



The Senate of the State of New Hampshire

107 North Main Street, Concord, N.H. 03301-4951

January 29, 2020

The Honorable Christopher Sununu, Governor
State House, Second Floor
107 North Main Street
Concord, New Hampshire 03301

RE: Committee to Study the Disparity in Reimbursement Among Organizations that Provide Case Management Under Social Security Act Section 1915(c) Waiver Programs

Dear Governor Sununu:

As required by HB 4, Chapter 346:381, Laws of 2019, I present the Recommendations and Findings of the Committee to Study the Disparity in Reimbursement Among Organizations that Provide Case Management Under Social Security Act Section 1915(c) Waiver Programs.

If you should have any questions or comments regarding this report or the work of the committee, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink that reads "Cindy Rosenwald".

Senator Cindy Rosenwald

CR/dm

Attachments

cc: Honorable Donna Soucy, Senate President
Honorable Stephen Shurtleff, Speaker of the House
Tammy L. Wright, Senate Clerk
Paul Smith, House Clerk
Michael York, NH State Librarian
HB 4 Study Committee Members

Final Report

The Committee to Study the Disparity in Reimbursement among Organizations that Provide Case Management Under Social Security Act Section 1915 (c) Waiver Programs January 27, 2020

HB 4 of 2019 established the committee to examine “the extent of any disparity among organizations that provide case management under Section 1915(c) waiver programs and the potential causes of and solutions to such disparity.” The study’s scope was to “include a comparison between all Section 1915(c) waiver case management reimbursements, including reimbursement for providers in the following programmatic areas: developmental services, choices for independence, in-home support, and acquired brain disorder services.”

The members appointed to the committee were: Sen. John Reagan, Sen. Cindy Rosenwald, Rep. Katherine Rogers and Rep. Erin Hennessey. Sen. Rosenwald was elected Chair, and Rep. Rogers was the Clerk.

The Committee met five times: Oct. 23, 2019, Dec. 3, 2019, Dec. 18, 2019, Jan. 13, 2020, and Jan. 27, 2020. Minutes of all meetings are attached to this report as appendices.

Recommendations

The Committee recommends:

1. DHHS develop case management definitions and reimbursement rates specific to each of the state’s four 1915 (c) waiver programs; and that the reimbursement rate specific to each waiver be the same for all case management providers delivering the case management services that are specific to each waiver. This recommendation also applies to any case management services that are state plan services, such as targeted case management, delivered through a waiver program. The committee is aware that area agencies also get general management fees that are a percentage of a client’s budget for administrative functions that are not strictly case management. As the committee’s charge was limited to case management, we did not pursue evaluation of this subject.
2. DHHS develop the new rates for implementation with the Fiscal Years 2022/2023 budget (July 1, 2021-June 30, 2023). The committee understands that agencies will begin developing their budgets for the next biennium during the spring of 2020 and that CMS approval of rates is required.

Findings

The study was brought forward during the Senate phase of the budget because of information that some case management entities were being reimbursed by DHHS differently for the same work as other entities. The study was timely because DHHS informed the committee that CMS is requiring the state to develop a corrective action plan to address conflict-free case management to be in place by August, 2021.

At the organizational meeting in October, DHHS was asked to provide waiver and statutory references to case management or service coordination for each of the four waivers, rate history for case management or service coordination for each waiver, and service description. That information was presented by DHHS on Dec. 3, 2019 and attached to this report in the appendices. DHHS informed the

committee that area agencies are organized health care delivery systems, which take on additional administrative tasks, technically not case management functions. They are required to be available 24/7, unlike case management for the Choices for Independence program which is limited to reimbursement for 25 days per month.

The New Hampshire Independent Case Management Association presented information on rates and operating conditions, which is also attached. The committee learned that case management rates do vary for different waiver programs and for different entities that provide case management services. In addition, besides case management rates, there are also general management fees paid to area agencies ranging from 3-12%. The committee also learned that independent case management agencies may provide case management to developmental disability clients under subcontracts to area agencies; in these cases, they will often receive a lower rate than the area agency would for the same service.

