New Hampshire Long Term Supports and Services (LTSS) for Seniors & Individuals with Physical Disabilities, Findings and Recommendations

Presented to:

New Hampshire Department of Health and Human Services

March 12, 2021

Presented by:

Guidehouse Inc.

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Executive Summary

Overview

Following passage of House Bill 1816, which ended the discussion and planning for Medicaid managed long-term services and supports (MLTSS), the Department of Health and Human Services (DHHS), Bureau of Elderly and Adult Services (BEAS) engaged Guidehouse Inc. (formally Navigant Consulting, Inc.) to conduct an independent assessment of NH's LTSS model for seniors and individuals with physical disabilities and to advise DHHS/BEAS accordingly. Guidehouse continued to work closely with ADvancing States to support several components of this assessment. To conduct our assessment, we performed stakeholder engagement, reviewed DHHS documentation, and conducted research on national programs and federal requirements to reinforce our recommendations.

The purpose of this report is to assist DHHS/BEAS as it aims to continue its efforts to improve NH's current LTSS delivery system for seniors and individuals with physical disabilities. Specifically, this report to DHHS/BEAS provides a summary of:

- Key themes and findings from BEAS staff and key informant groups.
- Guidehouse assessment of select findings from BEAS staff and key informant groups.
- Guidehouse recommendations for improvement.
- Activities completed by DHHS/BEAS to address stakeholder findings.

DHHS/BEAS has reviewed and approved the contents of this report.

Recommendations

Based on a thorough evaluation of other states, discussions with stakeholders, Guidehouse recommended that DHHS/BEAS pursue internal infrastructure/operational changes before it contemplated a larger system change. Our recommendations to DHHS/BEAS include:

1. Improve existing processes and public-facing materials related to Medicaid financial eligibility determinations.
2. Evaluate NH's home and community-based services (HCBS) payment rate methodologies.
3. Update the performance measures/waiver assurances included in the CFI waiver to improve quality and oversight of vendors.
4. Determine whether transitioning targeted case management (TCM) services to the CFI waiver would improve quality and performance.
5. Assess current IT infrastructure and data analytic capabilities to identify opportunities to improve information sharing, data collection, and reporting across the LTSS continuum.
6. Assess BEAS staff resources to improve vendor oversight and quality management.
7. Perform a detailed analysis of LTSS workforce shortages to determine whether there is an adequate supply of providers to meet care and service needs
8. Consider contracting with case management entities directly rather than having them licensed as home care providers through the standard Medicaid provider enrollment process.
9. Assess roles and responsibilities across case managers, ServiceLink contractors, and direct service providers to improve care coordination and reduce duplicate activities performed across providers.

Next Steps

While COVID-19 significantly impacted DHHS/BEAS's ability to move system dialog forward with stakeholders and to address all of Guidehouse's recommendations, DHHS/BEAS made progress to address several LTSS system issues by:

- Implementing several new processes to reduce Medicaid eligibility determination backlogs and processing times.
- Conducting a rate study (performed by Guidehouse) for the Choices for Independence (CFI) waiver using publicly available cost inputs and market prices.

As of the date of this report, DHHS/BEAS continues to analyze and address the findings presented in this report. DHHS/BEAS's immediate priorities and next steps include:

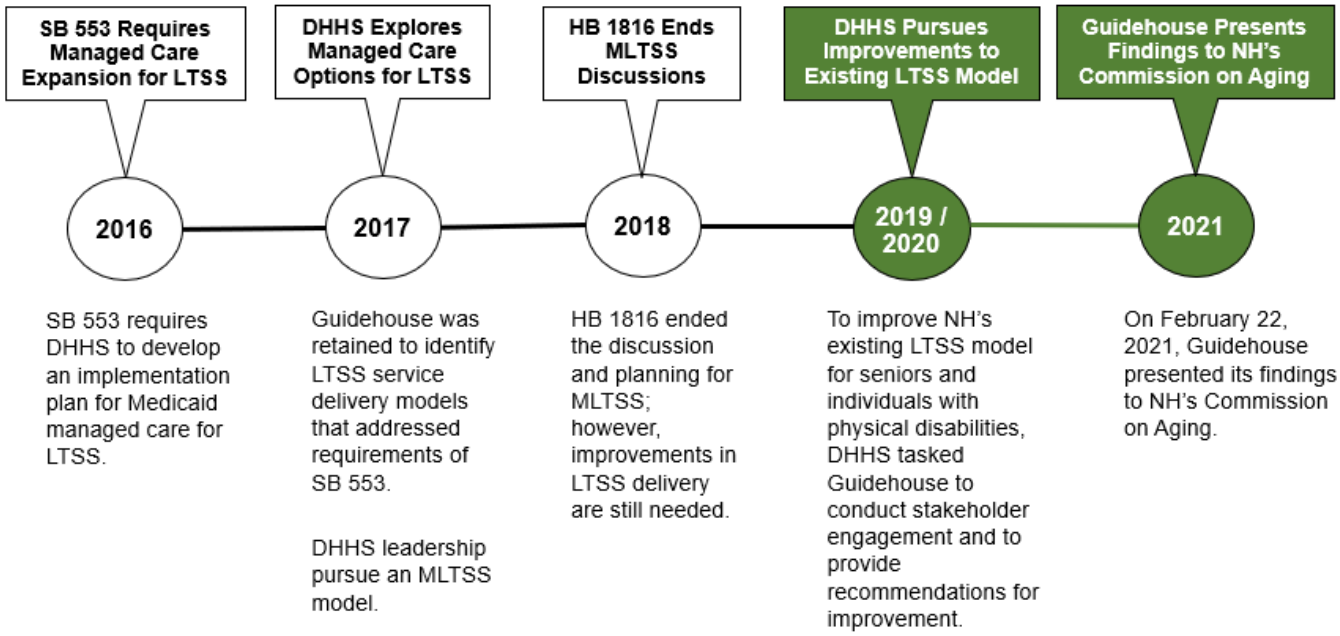
- Continuing to support all state efforts to fight COVID-19, including continuing to apply temporary flexibilities to policies and preparing for a resumption of "normal" state operations.
- Considering making permanent LTSS solutions tested during the COVID-19 pandemic that improved quality, costs, and access to care.
- Updating public-facing materials related to Medicaid LTSS eligibility.
- Updating the CFI waiver application taking into consideration stakeholder feedback.

Background

On June 6, 2016, the Governor signed into law Senate Bill (SB) 553 instructing the Department of Health and Human Services (DHHS) to develop an implementation plan for Medicaid managed care for long-term services and supports (LTSS). SB 553 indicated that nursing facility (NF) and in-home care services provided under the Choices for Independence (CFI) waiver shall transition to managed care. DHHS, Bureau of Elderly and Adult Services (BEAS) retained Guidehouse Inc. (formally Navigant Consulting, Inc.) to identify LTSS service delivery models that addressed requirements of SB 553. In response to SB 553, Guidehouse produced an options report that assessed different LTSS service delivery models including capitated managed care organizations, administrative services organizations, accountable care organizations, program of all-inclusive care for the elderly (PACE) models, and primary care case management models.

DHHS/BEAS leadership initially pursued a Medicaid managed long-term services and supports (MLTSS) model; however, passage of House Bill 1816 during the 2018 legislative session ended the discussion and planning for MLTSS. While the adoption of HB 1816 ended MLTSS discussions, it did not mean that NH's LTSS system should continue to operate in the same way. DHHS/BEAS tasked Guidehouse to conduct an independent assessment of NH's current service delivery network for seniors and individuals with physical disabilities and to advise DHHS/BEAS accordingly. The remainder of this report focuses on Guidehouse's work to identify and address issues with NH's current delivery of LTSS.

Figure 1. Background of Guidehouse's Work



Assessment Approach

Objective Areas

Guidehouse's assessment focused on identifying opportunities for improvement in NH's LTSS system across access, service coordination, service delivery, and quality. In partnership with DHHS/BEAS, Guidehouse planned stakeholder engagement efforts to address the participant experience engaging

with the states programs and to prioritize barriers and opportunities for improvement using the following objective areas to support our discussions with stakeholders:

Figure 2. Assessment Objective Areas

Methodology

Guidehouse's assessment was inclusive of both qualitative and quantitative methods. Guidehouse identified qualitative findings from stakeholders and then conducted quantitative analyses, where appropriate, to verify stakeholder feedback and to better understand existing system challenges and opportunities for improvement.

- **Feedback from BEAS Staff and Key Informant Groups**: From August 2019 through January 2020, Guidehouse collected feedback from over 100 stakeholders including BEAS staff and several key informant groups. The stakeholders that provided input to support this assessment each play a vital role in NH's current delivery of LTSS and are best positioned to identify opportunities for improvement. Figure 3 identifies the stakeholder groups that informed this assessment.

  Figure 3. Stakeholders

- **Documentation**: Guidehouse reviewed DHHS/BEAS documentation to verify stakeholder findings. This included Medicaid eligibility requirements, Medicaid eligibility determination data, organizational charts, and policies and procedures. We submitted multiple document requests to DHHS/BEAS throughout our assessment.

