
- (3) Information that a fair hearing on the denial may be requested within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

He-W 574.12 (General Medical Transportation - 2006)

Any recipient who has been denied general medical transportation reimbursement may appeal an adverse decision by requesting a fair hearing in accordance with He-C 200. Requests for fair hearings shall be submitted no later than 30 days after the date the notice of decision being appealed is issued.