The Committee heard from Ms. Robin Cooper, Director of Technical Assistance at the National Association of State Directors of Developmental Disabilities Services, the department's contracted consultant. Ms. Cooper presented to the committee on December 18 by conference call. Ms. Cooper advised the committee of three separated federal funding streams for case management with different federal match rates. States define case management, and there is wide variety among states. She advised the committee that best practices for case management definitions are person-centered and take into account system function, oversight, and quality assurance. She noted area agencies may also get cost allocation funding and transaction fees in addition to case management payments.

In response to Ms. Cooper's presentation, Carolyn Virtue of Granite Case Management asked three questions of DHHS :

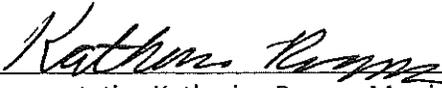
1. Do federal regulations require rate parity for similar scope of case management with similarly defined responsibilities, education, and experience for staffing? DHHS responds: "No. There are rate setting requirements and guidelines for State Plan services and Waiver services, but no Federal regulation that unequivocally states there must be rate parity for like case management activities."
2. Do federal regulations require states to treat different groups of beneficiaries equally? DHHS responds: "No. In fact, federal regulations specifically allow waivers to be tailored to different populations, and also allow targeted case management on the State Plan to be structured differently for different target populations."
3. If one single case management rate for providers with similar duties is substantially different among waivers and the state plan, does a rate disparity exist, and, if so, what federal guidance prohibits this practice? DHHS responds: "There is not one specific Federal regulation or guidance document that addresses this question specifically. CMS has approved all of the HCBS waivers. The CFI waiver specifically states that the participants will be provided with targeted case management in accordance with the State Plan. The State Plan targeted case management has been approved by CMS."

Appendices

- A—Information and data provided to the committee throughout the course of the committee meetings
- B—Agendas
- C—Minutes
- D—Additional documentation