In addition to these primary sources to understand the unique needs and challenges surrounding NH's LTSS programs, Guidehouse also completed the following secondary research and analyses:

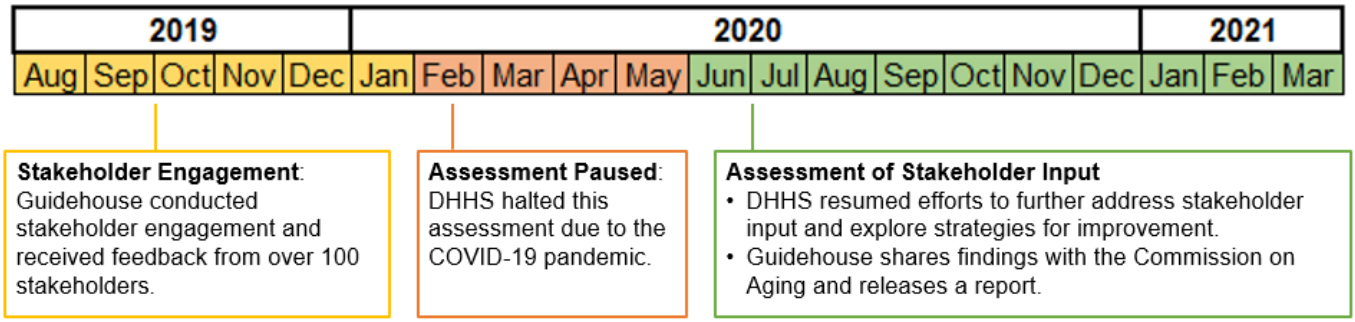
- **National Research:** Guidehouse conducted research on national programs and federal requirements to reinforce our recommendations and to help ensure that Guidehouse's perspective is aligned with the direction of Centers for Medicare and Medicaid Services (CMS) and other governing bodies.
- **Quantitative Analyses:** Guidehouse quantified the impact of select stakeholder input, where applicable, to support our recommendations.

Timeline

Guidehouse anticipated releasing its findings to stakeholders in December 2019; however, several components delayed the release of our findings including:

- **Research and Analysis to Assess Stakeholder Input:** DHHS/BEAS leadership requested that Guidehouse assess/verify stakeholder input to better inform DHHS/BEAS decision-making and next steps. Guidehouse conducted several activities to verify stakeholder input including conducting additional interviews with BEAS staff, performing other state research, performing a rate study for the CFI waiver, and using data, where appropriate, to further assess stakeholder identified challenges and the impact of suggested changes.
- **COVID-19**: The public health emergency significantly impacted and delayed DHHS/BEAS staff ability to support Guidehouse's validation efforts. DHHS/BEAS halted Guidehouse's assessment for approximately 4 months, allowing DHHS/BEAS staff to focus on addressing COVID-19 related matters. While COVID-19 significantly impacted the timing of this assessment, DHHS/BEAS did make progress to evaluate and address stakeholder input.

Figure 4. Assessment Timeline

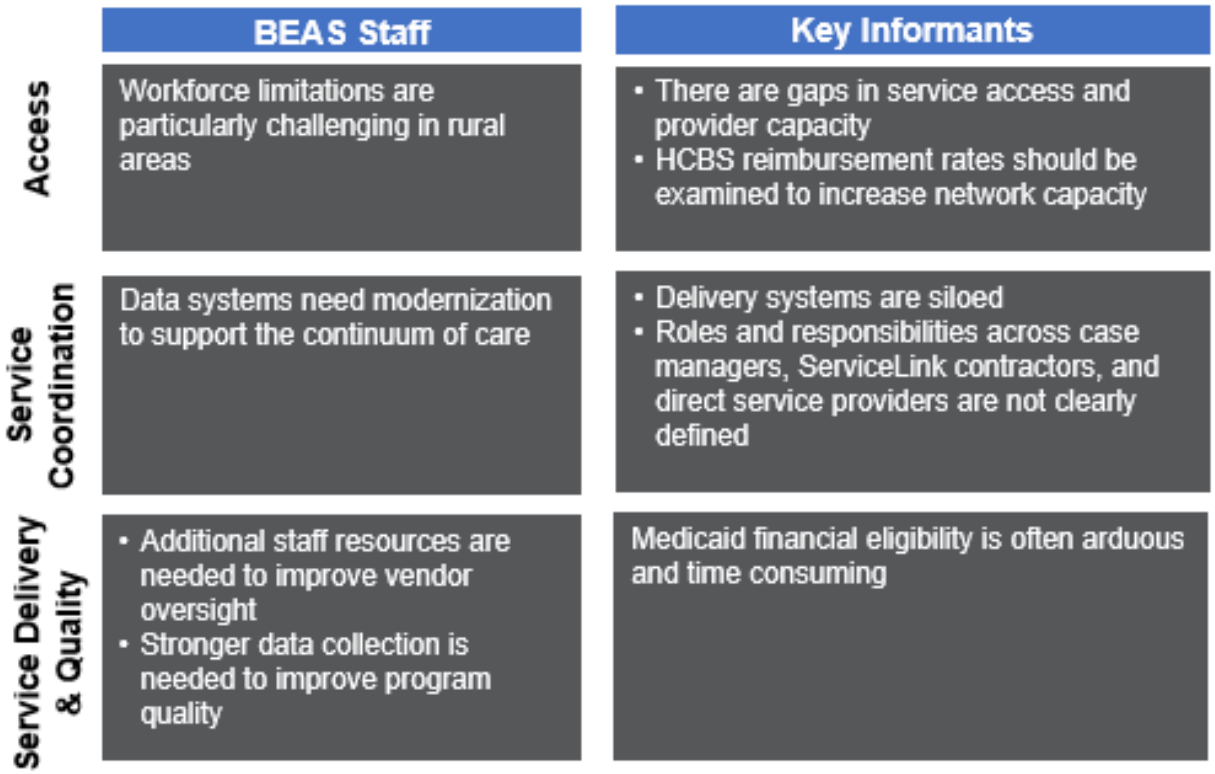


Stakeholder Findings and Assessment of Findings

Stakeholder Findings

BEAS staff and key informant groups identified consistent themes across the assessment objective areas. Figure 5 identifies key findings/themes from the perspective of BEAS staff and key informant groups. Detailed feedback from BEAS staff and key informant groups are included in **Appendices A-C** of this report.

Figure 5. Key Stakeholder Findings



Assessment of Findings

DHHS/BEAS requested that Guidehouse assess/validate stakeholder input to support DHHS/BEAS leadership decision-making and to better understand the challenges and opportunities identified by stakeholders. Guidehouse conducted several activities to verify stakeholder input including conducting additional interviews with BEAS staff, performing other state research, performing a rate study for the CFI waiver, and using data, where appropriate, to further assess stakeholder identified challenges and the impact of suggested changes. Figure 6 presents our assessment of select stakeholder findings.

Assessment limitations: Due to DHHS/BEAS priorities and timing, Guidehouse did not perform a detailed analysis of the activities listed below; however, we included many of these items as next steps in our recommendations to DHHS/BEAS:

- Efficiency of DHHS/BEAS data collection protocols and IT infrastructure.
- DHHS/BEAS staff resources needed to support vendor oversight and quality management.
- Roles and responsibilities across case managers, ServiceLink contractors, and direct service providers.
- Network adequacy/provider capacity for CFI waiver services.

Figure 6. Assessment of Stakeholder Findings

#	Stakeholder Finding	Assessment of Findings
1	CFI reimbursement rates are inadequate.	As part of NH's CFI waiver renewal application (due to CMS in early 2022), Guidehouse conducted a rate study for the CFI waiver using publicly available cost inputs and market prices. All CFI waivers rates

#	Stakeholder Finding	Assessment of Findings
		are supported by a rate setting method accepted by CMS. DHHS/BEAS will provide more detail regarding the CFI waiver rate study during the CFI waiver public comment period later this year.
2	Medicaid LTSS financial eligibility takes longer than 90 days (Federal requirement)	**CMS Requirements** • CMS requires Medicaid LTSS eligibility determinations to be made within ninety days of application; however, there are exceptions to this rule if applicant documentation is not provided timely. **Medicaid LTSS Eligibility Data Analysis:** • Based on Medicaid eligibility determination data (applications completed from July 2019-April 2020), Guidehouse estimates that the median # of days to process applications is 65. • The DHHS team sampled 82 applications that were above 90 days and found that 77% of these applications were delayed because the applicant, bank/insurance company, or nursing facility failed to provide financial or medical documentation in a timely manner. • There a several external factors that may negatively impact determination timeframes: o It takes some banks or life insurance companies 30-45 days to provide requested information. o Family members filling out applications are not aware of all of the applicant's financial information which requires additional follow-up from the State. **DHHS/BEAS Staffing** • The Medicaid LTSS eligibility unit for LTSS has not been fully staffed for 3+ years. In 2020, approximately 85% of the positions within the Medicaid LTSS eligibility unit were filled. • Factors that negatively impact staff retention and hiring include (per BEAS staff feedback): o Current salary ranges may be too low. Several staff have transitioned to other state positions (with similar qualification requirements) that offer higher salary ranges. o Lack of flexible work options (pre-COVID). • New Hampshire's aging population (age 65+) is expected to grow by 16% from 2020 to 2025 which may significantly increase the # of LTSS applications and the need for additional state staff to review applications.
3	Initial Medicaid LTSS eligibility and redetermination processes lack clarity regarding the type or format of paperwork required, due dates, sufficiently timed notifications, and contact persons.	• Given the number of available documents and websites, it is unclear where consumers and providers should go to better understand financial documentation requirements for Medicaid LTSS coverage. • Some of the Medicaid LTSS eligibility materials online are outdated and should be removed. • Certain DHHS financial documentation standards are inconsistent across public-facing materials. See **Appendix D** for a comparison of Medicaid LTSS financial eligibility requirements across DHHS documentation.
4	Medicaid LTSS financial documentation	• NH's financial documentation requirements are similar to other states. • New Hampshire requires a 60-month look-back period for all asset