Respectfully submitted,


Senator Cindy Rosenwald, District 13


Representative Katherine Rogers, Merrimack 28


Senator John Reagan, District 17


Representative Erin Hennessey, Grafton 1

APPENDIX A

**Statutory References
Rate History
Service Listing
DHHS**

| | A | B | C | D | E | F | G | H | I | J | K | L | M |
|----|--|-------|-----------|---|----------|-------|-------|-------|--------------------------------|--|--|--|--|
| 1 | Case Management Scope, Rule/Law and Authority across the DLTSS Waivers | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | 12/2/2019 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | Waiver | BP ID | Proc Code | Modifier Short Description | Unit | Mod 1 | Mod 2 | Mod 3 | Authority (Waiver, State Plan) | Scope - As defined in Waiver or State Plan | Case Management References by Waiver (See Separate Waiver PDF) | Service Coordination References by Waiver (See Separate Waiver PDF) | Rule or Law |
| 7 | CFI | ECIHC | T1016 | Case Management (Service Coordination) | Per Diem | HC | UI | | State Plan | <p><u>CFI Waiver:</u> C-1: Summary of Services Covered, Section C-1c NH enrolls private agencies that are licensed as case management providers and enrolled to provide targeted case management services in accordance with the approved State Plan and NH administrative rules. They support the individual in the development, implementation and monitoring of the person centered plan.</p> <p><u>State Plan Definitions:</u> Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance: -Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. -Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment; -Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services; and -Monitoring and follow-up activities: Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring.</p> | Application: 2 Request for Renewal Appendix A-2 Appendix C-1-b Appendix C-1-c Appendix C-2-d Appendix D-1-a Appendix D-2-a Appendix D-a-i(a) Appendix E-1-j Appendix E-1-j(1) Appendix E-2-b-iv Appendix F-1(2)-b Appendix F-1(3)-d(1) Appendix G-a-d Appendix G-a-d-ii Appendix A-2-a Appendix B-3-f(2)-b Appendix B-3-f(2)-d(1) Appendix C-1-a | No References | He-E 805 Targeted Case Management Services State Plan-(§1915(g)(1)) Statutory Authority: 42 USC § 1396n(g); RSA 151-E:12; http://www.gencourt.state.nh.us/rsa/html/xi/151-e/151-e-mrg.htm RSA 151-9; http://www.gencourt.state.nh.us/rsa/html/xi/151/151-mrg.htm RSA 161-I; https://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XII-161-I.htm He-E 801 Definitions - 801.02(e);(f);(g): RSA 151-E:1, 2 Eligibility Determination - 801.04(a);(d): RSA 151-E:3 Development of the Comprehensive Care Plan - 801.05(a);(b): RSA 151-E:4 Service Authorization - 801.06(c): RSA 151-E:1 Redetermination of Eligibility and Service Authorization - 801.07(e): RSA 151-E:3 Adult Family Care - 801.14(c): Section 1915 (c)(4)(B) of the Social Security Act; RSA 161-1 Environmental Accessibility Adaptations - 801.17(a);(d);(f): Section 1915 (c)(4)(B) of the Social Security Act; RSA 161-I Home-Delivered Meals Services - 801.18(a);(c): Section 1915 (c)(4)(B) of the Social Security Act; RSA 161-I Non-Medical Transportation Services - 801.21(d): Section 1915 (c)(4)(B) of the Social Security Act; RSA 161-I Personal Care Services - 801.22(d): Section 1915 (c)(4)(B) of the Social Security Act; RSA 161-I Specialized Medical Equipment Services - 801.27(a);(c): Section 1915 (c)(4)(B) of the Social Security Act; RSA 161-I Required Documentation - 801.30(a): 42 CFR 431.107 Waivers - 801.34(a);(b): Section 1915(c) of the Social Security Act |
| 8 | CFI | ECIHC | T1017 | Targeted Case Management (Transitional Case Management) | Per Diem | HC | | | State Plan | Same as the CFI T1016 Case Management (above) but for Transitional and limited to 30 days. Refer to State Plan Amendment. | | | |
| 9 | | MCAID | T2023 | Targeted Case Management | Month | SE | UD | U1 | State Plan | <u>State Plan:</u> Provided to individuals that are Medicaid not on the DD, ABD & IHS waiver. Refer to State Plan Amendment. | N/A | N/A | |
| 10 | | MCAID | T2023 | TCM - Family Support Coordination | Month | SE | UD | U2 | State Plan | <u>State Plan:</u> Provided to individuals that are Medicaid not on the DD, ABD & IHS waiver. Refer to State Plan Amendment. | N/A | N/A | |
| 11 | DD | DDWVR | T2022 | Case Management (Service Coordination) | Month | SE | U1 | UA | Waiver | <u>DD Waiver Definition:</u> <u>Service Coordination:</u> Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. | Appendix C-1-a Appendix C: C-1/C-3 Appendix C-2 Appendix C-5 Appendix E-1-g Appendix E-1-j Appendix E-1-k Appendix E-1-l Appendix E-1-f Appendix I-3-g-ii Appendix J-2-c | Appendix C-1-a Appendix C: C1-C3 Appendix C-2 Appendix C-5 Appendix E-1-g Appendix E-1-j Appendix E-1-k Appendix E-1-l Appendix I-3-g-ii Appendix J-2-c | 171-A:12 Individual Service Agreement. He-M 503.08 <u>Service Coordination</u> He-M 517.05 <u>Covered Services</u> (d) Service coordination services shall: |
| 12 | DD | DDWVR | T2022 | Family Support Coordination | Month | | U3 | UA | Waiver | | | | |

| | A | B | C | D | E | F | G | H | I | J | K | L | M |
|----|--|---|-----------|--|-------|-------|-------|-------|--------------------------------|---|--|---|---|
| 1 | Case Management Scope, Rule/Law and Authority across the DLTSS Waivers | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | 12/2/2019 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | Waiver | BP ID | Proc Code | Modifier Short Description | Unit | Mod 1 | Mod 2 | Mod 3 | Authority (Waiver, State Plan) | Scope - As defined in Waiver or State Plan | Case Management References by Waiver (See Separate Waiver PDF) | Service Coordination References by Waiver (See Separate Waiver PDF) | Rule or Law |
| 13 | ABD | ABDWVR | T2022 | Case Management (Service Coordination) | Month | SE | UB | U1 | Waiver | ABD Waiver Definition: Service Coordination: Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. | Appendix C-1-a Appendix C: C-1/C-3 Appendix C-1-b Appendix C-1-c Appendix E-1-j Appendix E-1-k | Appendix C: C-2 Appendix C: C-5 Appendix E-1-g Appendix E-1-j Appendix E-1-k Appendix E-1-l Appendix I-3-g-ii Appendix J: J2 Appendix J-2-d-i | He-M 522.09 <u>Service Coordination</u> |
| 14 | ABD | ABDWVR | T2022 | Family Support Coordination | Month | SE | UB | U3 | Waiver | | | | He-M 517.05 <u>Covered Services</u> (d) Service coordination services shall: |
| 15 | IHS | IHSWVR | T2025 | Participant & Managed Services Family Support/Service Coordination (PDM FS / SC) | Month | SE | UC | U3 | Waiver | IHS Waiver Definition: Family Support/Service Coordination: The Family Support / Service Coordination component includes the following: • Coordinating, facilitating and monitoring services provided under the waiver; • Assessing and reassessing service needs; • Assistance with recruiting, screening, hiring, and training in-home support providers; • Identifying, providing information regarding and assisting families to access community resources and supports; • Development, review, and modification of service agreements; • Providing counseling and support; • Skills and advocacy training for the child/individual or representative; • Monitoring consumer satisfaction; • Initiating, collaborating and facilitating the development of a transition plan at the age of 16, to access adult supports, services, and community resources when the child/individual turns age 21; and • Creating and maintaining work registries. | Appendix C-1-a Appendix C: C-1/C-3 Appendix D-2-a Appendix E-1-g Appendix E-1-j Appendix E-1-l Appendix I-2-a Appendix I-3-g-ii Appendix J-2 | He-M 524.07 <u>Coordination of In-Home Supports</u> | |
| 16 | | | | | | | | | | | | | |
| 17 | | | | | | | | | | | | | |
| 18 | References: | | | | | | | | | | | | |
| 19 | | | | | | | | | | | | | |
| 20 | Link to DHHS Home and Community Based Care Services Waivers: | | | | | | | | | | | | |
| 21 | CFI Waiver: | https://www.dhhs.nh.gov/dcbcs/bds/documents/cfiwaiver2017.pdf | | | | | | | | | | | |
| 22 | DD Waiver: | https://www.dhhs.nh.gov/dcbcs/bds/documents/ddwaiver.pdf | | | | | | | | | | | |
| 23 | ABD Waiver: | https://www.dhhs.nh.gov/dcbcs/bds/documents/abdwaiver.pdf | | | | | | | | | | | |
| 24 | IHS Waiver: | https://www.dhhs.nh.gov/dcbcs/bds/documents/ihswaiver.pdf | | | | | | | | | | | |

Case Management Rates across the DLTSS Waivers, as of 11-30-19

12/2/2019

| Waiver | BP ID | Proc Code | Modifier Short Description | Unit | Mod 1 | Mod 2 | Mod 3 | Authority (Waiver, State Plan) | Current |
|--------|--------|-----------|--|----------|-------|-------|-------|--------------------------------|------------|
| CFI | ECIHC | T1016 | Case Management (Service Coordination) | Per Diem | HC | U1 | | State Plan | \$ 8.86 |
| CFI | ECIHC | T1017 | Targeted Case Management (Transitional Case Management) | Per Diem | HC | | | State Plan | \$ 45.00 |
| | MCAID | T2023 | Targeted Case Management | Month | SE | UD | U1 | State Plan | \$ 257.35 |
| | MCAID | T2023 | TCM - Family Support Coordination | Month | SE | UD | U2 | State Plan | \$ 257.35 |
| DD | DDWVR | T2022 | Case Management (Service Coordination) | Month | SE | U1 | UA | Waiver | \$ 257.35 |
| DD | DDWVR | T2022 | Family Support Coordination | Month | SE | U3 | UA | Waiver | \$ 257.35 |
| ABD | ABDWVR | T2022 | Case Management (Service Coordination) | Month | SE | UB | U1 | Waiver | \$ 257.35 |
| ABD | ABDWVR | T2022 | Family Support Coordination | Month | SE | UB | U3 | Waiver | \$ 257.35 |
| IHS | IHSWVR | T2025 | Participant & Managed Services Family Support/Service Coordination (PDM FS / SC) | Month | SE | UC | U3 | Waiver | Ind. Det * |