#	Stakeholder Finding	Assessment of Findings
	requirements are a strain on applicants and it often delays the application process	transfers. • Guidehouse reviewed look-back period requirements for 7 states and found that most states require a 60-month look-back period; however, states appear to give themselves flexibility by using language "up to 5 years as determined by the State." Guidehouse's other state research is included in **Appendix E**.
5	BEAS staff identified that transitioning from Medicaid Eligibility 209(b) to 1634 will streamline the Medicaid application process.	Transitioning to 1634 simplifies the Medicaid application process for SSI-related Medicaid; however, it will have a minimal impact on New Hampshire's Medicaid eligibility timeframes for LTSS. Guidehouse did not recommend that DHHS/BEAS transition from 209(b) to 1634 since it may significantly increase state expenditures and it will have a minimal impact on New Hampshire's Medicaid eligibility timeframes for LTSS. See **Appendix F** for a summary of the program/financial impact of transitioning from 209(b) to 1634.

In addition to the validation of findings presented above, DHHS/BEAS requested that Guidehouse perform a high-level assessment of provider capacity for nursing facilities (NF) and home and community-based services (HCBS) providers. DHHS/BEAS leadership requested this analysis to determine whether NF capacity required a detailed analysis relative to a moratorium and to assess stakeholder concerns regarding gaps in HCBS provider capacity. Our high-level provider capacity assessment is included in **Appendix G** of this report. This assessment is marked as **DRAFT** since DHHS/BEAS staff did not validate the findings presented in this analysis, due to COVID-19 priorities, and it does not reflect COVID-19 considerations since most of the analyses were performed pre-COVID. Guidehouse expects that the public health emergency significantly impacted provider capacity in NH as it has nationally.

Recommendations and Activities Completed to Date

Based on stakeholder feedback and review of DHHS/BEAS documentation, there are significant opportunities to improve NH's current LTSS program. We heard consistently across BEAS staff and key informant groups that the current LTSS system lacks sufficient staff, IT systems, workforce capacity, and processes to run effectively. These issues, along with others discussed in this summary, are not unique to NH. Our findings are consistent with other states that we have worked in including Alabama, Colorado, Iowa, Kentucky, Kansas, Minnesota, Pennsylvania, and South Dakota. Each of these states improved their existing LTSS programs by prioritizing issues and having state leadership commit to a proposed solution.

Based on our discussions with stakeholders and analysis of DHHS/BEAS documentation, Guidehouse recommended that DHHS/BEAS pursue internal infrastructure/operational changes before it contemplated a larger system change. Figure 7 identifies Guidehouse's recommendations to DHHS/BEAS and DHHS/BEAS activities completed to date to address these recommendations.

Figure 7. Guidehouse Recommendations to DHHS/BEAS and DHHS/BEAS Activities Completed to Date to Address Recommendations

#	Guidehouse Recommendations to DHHS/BEAS to Improve Foundational LTSS Components	DHHS/BEAS Activities Completed to Address Recommendations
1	Improve existing processes and public-facing materials related to Medicaid financial	**Complete**: DHHS's Disability Determination Unit has developed processes regarding the

#	Guidehouse Recommendations to DHHS/BEAS to Improve Foundational LTSS Components	DHHS/BEAS Activities Completed to Address Recommendations
	eligibility determinations.	lack of timely submission of required information as well as outreach to the applicant. **Ongoing**: DHHS is updating public-facing materials related to Medicaid LTSS eligibility to better define financial documentation requirements and to ensure that requirements are described consistently across materials.
2	Evaluate NH's home and community-based services (HCBS) payment rate methodologies.	**Complete**: As part of NH's CFI waiver renewal application (due to CMS in early 2022), Guidehouse conducted a rate study for the CFI waiver using publicly available cost inputs and market prices. All CFI waivers rates are supported by a rate setting method accepted by CMS. DHHS/BEAS will provide more detail regarding the CFI waiver rate study during the CFI waiver public comment period later this year. The Governor's budget includes a $7,703,584 increase for CFI waiver rate increase. The increase is attributable to rate increases effective 7\1\2021 as follows: ▪ Personal Care from $4.89 to $5.62 ▪ Homemaker from $5.09 to $5.40 ▪ Case Management Rate Parity across all 4 HCBS Waivers resulting in a $2,956,990 increase.
3	Update the performance measures/waiver assurances included in the CFI waiver to improve quality and oversight of vendors.	**Ongoing**: As part of the CFI waiver renewal, DHHS is updating the waiver assurance performance measures to improve vendor oversight and quality.
4	Determine whether transitioning targeted case management (TCM) services to the CFI waiver would improve quality and performance.	**Ongoing**: As part of the CFI waiver renewal, DHHS is considering moving state plan targeted case management (TCM) services for CFI waiver participants into the CFI waiver to improve quality and performance.
5	Assess current IT infrastructure and data analytic capabilities to identify opportunities to improve information sharing, data collection, and reporting across the LTSS continuum.	**Outstanding**: DHHS will consider these recommendations at a later date.
6	Assess BEAS staff resources to improve vendor oversight and quality management.	
7	Perform a detailed analysis of LTSS workforce shortages to determine whether	

#	Guidehouse Recommendations to DHHS/BEAS to Improve Foundational LTSS Components	DHHS/BEAS Activities Completed to Address Recommendations
	there is an adequate supply of providers to meet care and service needs.	
8	Consider contracting with case management entities directly rather than having them licensed as home care providers through the standard Medicaid provider enrollment process. Contracting with the CM entities directly puts the state in a better position to hold the CM entities accountable to quality standards.	
9	Assess roles and responsibilities across case managers, ServiceLink contractors, and direct service providers to improve care coordination and reduce duplicate activities performed across providers.	

Next Steps

As of the date of this report, DHHS/BEAS continues to analyze and address the findings presented in this report. DHHS/BEAS's immediate priorities and next steps include:

- Continuing to support all state efforts to fight COVID-19, including continuing to apply temporary flexibilities to policies and preparing for a resumption of "normal" state operations.
- Considering making permanent LTSS solutions tested during the COVID-19 pandemic that improved quality, costs, and access to care.
- Updating public-facing materials related to Medicaid LTSS eligibility.
- Updating the CFI waiver application taking into consideration stakeholder feedback.

Appendices

Appendix A: Key Themes from BEAS Staff

The following themes address overall LTSS systems issues from the perspective of BEAS staff. Guidehouse collected feedback from BEAS staff via interviews in late 2019.

Theme 1: Workforce limitations are particularly challenging in rural areas.

- Rural parts of the State are experiencing a shortage in workforce supply.
- Provider availability/service maps are not available in current infrastructure.
- Provider agencies should be required to report capacity.
- Workforce development initiatives are necessary to meet the current and long-term healthcare needs.
- BEAS does not track unmet needs which is an indicator of network adequacy.

Theme 2: Data systems need modernization to support the continuum of care.

- BEAS should consolidate data collection systems. Current IT systems use antiquated technology, with some no longer receiving technical support. Updated systems with modern capability would improve the timeliness and quality of data collection.
- Technology does not allow for on-site data entry for programs that require field visits.
- BEAS's sentinel or critical incident reporting process is manual.
- Most programs within the LTSS framework use different data and reporting systems. These separate systems produce reports which staff must manually consolidate and analyze.
- Create a streamlined data strategy that allows visibility of the participant record across programs.
- Create electronic systems for invoicing all provider reimbursements.

Theme 3: Additional staff resources are needed to improve quality and vendor oversight.

- BEAS lacks sufficient resources to monitor and administer vendor contracts.
- BEAS staff indicated that they do not have sufficient resources to appropriately manage CMS requirements pertaining to critical incident reporting and tracking of 1915(c) waiver assurance performance measures.
- Case managers do not contract directly with BEAS; therefore, it is difficult for BEAS to enforce program requirements.
- CFI staff cannot manage case management providers in real time since limited information is provided on an ongoing basis. For example, service plans and other participant contingency plans are not provided unless requested during an audit.
- Some case management agencies do not share their care plan information since there is no mandate and the care plans are considered "proprietary" by the case management agencies.
- BEAS has limited insights into ServiceLink performance.
- BEAS staff do not certify or regularly monitor direct service providers since direct service providers are licensed by Program Integrity.

Theme 4: Stronger data collection is needed to improve program quality.

- There is limited data or metrics available to assess performance and quality.

- Few BEAS program areas use data or dashboards to monitor program performance.
- The State should use a national survey (e.g., NCI-AD) to assess participant satisfaction across BEAS programs.
- Case management entities use different care plan templates and consumer satisfaction surveys which results in inconsistent service delivery.
- Some case managers do not complete recertifications in a timely manner which leads to gaps in services.