Notes:

* Independently Determined (Ind. Det) or Manually priced as part of the Participant Direct and Managed Services (PDMS) budget; however, as a matter of practice only \$257.35 per month is billed for this service.

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | |
|----|---|--------|-----------|--|----------|-------|-------|-------|------------------|------------------|------------------|-------------------|------------------|------------------|-------------------|------------------|--------------------|------------------|------------------|----------------|------------|
| 1 | Case Management Rate History | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | | |
| 3 | 12/2/2019 | | | | | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | | | | | |
| | Waiver | BP ID | Proc Code | Modifier Short Description | Unit | Mod 1 | Mod 2 | Mod 3 | 3/1/04 - 6/30/07 | 7/1/06 - 6/30/07 | 7/1/07 - Current | 7/1/07 - 12/31/08 | 1/1/09 - 3/31/10 | 1/1/09 - Current | 2/16/10 - Current | 5/1/10 - 6/30/11 | 12/28/10 - Current | 7/1/11 - 6/30/17 | 7/1/17 - current | Current 7/1/19 | |
| 6 | CFI | ECHC | T1016 | Case Management (Service Coordination) | Per Diem | HC | U1 | | | \$ 8.35 | | \$ 8.52 | \$ 8.69 | | | \$ 8.52 | | \$ 8.52 | \$ 45.00 | \$ 8.86 | \$ 8.86 |
| 7 | CFI | IECHC | T1017 | Targeted Case Management (Transitional Case Management) | Per Diem | HC | | | | | | | | | | | | \$ 45.00 | \$ 45.00 | \$ 45.00 | \$ 45.00 |
| 8 | | MCAID | T2023 | Targeted Case Management | Month | SE | UD | U1 | | | | | | | | | | | | | |
| 9 | | MCAID | T2023 | TCM - Family Support Coordination | Month | SE | UD | U2 | | | | | | | | | | | | | \$ 257.35 |
| 10 | DD | DDWVR | T2022 | Case Management (Service Coordination) | Month | SE | U1 | UA | \$ 252.30 | | \$ 257.35 | | | \$ 257.35 | | | | | | | \$ 257.35 |
| 11 | DD | DDWVR | T2022 | Family Support Coordination | Month | SE | U3 | UA | | | | | | | \$ 257.35 | | | | | | \$ 257.35 |
| 12 | ABD | ABDWVR | T2022 | Case Management (Service Coordination) | Month | SE | UB | U1 | \$ 252.30 | | \$ 257.35 | | | \$ 257.35 | | | | | | | \$ 257.35 |
| 13 | ABD | ABDWVR | T2022 | Family Support Coordination | Month | SE | UB | U3 | | | | | | \$ 257.35 | | | | | | | \$ 257.35 |
| 14 | IHS | IHSWVR | T2025 | Participant & Managed Services Family Support/Service Coordination (PDM FS / SC) | Month | SE | UC | U3 | | | | | | | | | | | | | Ind. Det * |
| 15 | | | | | | | | | | | | | | | | | | | | | |
| 16 | | | | | | | | | | | | | | | | | | | | | |
| 17 | Notes: | | | | | | | | | | | | | | | | | | | | |
| 18 | * Independently Determined (Ind. Det) or Manually priced as part of the Participant Direct and Managed Services (PDMS) budget; however, as a matter of practice only \$257.35 per month is billed for this service. | | | | | | | | | | | | | | | | | | | | |

References to “Case Management” in He-E 800

He-E 801 CHOICES FOR INDEPENDENCE PROGRAM

He-E 801.02 Definitions.