Other comments provided from BEAS staff:

- The State should consider transitioning from Medicaid Eligibility 209(b) to 1634 will streamline the Medicaid application process.
- The State is likely paying for duplicate services under the State Plan and HCBS waivers. Adult Day, skilled nursing visits, and personal care are services included in both the CFI waiver and in State Plan (services offered by MCOs). BEAS is analyzing this issue to determine how much duplication exists.
  Service providers may be underreporting sentinel events since BEAS training on this topic is relatively new.
- BEAS should review its current approach to Medicaid administrative claiming to see if there are opportunities for an increased match.
- Funding allocations do not reflect the needs of the growing aging population in New Hampshire. DHHS should allocate program funding based on program and population needs.
- Staff expressed a need for additional funding opportunities to increase available resources across the LTSS spectrum.
- Lack of awareness of ServiceLink is a barrier. Additional marketing and outreach should be provided in rural parts of the State.
- BEAS should provide ongoing training or online training for nursing homes and hospitals regarding the Medicaid waiver eligibility process. Staff turnover at these provider agencies often creates a knowledge gap and misinformation.
- BEAS should produce a regular annual report that highlights program performance. This may reduce the number of legislative requests for information.
- BEAS needs to do a better job at communicating program changes to service providers. BEAS should be proactive in its communication strategy and not reactive.
- The current service authorization process in MMIS does not allow for accurate service management by units/dates. The current MMIS vendor tracks total allowable service units but not allowable units by frequency. Often times, the service provider exceeds the total allowable units mid-year since this was not flagged earlier on.

Appendix B: Key Themes from Key Informant Groups

The following themes address overall LTSS systems issues from the perspective of key informant groups. Guidehouse collected feedback from key informant groups via interviews and a web-based survey from August 2019 to January 2020. Results from the web-based survey are shown in **Appendix C** of this report.

Theme 1: There are gaps in service access and provider capacity.

- There are significant gaps in service access and provider capacity which often leads to individuals not receiving care or receiving care in an inappropriate setting (e.g., hospital v. home)
- There are major barriers to timely hospital discharges due to a lack of mental health care, transportation, or specialty care services.
- One key informant indicated that hospital geropsychiatric units have limited capacity.
- It is difficult for case managers to find direct service providers to provide adult day health services or homemaker.
- NH's provider directory is often outdated and inaccurate. While key informants did not specify the name of the provider directory, Guidehouse assumed that key informants were referring to the NH Easy provider directory. Several case management entities and ServiceLink offices noted keeping their own list of direct service provider availability/"open panel" status.

Theme 2: HCBS reimbursement rates should be examined to increase network capacity.

- Key informants believe low reimbursement rates are causing direct service provider shortages
- Key informants believe reimbursement rates are not adequate or equitable, which they suggested affects the quality of care that can be provided and network adequacy.

Theme 3: Delivery systems are siloed.

- Information is not shared across case managers, ServiceLink contractors, and direct service providers which often leads to duplicate processes/participant requests.
- Information that is collected from ServiceLink is not shared with case managers; therefore, case managers often request the same information from participants when they conduct face-to-face visits.
- Some case managers do not provide participant information (e.g., the participant is a known sex offender or the home environment is dangerous) or circumstances that impact a participant (e.g., hospitalization or loss of eligibility) to direct service providers.

Theme 4: Roles and responsibilities across case managers, ServiceLink contractors, and direct service providers are not clearly defined.

- Roles and responsibilities across case managers, ServiceLink contractors, and direct service providers is unclear and inconsistent. The functions and responsibilities across each of these groups often varies by county (e.g., ServiceLink may help a participant during redetermination but in another county, this is the responsibility of the case manager). In addition, many direct service providers indicated that they were providing uncompensated case management to participants.

Theme 5: Medicaid financial eligibility is often arduous and time consuming.

- Medicaid LTSS financial eligibility takes longer than 90 days (Federal requirement) for many participants. This delay leads to institutionalization and increases risks related to health and wellness of members within the community.
- Several stakeholders attributed this issue to a lack of state staff to appropriately manage this process.

Other comments provided from key informant groups:

- Conduent provides basic provider enrollment services but does not have provider relations/management staff to address ongoing billing issues. Information about policy changes are not consistently communicated, nor available electronically in a central location. Using provider enrollment as the only contact point with Medicaid providers limits BEAS' ability to effectively manage performance and quality outcomes.
- Major barriers exist related to timely hospital discharges. Healthy NH produced a report in 2017 that identified several issues with timely hospital discharges.[1] This report analyzed 421 people who were medically cleared to leave the hospital but were unable to do so during a 3-month period and found the following:
  - 42% - Unable to access a place to live with appropriate supportive care.
  - 23% - Unable to access needed mental health care, transportation or specialty care.
  - 20% - Difficulty with the Medicaid application process or under-insured.
  - 8% - Persons lacks decision-making capacity and needs a guardian.
  - 7% - Other barriers including history of IV drug abuse, sex offender or criminal record.
- Redeterminations take months and are not performed on a consistent cycle (e.g., some are done after 9 months and others after 12 months) causing confusing for participants and service providers and potential lapse in care.[2]
- NH's Medicaid eligibility system (NH Easy) is often inaccurate and lacks details to assess an application status, requiring service providers and ServiceLink staff to call to check eligibility status.
- Initial eligibility and redetermination processes lack clarity regarding the type or format of paperwork required, due dates, sufficiently timed notifications, and contact persons resulting in delays and frustration on behalf of individuals helping consumers with the eligibility process.
- Application materials and requests for additional financial documentation are sent to the applicant's home, many of whom are not able to comprehend what is requested and the person supporting the applicant (e.g., family member) with the application is often unaware of such requests. These requests often result in a denied application which further prolongs the application process.
- Service authorization notifications are often incomplete (e.g., missing the Medicaid recipients name), requiring the direct service providers to follow-up directly with the State to verify what has been approved.
- BEAS requests data from direct service providers when the information is readily available in its Social Assistance Management System (SAMS). SAMS is used to track services provided for nutrition providers and other Older American Act programs.
- Direct service providers have different reporting depending on the funding stream (e.g., Medicaid v. Older Americans Act). BEAS should conduct a comprehensive review of the reports and performance measures used across funding streams.

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[1] https://www.healthynh.com/images/FHC_Report_Barriers_to_Care_2017.pdf
[2] The term "service providers" refers to direct service providers and case management entities providing HCBS services.

- Funding for transportation services went from per trip to per person which does not consider the service being provided and the practice used to deliver the service (e.g., bus v. private vehicle).
- Nutrition providers expressed dissatisfaction with funding policies that impact meal services.[3]

[3] On Jan. 15, 2020, Governor Chris Sununu issued a letter to NH's Congressional Delegation regarding the need to increase federal funding for nutrition services and to advocate for substantive funding authorizations. https://www.governor.nh.gov/news-media/press-2020/documents/meals-on-wheels.pdf

Appendix C: Key Informant Survey

Guidehouse issued a web-based survey to key informant groups to obtain additional feedback regarding LTSS system challenges and opportunities for improvement. This survey was issued to approximately six hundred (600) individuals and forty-seven (47) individuals responded which represents an 8% (47/600) response rate. Key findings from this survey include:

- The survey responses align with the information collected during Guidehouse's in-person interviews.
- 45% of respondents indicated that they have a caseload greater than 90 (question 8); however, this may be due to the individuals that responded to this survey (e.g., service providers v. case managers).
- 68% of respondents indicated that they are satisfied with ServiceLink (Questions 32); however, 74% rarely or never receive referrals from ServiceLink. There may be a disconnect between the provider relationship with ServiceLink and the perceived execution of ServiceLink's core purpose.
- Respondents agreed with the quality initiatives proposed by DHHS/BEAS in questions 52-59. This includes 1) Expanding marketing efforts of ServiceLink 2) Providing additional training to HCBS direct service providers 3) Implementing a uniform care planning process for needs assessment and service plan development so that all eligible individuals have access to the same services and supports.

The figure below summarizes responses across key survey questions.

Figure 8. Detailed Survey Results Presented to DHHS/BEAS Leadership

Some questions may exceed 100% when the response type "Select all that Apply" was provided.

Section 1 (General Information)

Q #	Question	Answered	DSP	CM	NH	ServiceLink	Other
3	What is your role in LTSS?	47	28%	15%	9%	2%	60%

Q #	Question	Answered	< 20	20-39	40-69	70-89	> 90
8	What is your average caseload?	38	21%	5%	18%	11%	45%

Section 2 (LTSS System Delivery)

Overall impression of NH's LTSS system

Q #	Question	Answered	Excellent	Very good	Good	Fair	Poor	Not sure
9	How would you rate the overall quality of NH's LTSS system?	43	0%	7%	28%	30%	26%	9%

Q #	Question	Answered	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not sure
10	There are sufficient direct service providers to deliver all covered HCBS	44	0%	7%	7%	18%	57%	11%
11	HCBS reimbursement rates are adequate	44	2%	0%	2%	18%	66%	11%
12	The balance between institutional care and HCBS is appropriate	43	0%	12%	14%	26%	30%	19%
13	It is easy for participants to access and learn about available LTSS	44	0%	14%	18%	41%	20%	7%
14	The Medicaid eligibility process is clear and timely	44	2%	2%	16%	30%	41%	9%
15	The Medicaid HCBS provider enrollment process is clear	44	0%	11%	30%	16%	18%	25%

Objective Area 1: How to Help People Access Services and Support

Q #	Question	Answered	Excellent	Very good	Good	Fair	Poor	Not sure
32	Based on what you know about ServiceLink, how would you rate your overall relationship with ServiceLink?	38	16%	18%	21%	13%	18%	13%

Q #	Question	Answered	Daily	Weekly	Monthly	Rarely	Never
33	How frequently do you receive referrals from ServiceLink?	34	0%	9%	18%	47%	26%
34	How frequently do you refer clients to ServiceLink for assistance?	35	9%	26%	23%	23%	20%

Q #	Question	Answered	Very Easy	Easy	Difficult	Unknown
35	How easy is it for consumers of LTSS to find information regarding available supports and services?	38	8%	11%	58%	24%

Q #	Question	Answered	ServiceLink	BEAS	Search Engine	Other
36	How do you primarily find out about available supports and services for consumers of LTSS?	37	41%	27%	59%	43%

Q #	Question	Select Comments
38	How would you improve the way people access or learn about NH LTSS services?	- More information on the front end regarding availability of services, limitation of scope of care - An informational sheet with all services available and contact information, provided by the state, could be given to all providers to distribute to clients as they enroll in a program. - Less paper, Better technology at DHHS, DHHS needs more staff or better methods of completing their work load. Takes to long to get what the regions need to complete their jobs. Stop asking for information that DHHS already has access too. - Service link needs an updated platform.

Objective Area 2: How to improve coordination and case management

Q #	Question	Answered	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not sure
39	Information and data is seamlessly shared across ServiceLink, HCBS case managers, BEAS, institutional care providers, and HCBS direct service providers	38	0%	8%	11%	34%	32%	16%
40	The roles and responsibilities across ServiceLink, HCBS case managers, institutional care providers, and HCBS direct service providers are clear	38	3%	13%	8%	37%	26%	13%

Q #	Question	Select Comments
41	How would you improve coordination and case management for LTSS participants?	- Case managers role needs to be better defined and accountable for Medicaid eligibility and coordination of services - Communication with BEAS from the case management agency can be challenging - often with long delays in responses due to BEAS staffing challenges. - Enhance system to allow sharing of parties included in case to see what services are in the home and by who. - More staff to handle caseload/need - Create clearer policies and have greater oversight of service delivery - Installing uniform procedures and practices for communication

Q #	Question	Answered	Yes	Sometimes	Never	Not sure	N/A
42	Does the care plan typically document the individual's strengths related to independent living?	38	29%	16%	8%	26%	21%
43	Does the care plan typically capture the individual's wants, needs, and preferences, related to independent living?	38	29%	21%	8%	21%	21%
44	Does the care plan typically describe the individual's personal and/or employment goals?	38	16%	13%	16%	26%	29%
45	Does the care plan typically reference the individual's medical needs and how they will be met in the community?	38	32%	13%	11%	21%	24%
46	Does the care plan typically describe the desired outcomes?	38	29%	16%	16%	21%	18%
47	Does the care plan typically document the individual's support needs to be addressed by the planned services?	38	32%	16%	13%	21%	18%

Objective Area 3: How to improve service delivery

Q #	Question	Select Comments
48	How would you improve service delivery for LTSS (Medicaid and non-Medicaid)?	- Define role of Case managers Improve timeliness of accessing CFI services & redetermination process - Workforce incentive programs, increased wages, higher reimbursement - Make it MUCH easier to apply for Medicaid. I have people waiting months and months for services, and in some cases, pass before they can get any help. - Coordinate the eligibility rules for all services. - Would set standards for training requirements. - Better training opportunities at all levels.

Objective Area 4: How to improve the quality of services provided

Q #	Question	Answered	Yes	No	Not sure
	Would the following items or initiatives improve quality of services provided in NH?				
52	Creating a standardized consumer satisfaction survey that can be used across DHHS/BEAS HCBS funded programs.	38	34%	21%	45%
53	Creating a standard set of performance measures that can be used across DHHS/BEAS HCBS funded programs.	38	42%	21%	37%
54	Creating a standardized care plan that can be used across DHHS/BEAS HCBS funded programs.	38	39%	16%	45%
55	Implementing a uniform care planning process for needs assessment and service plan development so that all eligible individuals have access to the same services and supports.	38	61%	13%	26%
56	Implementing systems to require and support person-centered care plans driven by individuals' needs, goals and preferences.	38	63%	16%	21%
57	Expanding marketing efforts of ServiceLink.	38	63%	21%	16%
58	Providing additional training to HCBS direct service providers.	38	76%	8%	16%
59	Making it easier to become an HCBS direct service provider.	38	39%	26%	34%

Q #	Question	Select Comments
60	Is there anything else you would like to tell us that was not covered in this survey?	- The CFI program needs to start with the CM agencies first, others may/could be brought into the mix but not until collectively a framework is developed - Most transportation providers are already reporting to NHDOT and other funding sources. The reporting required by BEAS is far more complicated and requires data tracking that results in new tracking systems being implemented just for a relatively small amount of funding. Accepting NHDOT reporting standards would reduce the amount of reporting and data tracking time involved and allow resources to be spent on providing more actual transportation. - A "care" plan format she be a little more individualized depending on what group it is targeted toward.

Appendix D: Comparison of Medicaid LTSS Financial Eligibility Requirements across DHHS Documentation

Guidehouse analyzed four documents to determine how financial documentation requirements for Medicaid LTSS coverage are explained to consumers and providers. Guidehouse noted several inconsistencies across DHHS materials. Guidehouse's analysis is shown in the figure below:

Figure 9. Comparison of Medicaid LTSS Financial Eligibility Requirements across DHHS Documentation

	Source			
	Medicaid for Long Term Care	Medicaid for HCBS	Verification Checklist - Long Term Care	Examples of Acceptable Proofs
Documentation Type	Applicability: Long Term Care	Applicability: HCBS	Applicability: Long Term Care - NH & HCBS/CFI	Applicability: All BFA programs
Citizenship and Date of Birth	X	X		X
Burial contract and Burial Plot paperwork	X	X	X	
ID card	X	X		X
History of residence / proof of residence	X	X	X	
Proof of income	X	X	X	X
Annuities	X	X	X	X
Trusts	X	X	X	X
Bank statements			X	X
SSI or disability benefits	X	X		X
Other	X	X	X	X
Expenses (e.g., rent, utilities, childcare, medical expenses, etc.)				X
Proof of marital status (if applicable)	X	X	X	X
Spousal income information (if applicable)			X	
Social Security number and/or Veterans claim number	X	X	X	X
Life insurance	X	X	X	X
Health insurance card and proof of premiums	X	X	X	X
Authorized Representative Form, General Power of Attorney or Guardianship papers (if applicable)	X	X	X	
Property and/or "Life Estate"	X	X	X	X
Lookback / All assets for past 60 months		X	X	
Student status (if applicable)				X
Medical condition status				X
Vehicle ownership information				X
Proof of terminated employment (if applicable)				X

Appendix E: Comparison of Other State Look-Back Period Requirements

Guidehouse reviewed look-back period requirements for 7 states and found that most states require a 60-month look-back period; however, states appear to give themselves flexibility by using language "up to 5 years as determined by the State." Guidehouse's other state research is shown in the figure below.

Figure 10. Comparison of Other State Look-Back Period Requirements

State	Eligibility Policy	Asset Verification System Policy
New Hampshire	The look-back period for all asset transfers is 60 months.	Look-back Period for Transfers of Assets: AVS will request 60 months of financial records from Financial Institutions. Assets include all income and resources of a financial assistance or institutionalized medical assistance applicant/or recipient or of the individual's spouse. AVS will provide the worker with monthly balances on all accounts as of the 3rd of each month for the 60 months prior to the application.
Arizona	Any transfers that occurred during or after the 60-month look-back period must be reviewed to see if the customer received compensation for the full value of the asset.	State Plan requirement: The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.
Arkansas	The caseworker will look at all transfers made during the look back period. The look back period is the 60 months immediately prior to the date on which an individual is both in an institution and has applied for medical assistance or, in the case of a Waiver individual, prior to the date the individual applies for Waiver assistance.	All requests sent to Financial Institutions shall include a request for information on both open and closed accounts, going back for a period of up to five (5) years as requested by AR DHS.
Indiana	As stated in the preceding section, the transfer of property law is made an active consideration only by the applicant/recipient being or becoming institutionalized in a nursing facility (or receiving Home and Community-Based Services). When this factor is present in a case situation, the worker must then determine the time period that must be reviewed, during which transfers made could be violative. This time period is the "review period", or "look-back" period. Upon November 1, 2014, the review period for looking at a transfer involving non-trust property is 60 months prior to the first date when the individual was institutionalized and had applied for Medicaid, and continues indefinitely thereafter. The review period for transfers involving trust funds in the circumstances explained in Section 2615.75.15 is 60 months prior to the baseline date defined above and	State RFI for AVS: Financial institution verification requests must include a request for information on both open and closed accounts, going back for a period up to 5 years, as determined by the State. Property and physical asset verification requests must include property and/or assets acquired or liquidated going back for a period up to 5 years, as determined by the State. (Eligibility Policy will determine when this is appropriate)

State	Eligibility Policy	Asset Verification System Policy
	continues indefinitely thereafter.	
California	The current look-back period is 30 months.	Account information provided can be from both open and closed accounts over the previous five years.
Minnesota	NA - Silent on the lookback period.	For applications, the AVS will return information from participating financial institutions about accounts owned by MA-ABD applicants and, when applicable, spouses and sponsors, for the month of application and the three consecutive months before the month of application.
North Carolina	If the starting point is on or after November 1, 2012, look back 5 years for all transfers. Request bank statements, investment accounts, and other financial documents that can verify the a/b's (and spouse's) assets for the entire lookback period. If requested information is unavailable, evaluate the information presented and determine if the information provides a reasonable picture of the applicant's financial situation.	AVS can provide monthly balances held by the applicant/beneficiary at any time in the immediate past 60 months. Enter a Look Back Date. This will auto populate 60 months prior to the start date. An end date can be entered if the entire 60 months review is not needed.
Tennessee	The look-back period for all transferred assets is 60 months	Each Financial Institution shall respond electronically, providing any information it has about assets the Applicant, Recipient, and any other person whose resources are required by law to be disclosed, has or has had in the institution within the previous sixty (60) months.