- (e) “Care plan” means a written guide that: (2) Is developed as a result of an assessment process which includes communication with the participant’s case manager;
- (f) “Case management agency” means an agency that is enrolled as a New Hampshire Medicaid provider to provide targeted case management services to CFI participants in accordance with He-E 805.
- (g) “Case manager” means a person providing services in accordance with He-E 805, who has the primary responsibility for assessing the participant’s needs, developing a comprehensive care plan, and coordinating and monitoring the services described in the comprehensive care plan.

He-E 801.04 Eligibility Determination.

- (a) The department shall make the clinical eligibility determination of the applicant as follows: (2) The applicant shall sign the following: b. A consent for participation in the CFI program, including whether or not he or she has a preference of a case management agency;
- (d) Upon a determination of eligibility, the applicant or his or her legal representative shall be sent an approval notice, including: (1) The name and contact information of the case management agency and case manager chosen by the applicant or assigned to the applicant by the department, if available at the time of the notice; and

He-E 801.05 Development of the Comprehensive Care Plan.

- (a) The case manager assigned to the participant shall develop and maintain a comprehensive care plan through a person-centered planning process in accordance with He-E 805.
- (b) The case manager shall request authorization from the department of the CFI services contained in the comprehensive care plan, including the specific service providers selected by the participant.

He-E 801.06 Service Authorization.

- (c) Service authorizations shall be issued to specific service providers identified by the participant’s case manager as a result of person centered planning.

He-E 801.07 Redetermination of Eligibility and Service Authorization.

- (e) If a participant is determined ineligible, or if services are identified as no longer being clinically necessary, the department shall either terminate CFI eligibility or reduce or terminate the services authorized, respectively, as follows: (2) A written notice of eligibility termination or the reduction or termination of the services authorized, as applicable, shall be sent to the participant, or his or her legal representative, and the participant’s case manager, including:

He-E 801.14 Adult Family Care.

(c) The home provider of a residence in (a)(1)b. above shall: (7) During a planned absence or in the event of an emergency, collaborate with the oversight agency and the participant's case manager to arrange for a substitute caregiver in accordance with the participant's care plan;

He-E 801.17 Environmental Accessibility Adaptations.

(a) Environmental accessibility adaptations (EAA) shall be a covered service when: (2) The participant's case manager has requested prior authorization for the service in accordance with (d) below;

(d) The participant's case manager shall submit the following when requesting prior authorization for an EAA:

(1) A completed Form 3715, "Choices for Independence Prior Authorization Request Form" (4/2011);

(2) A copy of the evaluation in (a)(1) above that describes:

- a. The medical or functional need for the adaptation;
- b. The description and measurements required for the adaptation; and
- c. The proposed training plan for the client and caregiver to ensure safe use of the adaptation;

(3) Proposals from at least 2 registered providers or contractors, except that one proposal may be submitted with a written explanation of why only one proposal is available or appropriate, including the following, as applicable to the project:

- a. A list of supplies and materials;
- b. Blueprints or scaled drawings;
- c. The name(s) of any subcontractors that will be involved;
- d. Written confirmation of whether or not a building permit is required;
- e. If electrical or plumbing work is required to support the adaptation, then:
 1. A statement signed by the provider or contractor stating that the requested adaptation can be done within the current electrical or plumbing capacity of the residence; and
 2. A copy of the electrician or plumber's license;
- f. A statement signed by the provider or contractor affirming knowledge of all applicable building codes and permitting requirements and affirming that any subcontractors involved in the work are appropriately licensed; and
- g. An agreement signed by the provider or contractor stating that reimbursement for the authorized service through CFI will be payment in full;

- (4) If a participant prefers one bid over the other(s), then an explanation of the preference shall be submitted; and
- (5) A notarized written statement from the property owner granting permission to complete the project if the participant is not the owner of the residence.
- (f) Payment for EAAs shall not be made until the department receives the following: (3) A signed confirmation from the case manager stating that the work was completed.