Sources:

New Hampshire
- Policy: https://www.dhhs.nh.gov/mam_htm/newmam.htm
- AVS: https://www.dhhs.nh.gov/sr_htm/html/sr_17-03_dated_09_17.htm

Arizona
- Policy: https://www.azahcccs.gov/Resources/guidesmanualspolicies/eligibilitypolicy/eligibilitypolicymanual/index.html#t=Introduction%2FHome.htm
- AVS: https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/AssetVerification.pdf

Arkansas
- Policy: https://humanservices.arkansas.gov/images/uploads/lia-rules/DCO_Arkansas%20Private%20Option%20%28Health%20Care%20Independence%20Act%20of%202013%29_12312019.pdf
- AVS: http://www.ark.org/dfa/procurement/bids/get_document.php/popup?doc_id=11454&doc_type=PDF

Indiana
- Policy: https://www.in.gov/fssa/files/Medicaid_PM_2600.pdf
- AVS: https://www.in.gov/idoa/proc/bids/19-101/

California
- Policy Manual: https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Article21-IEVS.pdf
- Policy on look-back: https://www.dhcs.ca.gov/services/ltc/Pages/CPLTCAMedi_CalInformation.aspx
- AVS: https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL/2017/I17-05.pdf

Minnesota
- Eligibility Policy Manual: http://hcopub.dhs.state.mn.us/epm/ml_20_1.pdf
- AVS Policy: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-312963

State	Eligibility Policy	Asset Verification System Policy
North Carolina • Policy: https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/adult-medicaid/policies-manuals/ma2240-1.pdf • AVS: https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/family-and-childrens-medicaid/administrative-letters/documents/ma_al03-14.pdf **Tennessee** • Policy: https://www.tn.gov/content/dam/tn/tenncare/documents/HCFAEligibilityPolicyConsolidated.pdf • AVS: https://www.tn.gov/content/dam/tn/tenncare/documents2/PublicConsultingAVS486.pdf		

Appendix F: Transitioning from Medicaid Eligibility Authority 209(b) to 1634

States are required to provide coverage to aged, blind, and disabled (ABD) persons receiving cash-assistance through the Supplemental Security Income (SSI) program. States have the option to delegate some or all of Medicaid determinations for SSI recipients to the SSA. States have three options for determining Medicaid eligibility for SSI recipients:

Figure 11. Medicaid Eligibility Authority Options for SSI Recipients

Eligibility Authority	Scope of Coverage	Entity that Determines Eligibility	Medicaid Enrollment Process	States
1634	All SSI recipients	Social Security Administration	Automatic (part of the SSI application process)	35
SSI	All SSI recipients	State Medicaid agency	Separate application required	8
209(b)	Only those SSI recipients who meet more restrictive eligibility criteria than SSI criteria	State Medicaid agency	Separate application required	8

= New Hampshire

Guidehouse performed a high-level analysis to determine the program and financial impact of transitioning from eligibility authority 209(b) to 1634. Guidehouse's analyses are shown in the figures below.

Figure 12. Program Impact of Transitioning from 209(b) to 1634

Category	Scale of Impact
Addresses stakeholder feedback regarding Medicaid eligibility timeframes for NF and HCBS.	
Administrative simplicity for SSI-related Medicaid.	
Frees up state staff resources and potentially reduces vendor expenses	
Expanded eligibility and coverage for certain individuals.	
Loss of eligibility and coverage for certain individuals.	
Eliminates the Medicaid spenddown requirement for ABD individuals.	
Requires ABD individuals who require LTSS to create a Qualified Income Trust (QIT).	
Requires state agency staff time and resources to implement.	
Requires a detailed analysis to determine the financial impact and whether the change will impact budget neutrality.	
Requires close coordination and technical integration with the SSA.	
Requires updates to state regulations and materials.	

Scale of Impact Legend
- Significant negative impact
- Slight negative impact
- Neutral
- Slight improvement
- Significant improvement

Figure 13. Financial Impact of Transitioning from 209(b) to 1634

Calculation Methodology	NH ABD Enrollment (Jul. 2019)	Projected Increases: *Multiplier*	Projected Increases: Anticipated Additional Increase in ABD Enrollment	Projected Increases: Anticipated Additional Increase in ABD Cost [3]	Projected Increases: *% Change*
Method 1: Analysis based on ABD enrollment and population data from other comparable 1634 states (Washington and Iowa).	***26,348***	***44%*** [1]	11,593	$578,159,245	***26%***
Method 2: Analysis based on Ohio's % increase in enrollment from Jan. 2017 to Jan. 2019. Ohio switched from 209(b) to 1634 on 8/1/2016.		***55%*** [2]	14,491	$722,699,057	***32.5%***

Notes:

(1) 44% is based on a relativity factor using ABD enrollment and population data from Washington and Iowa. Iowa and Washington were chosen because they are expansion states, with a disability under 65 population similar to that of New Hampshire, and have the same % FPL.

(2) 55% is based on Ohio's % increase in enrollment from Jan. 2017 to Jan. 2019.

(3) This column is calculated by multiplying the estimated change in ABD enrollment by the average yearly cost of an ABD member. Average yearly cost of an ABD Member = $2,227,115,737 (Total Medicaid spend for 2018, trended forward by 3% to approximate 2019 spend) x 59% (% of ABD spend identified in a KFF report dated Oct. 2019) = $1,313,998,288 / 26,348 (NH ABD enrollment as of Jul. 2019) = $49,871 (average yearly cost of an ABD member).

Caveats:

- This analysis does not consider any offsetting savings from shifting state staff resources.
- Our high-level analysis above relies on limited state information; we did not conduct an exhaustive market analysis.
- Indiana, which transitioned from 209(b) to 1634 in 2014, was excluded from this analysis due to reclassification of aid categories and fluctuations in enrollment based on expansion.

Data Source: US Census, Kaiser Family Foundation, CMS, and other state agency data.

Appendix G: Provider Capacity Analysis

DHHS/BEAS requested that Guidehouse perform a high-level assessment of provider capacity for nursing facilities (NF) and home and community-based services (HCBS) providers. DHHS/BEAS leadership requested this analysis to determine whether NF capacity required a detailed analysis relative to a moratorium and to assess stakeholder concerns regarding gaps in HCBS provider capacity. This assessment is marked as **DRAFT** since DHHS/BEAS staff did not validate the findings presented in this analysis, due to COVID-19 priorities, and it does not reflect COVID-19 considerations since most of the analyses were performed pre-COVID. Guidehouse expects that the public health emergency significantly impacted provider capacity in NH as it has nationally. Our high-level provider capacity assessment is included in the figure below.

Figure 14: Provider Capacity Analysis Memo (DRAFT)

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Provider Capacity Study for Nursing Facilities and HCBS
- DRAFT

OVERVIEW:

This document provides high-level considerations and other state approaches for conducting capacity studies for nursing facilities and home and community-based services (HCBS) providers. New Hampshire's Department of Health and Human Services (DHHS) should use this summary to support future dialogue with nursing facility and HCBS providers and to use this summary as a starting point for further review and analysis.

Based on Navigant's review of other state provider capacity studies and high-level data from BEAS, we found the following:

1. **Other State Approaches to Conducting Capacity Studies**: There is limited state and Federal data available to assess provider capacity for HCBS. Most state provider capacity studies for long-term services and supports (LTSS) focused on nursing facility and not HCBS.
2. **Nursing Facility Capacity in New Hampshire**: The aggregate nursing facility occupancy rate in New Hampshire is high in comparison to the national average (89% v. 81%); however, this may be related to: 1) lack of home and community-based alternatives 2) lack of consumer awareness of available service options or 3) inappropriate referrals. **BEAS should issue an electronic survey to nursing facilities to better assess occupancy rates and waitlist data for each individual nursing facility. BEAS should also verify that proper referrals and options counseling is provided to individuals for the appropriate care setting.**
3. **HCBS Capacity in New Hampshire**:
   - There are significant gaps between the number of authorized Choices for Independence (CFI) waiver services to the number of paid units (31% of the authorized units are not paid) which may be an indication of network adequacy gaps. **BEAS should work with case managers to analyze gaps between authorized services and paid services by service area to better understand variances.**
   - There is limited data available to assess service fulfillment for the CFI waiver; however, in October 2019, BEAS added the service authorization category "no provider available" to begin tracking services that are authorized but not provided because a provider not available. **BEAS should continue to evaluate and track service fulfillment for the CFI waiver by service area to better assess service gaps.**

APPROACH AND CONSIDERATIONS FOR CONDUCTING A CAPACITY STUDY:

States conduct provider capacity studies to determine whether the existing healthcare supply is appropriate to meet current and future demand of the states' population. Oftentimes, provider capacity studies for healthcare facilities relate to "certificate of need" (CON) laws, which are laws that regulate the number of health care facilities or services to control health care costs and increase access to care. While New Hampshire repealed its CON laws in 2016, a moratorium on nursing homes is still in place.