He-E 801.18 Home-Delivered Meals Services.

- (a) Covered home-delivered meals services include: (2) The monitoring of the participant and the reporting of emergencies, crises, or potentially harmful situations to emergency personnel or the participant's case manager, as appropriate.
- (c) Providers of home-delivered meals services shall: (3) Provide meals that accommodate diabetic or salt restricted diets, or both, if such are requested by the case manager;

He-E 801.21 Non-Medical Transportation Services.

- (d) When requesting authorization for non-medical transportation services, the participant's case manager shall:
 - (1) Document the following in the participant's record:
 - a. What public transportation resources were investigated by the case manager and why they do not meet the participant's needs;
 - b. What private transportation resources were investigated by the case manager, such as friends or family members, including who was contacted and when that person denied transportation; and
 - c. How the non-medical transportation requested will implement the comprehensive care plan; and
 - (2) Send the following information with the request for non-medical transportation to BEAS:
 - a. The specific destination(s) of the requested transportation;
 - b. How the participant has previously been transported to that destination(s), if applicable;
 - c. The name of the person or provider that will provide the transportation;
 - d. If more than one trip to the same destination is being requested, identify the frequency requested;
 - e. A copy of the section of the comprehensive care plan that documents that the requested transportation is necessary for it to be implemented; and

- f. Which specific public and private resources were investigated, as described above in (1)a. and b., and why they are not available to the participant.

He-E 801.22 Personal Care Services.

(d) The participant, his or her legal guardian, or a person granted power of attorney by the participant may designate a personal care services (PCS) representative to act on the participant's behalf:

(2) Under the following conditions:

- a. The following persons shall not serve as a PCS representative for purposes of directing personal care services:
 - 2. The participant's case manager; and
- b. The PCS representative shall be designated through a written document, stating that:
 - 3. The responsibilities of the PCS representative shall be to:
 - (ii) At a minimum, have monthly contact with the participant's case manager concerning personal care services;

He-E 801.27 Specialized Medical Equipment Services.

(a) Specialized medical equipment shall be a covered service when: (2) The participant's case manager has requested prior authorization for the item in accordance with (c) below;

(c) The participant's case manager shall submit the following when requesting prior authorization for specialized medical equipment:

- (1) A completed Form 3715, "Choices for Independence Prior Authorization Request Form" (4/2011);
- (2) A copy of the evaluation in (a)(1) above that describes:
 - a. The medical or functional need for the equipment;
 - b. The description and any measurements required for the equipment; and
 - c. The proposed training plan for the client and caregiver to ensure safe use of the equipment;
- (3) Proposals from at least 2 enrolled providers, except that one proposal may be submitted with a written explanation of why only one proposal is available or appropriate, including the following, as applicable to the equipment:
 - a. A list of supplies and materials; and
 - b. A description, including measurements, of the equipment; and

- (4) If a participant prefers one bid over the other(s), then an explanation of the preference.

He-E 801.30 Required Documentation.

(a) Each participating provider, with exceptions noted in (b) below, shall develop, maintain, and implement a written care plan as follows:

(2) The provider shall communicate with the participant's case manager in order to ensure the care plan is consistent with and addresses the applicable service needs identified in the comprehensive care plan

(5) The provider shall communicate the elements of the care plan to the participant's case manager, upon the completion or revision of the plan, and document the date it was communicated.

He-E 801.34 Waivers

(a) An applicant, case manager, provider agency, individual, or guardian, may request a waiver of specific procedures outlined in He-E 801 using the form titled "NH Bureau of Elderly and Adult Services Waiver Request." (August 2018) The case management agency or provider agency shall submit the request in writing to (c) below.

(b) A completed waiver request form shall be signed by: (2) The case manager and provider agency executive director or designee recommending approval of the waiver.