There are several key data points that states use to assess provider capacity. The approach and data points vary based on the type of provider or setting:

- *Nursing Facilities:* States often rely on state-wide surveys and utilization and occupancy data to assess capacity for nursing facilities. Key metrics/data include:
  - Utilization rates in comparison to national averages
  - Nursing facility beds per 1,000 elderly individuals (age 65+)
  - Number of facilities in a geographic area in comparison to population density
  - Nursing facility financial ratios to determine financial stability
  - Occupancy and waitlist information
- *HCBS:* The best approach to assess gaps in service coverage for HCBS is to track service authorizations with no assigned service provider (i.e., this indicates whether there are sufficient providers in the area to meet client service requests). Additional metrics may include:
  - Number of providers licensed to practice in a geographic area in comparison to population density
  - Average time between service authorization and initiation of services
  - Number of service hours delivered minus the number of service hours approved
  - Percentage of people who do not use authorized hours or services

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HIGH-LEVEL SUMMARY OF PROVIDER CAPACITY IN NEW HAMPSHIRE:

This section provides a high-level summary of provider capacity in New Hampshire using data provided by BEAS and information obtained in the American Association of Retired Persons' (AARP) state profile report. For HCBS, Navigant leveraged information related to the CFI waiver; therefore, this analysis does not provide a comprehensive view of the HCBS landscape in New Hampshire. DHHS should use this summary as a starting point for further review and analysis.

Nursing Facilities

Per Figure 1 below, the aggregate nursing facility occupancy rate in New Hampshire was 89% in 2016, which was eight percentage points higher than the national average. Maintaining high occupancy levels is desirable to increase asset utilization; however, high capacity can also negatively constrain access to services and leave unmet demand in the community. For example, severe capacity constraints can cause bottlenecks in discharging patients from acute facilities.

While a high occupancy rate may suggest that additional beds are needed to meet future demand, this issue may be related to several factors including:

- *Lack of home and community-based alternatives*. In 2016, New Hampshire spent only 14% of Medicaid LTSS spending (for older people and adults with physical disabilities) on HCBS, compared to the national average of 45%. New Hampshire ranks #50 among other states for HCBS spending.[1] In addition, 13.2% of nursing facility residents have low care needs which identifies opportunities to provide services in a less restrictive and expensive setting. HCBS can offer avenues to rebalance care and alleviate capacity constraints in nursing facilities.
- *Lack of consumer awareness of available service options*. Nursing Facilities may have high capacity because consumers are unaware of their service options. New Hampshire's State Plan on Aging (released in 2019) determined that 44% of survey respondents were unaware of service availability and only 20% used the State's Aging and Disability Resource Connection (ADRC) (Referred to as ServiceLink in New Hampshire) to receive information on community services.
- *Inappropriate referrals*. Hospital discharge planners may be making referrals directly to nursing homes as opposed to connecting consumers with the State's ADRC.

Figure 1. Key Metrics for Nursing Facilities from the AARP Report[2]

Nursing Facilities, Utilization, and Resources	State	Per 1,000 Ages 75+	Rank	U.S.
Total nursing facilities, 2016	75	0.82	25	0.76
Nursing facility beds, 2016	7,471	82	26	80
Nursing facility residents, 2016	6,664	73	21	65
Nursing facility occupancy rate, 2016	89%		6	81%
% Change in nursing facility residents, 2011-2016	-4.4%		30	-3.9%
Direct care nursing hours per resident day, 2016	4.05		28	4.03
RN hours per resident day, 2016	0.89		18	0.79
Nursing assistants, 2015 **	4,757	53	17	43
Median hourly wage, 2017	$14.56		13	$13.23

Nursing Facility Quality and Resident Characteristics	State	Rank	U.S.
Long-stay residents receiving an antipsychotic medication, 2017	15.0%	31	15.5%
High-risk residents with pressure sores, 2017	4.1%	42	5.6%
Long-stay residents with a hospital admission, 2014	13.7%	33	17.0%
Nursing facility residents with low care needs, 2014 ****	13.2%	17	11.5%
Residents with Medicaid as primary payer, 2016	63%	19	62%
Residents with Medicare as primary payer, 2016	16%	10	14%
Residents with "other" as primary payer, 2016	21%	36	25%

[1] AARP state profile: https://www.aarp.org/content/dam/aarp/ppi/2018/08/new-hampshire-LTSS-profile.pdf

[2] https://www.aarp.org/content/dam/aarp/ppi/2018/08/new-hampshire-LTSS-profile.pdf

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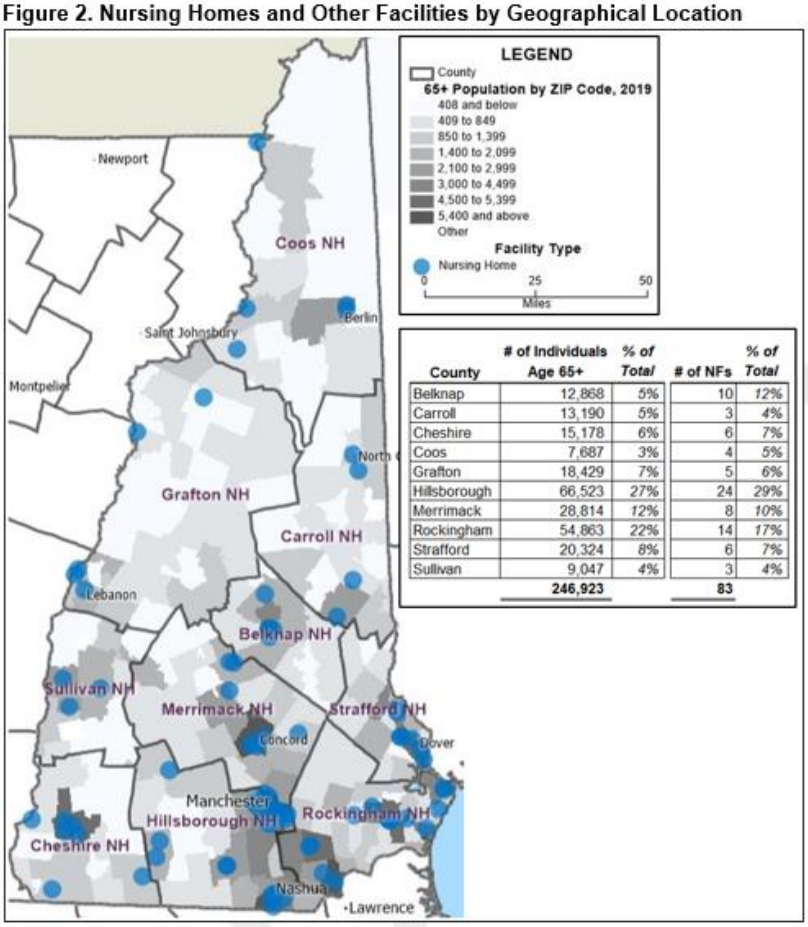
Figure 2 below depicts the geographic distribution of nursing home locations overlaying population density for individuals 65 years or older.[3,4] As of March 2020, there are 83 nursing facilities and 7,519 beds in New Hampshire. All counties in New Hampshire include three or more nursing facilities and the number of nursing facilities correlates with the population density (e.g., 61% of individuals age 65+ and 55% of nursing facilities are located in three counties).

Figure 2. Nursing Homes and Other Facilities by Geographical Location



County	# of Individuals Age 65+	% of Total	# of NFs	% of Total
Belknap	12,868	5%	10	12%
Carroll	13,190	5%	3	4%
Cheshire	15,178	6%	6	7%
Coos	7,687	3%	4	5%
Grafton	18,429	7%	5	6%
Hillsborough	66,523	27%	24	29%
Merrimack	28,814	12%	8	10%
Rockingham	54,863	22%	14	17%
Strafford	20,324	8%	6	7%
Sullivan	9,047	4%	3	4%
	246,923		83	

[3] Nursing facility data was provided by BEAS (Excel file titled "Nursing and ALFs.xls").
[4] Population estimates are calculated by Claritas using US Census data and age distribution projections. The Claritas demographic estimates are updated annually for many geographic levels such as national, state, county, ZIP codes, and metropolitan areas.

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Home and Community-Based Services Under the CFI Waiver

Per Figure 3 below, there are significant gaps between the number of authorized CFI waiver services to the number of paid units (31% of the authorized units are not paid). This may be an indication of network adequacy gaps; however, BEAS should analyze this issue in more detail to better understand the variances. BEAS should also look at gaps by service area or county to see if these issues are more pronounced in rural areas. For example, it appears that there is a significant gap in non-medical transportation; however, case managers may be adding more units than necessary for non-medical transportation to ensure that consumers are always able to access transportation services.

Figure 3. CFI Waiver Services: Comparison of Authorized Units and Paid Units from SFY 2017-2020

	A	B	C = A-B	D = C/A
CFI Waiver Service	# Auth Units	# Paid Units	Difference	% of Units Not Paid*
Non-Medical Transportation	71,028	10,374	60,654	85%
Personal Care Consumer Directed Special Rates	30,685	7,347	23,338	76%
Electronic Rx Device Monthly Service	1,315	459	856	65%
Sealed Rx Drug Packets	18,634	6,746	11,888	64%
Community Transition - MFP Demo	7	3	4	57%
Homemaker	1,448,026	728,113	719,913	50%
Home Health Aide Per Visit	213,293	109,129	104,164	49%
Electronic Rx Device Installation	252	138	114	45%
Electronic Rx / Cell Based PERS	3,155	1,786	1,369	43%
Home Delivered Meal	1,204,340	693,244	511,096	42%
Skilled Nurse Per Visit	192,564	119,668	72,896	38%
Day Care Services (Adult Medical Day Care)	141,175	89,355	51,820	37%
Home Health Aide 8+ Units	1,792,038	1,144,287	647,751	36%
Personal Care Agency Directed	19,685,482	13,370,019	6,315,463	32%
Electronic Rx / PERS Device	1,992	1,372	620	31%
Personal Care Consumer Directed	11,480,693	8,008,783	3,471,910	30%
Cell Based PERS	43,831	30,864	12,967	30%
Respite Care Services Special Rates	1,872	1,347	525	28%
Emerg Response System	50,560	37,751	12,809	25%
Kinship Care - Level 2 Per Diem	36,447	27,898	8,549	23%
Residential Care Dementia L2	25,103	20,100	5,003	20%
Case Management	3,504,010	2,909,055	594,955	17%
Supported Housing Level 2	109,267	91,307	17,960	16%
Respite Care Services	314,558	263,447	51,111	16%
Specialized Medical Equipment	1,249	1,058	191	15%
Adult Family Care - Level 2 Per Diem	3,380	2,870	510	15%
Kinship Care - Level 1 Per Diem	22,469	19,110	3,359	15%
Adult Family Care - Level 1 Per Diem	3,648	3,147	501	14%
Community Transition	26	23	3	12%
In-Home Day Care	29,391	26,037	3,354	11%
Residential Care	771,511	683,580	87,931	11%
Residential Care Dementia L1	15,501	13,877	1,624	10%
Environmental Accessibility Adaptations	520	469	51	10%
Supported Housing Level 3 (Betty's Dream)	15,894	15,174	720	5%
Residential Care Special Rates	14,701	14,892	-191	-1%
	41,248,617	**28,452,829**	**12,795,788**	**31%**

*Red shade = % of Units Not Paid ≥ 30%

The best approach to assess gaps in service coverage for HCBS is to track service authorizations with no assigned service provider (i.e., this indicates whether there are sufficient providers in the area to meet client service requests). On October 28, 2019, BEAS added the service authorization category "no provider available" to begin tracking service gaps. Figure 4 below presents a summary of service authorization requests with "no provider available" logged in BEAS's system from October 28, 2019 to June 19, 2020. Since BEAS recently required case managers to track this information, it is likely that this information is under reported. BEAS should continue to track and evaluate this data on an ongoing basis to identify gaps in service coverage.

Figure 4. Service Authorization Requests with No Assigned Provider (October 28, 2019 – June 19, 2020)

Service Category	# of Service Requests with No Assigned Provider
Day Care Services (AMDC)(S5102 HC U2)	76
Personal Care Agency Directed (T1019 HC U1)	39
Homemaker (S5130 HC)	11
Personal Care Consumer Directed (T1019 HC U2)	8
Home Health Aide 8+ Units (G0156 HC U1)	4
Home Health Aide Per Visit (T1021 HC)	2
Emerg Response System (S5161 HC)	2
Non-Medical Transportation (T2002 HC)	2
Skilled Nurse Per Visit (T1030 HC)	2
Specialized Medical Equipment (T2029 HC)	1
Total	**147**

OTHER STATE REPORTS TO ASSESS PROVIDER CAPACITY FOR NURSING FACILITIES AND HCBS

Figure 5 summarizes other state provider capacity studies for nursing facilities and HCBS. The purpose of these reports is to calculate current state capacity and to provide high-level recommendations on how to address deficiencies. Each state's report varies in its approach and level of sophistication. For example, some states may focus on occupancy and utilization data while other states may use a state-wide survey to assess gaps in service access.

Figure 5. Other State Provider Capacity Assessment Reports

State	Provider Types	Approach / Key Components Analyzed
Minnesota - Status of LTSS Legislative Report (2017)[5]	• Nursing Facilities • HCBS	Minnesota relied on feedback from stakeholders to understand service access and gaps for publicly funded HCBS. To assess service access and gaps for nursing facilities, Minnesota relied on occupancy and utilization data. This report includes several high-level recommendations to address provider shortages: • Increase flexibility to retain older workers. • Identify practices that will help employers better match people to the work. • Use Innovation and Live Well at Home grant funding to solicit and test ideas along with promising practices for hiring and retaining staff. • Explore further rate and pay changes that increase income for direct support workers. • Continue roll-out of the Direct Support Registry.
Rhode Island – Utilization and Capacity Study (2015)[6]	• Nursing Facilities • Assisted Living Residences • Adult Day Care Programs • Home Care Providers and Home Nursing Care Providers	Rhode Island conducted a "state-wide health inventory" by issuing a state-wide survey to assess: • Facility ownership • Accepting new residents with private pay • Accepting new residents with Medicaid benefits • Wait lists • Personnel staffing • Hours of operation • Payment source • Health care services provided • Use of information technology • Provision of interpreter services • Resident demographic information (e.g., race/ethnicity) This report includes several high-level recommendations to address provider shortages:

[5] https://mn.gov/dhs/assets/2017-08-long-term-services-supports_tcm1053-309107.pdf
[6] https://health.ri.gov/data/healthinventory/

New Hampshire Bureau of Elderly and Adult Services (BEAS) Provider Capacity Study for Nursing Facilities and HCBS - DRAFT

State	Provider Types	Approach / Key Components Analyzed
		• Conduct further research to explore how many dementia care units in long-term care settings are needed. • Decrease the number of Medicaid beneficiaries who reside in institutional long-term care settings but might be appropriately placed in other community-based living arrangements, such as assisted living residences.
New York – Weekly Nursing Facility Bed Availability Reports[7]	Nursing Facilities	New York assesses current capacity by requiring each nursing facility to submit counts of facility beds and availability by bed category on a weekly basis. New York's survey results are posted online in an easy to use web-based tool.
South Dakota – Evaluating Long-Term Care Options (Two reports produced in 2007 and 2015)[8,9]	• Nursing Facilities • Assisted Living Residences • Home Health Care • HCBS	South Dakota evaluated current capacity and service delivery challenges and projected future demand for LTSS services based on extrapolations from recent service utilization levels and trends. Key metrics analyzed for nursing facilities: • Utilization rates in comparison to national averages • Nursing facility beds per 1,000 elderly individuals (age 65+) • Number of facilities/entities by county • Nursing facility financial ratios to determine financial stability • Nursing facility travel patterns Key metrics analyzed for HCBS (this includes adult day services, senior centers, nutrition programs, and homemaker / in-home personal care): • Number of facilities/centers/agencies/programs by county and per 1,000 elderly (when available) • In-home service clients per 1,000 elderly by county This report includes several high-level recommendations including: • Pursue means to provide Medicaid-certified nursing facilities in South Dakota with low interest financing for capital improvements and to provide financial assistance to foster the growth of HCBS infrastructure which could include a revolving loan fund, provision of bonds, or other mechanisms. • Continue to evaluate and modify the Medicaid reimbursement rate setting structure to a) better fund facility depreciation and capital improvements in all Medicaid-certified nursing facilities, and b) promote the growth and expansion of HCBS, specifically adult day services.
South Dakota – Annual Report on the Need for Additional Nursing Facility Beds or Nursing Facilities (2018)[10]	Nursing Facilities	South Dakota conducted an annual review to determine whether the state has a sufficient number of nursing facilities and beds, and the Department of Health is required to address any identified needs. This report was prepared to evaluate South Dakota's cap on the number of nursing facilities. The report incorporates three components to determine nursing facility adequacy: 1. Estimated bed counts based on utilization and population 2. Occupancy data 3. Information obtained from a nursing facility survey to assess: • Wait lists • Staff shortages • Barriers to accepting referrals • Need for additional beds

[7] https://data.ny.gov/Health/Nursing-Home-Weekly-Bed-Census-Last-Submission/izta-vnpg/data
[8] https://ltcpartnership.sd.gov/docs/Final%20Report%20SD%20LTC%2012-07-07%20.pdf
[9] https://dss.sd.gov/docs/news/reports/finalreportsdltc.pdf
[10] https://doh.sd.gov/documents/Providers/Licensure/2017NursingFacilityMoratoriumReport.pdf

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