He-E 805 TARGETED CASE MANAGEMENT SERVICES

Statutory Authority: 42 USC § 1396n(g); RSA 151-E:12; RSA 151:9

He-E 805.01 Purpose. The purpose of this rule is to describe the requirements for targeted case management services provided to participants in the home and community based care for the elderly and chronically ill Choices for Independence (CFI) program.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.02 Definitions.

(a) "Activities of daily living" means those activities associated with personal care, including personal hygiene, bathing, eating, dressing, toilet use, walking, transferring from one surface to another, moving between locations, and bed mobility.

(b) "Biopsychosocial history" means information about a participant's past and present functioning in the areas of:

- (1) Physical health;
- (2) Psychological health, including emotional/coping ability;
- (3) Decision-making ability;
- (4) Social environment, including interactive skills, activities and supports;
- (5) Family relationships;
- (6) Financial considerations;
- (7) Employment;
- (8) Any vocational interests and activities, including spiritual preferences; and
- (9) Any other area of significance in the participant's life, including, but not limited to, substance abuse or misuse, involvement with the behavioral health care system, developmental disability system, or legal system.

(c) "Case management agency" means an agency that is licensed in accordance with RSA 151:2, I(b), and enrolled as a New Hampshire medicaid provider to provide targeted case management services to CFI participants, and that operates without a conflict of interest. This term includes independent case management agencies.

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(d) "Case manager" means an individual employed by, or contracted with, a case management agency who:

- (1) Meets the qualifications described in He-E 805.06;
- (2) Is responsible for the ongoing assessment, person-centered planning, coordination, and monitoring of the provision of services included in the comprehensive care plan; and
- (3) Does not have a conflict of interest.

(e) "Complaint" means:

- (1) Any allegation or assertion that a right of a participant has been violated;
- (2) Any allegation or indication that an individual has been abused, neglected, or exploited by an employee of, or a volunteer or consultant for, a facility, provider, or program; or
- (3) Any allegation or assertion that the department or a facility, agency, or service provider has acted in an illegal or unjust manner with respect to a participant or category of participants.

(f) "Comprehensive assessment" means a person-centered process of gathering information about a participant's abilities and needs through a face-to-face interview with the participant, and other methods as needed, which culminates in a written document.

(g) "Comprehensive care plan" means an individualized plan described in He-E 805.05(c) that is the result of a person-centered process that identifies the strengths, capacities, preferences, and desired outcomes of the participant.

(h) "Conflict of interest" means a conflict between the private interests and the official or professional responsibilities of a person, such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant.

(i) "Department" means the New Hampshire department of health and human services.

(j) "Home and community-based care for the elderly and chronically ill (Choices for Independence)" means a system of long-term care services provided in non-institutional settings and described in He-E 801, and provided under a waiver of Section 1902(a)(10) and 1915(c) of the Social Security Act for participants who are elderly or adults who have a disability or chronic illness.

(k) "Incident" means an occurrence or event that interrupts normal procedure, including a serious injury or other event threatening the health or safety of a participant or staff.

(l) "Individualized contingency plan" means the person-centered plan that addresses unexpected situations that could jeopardize the participant's health or welfare, and which:

- (1) Identifies alternative staffing resources in the event that normally scheduled care providers are unavailable; and

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(2) Addresses special evacuation needs that require notification of the local emergency responders.

(m) “Instrumental activities of daily living” means those activities associated with home management, including grocery shopping, meal preparation, telephone use, and managing finances, and routine housework such as washing dishes, making beds, dusting, and laundry.

(n) “Medical eligibility assessment (MEA)” means an initial assessment and subsequent re-assessments conducted in accordance with RSA 151-E:3, I.

(o) “MEA needs list/support plan” means a document generated by the department that identifies participant needs to be addressed in the comprehensive care plan.

(p) “Participant” means an individual who has been found by the department to be eligible for the CFI program.

(q) “Person-centered” means a process for planning and supporting the participant receiving services that builds upon the participant’s capacity to engage in activities that promote community life and honors the participant’s preferences, choices, and abilities, and which involves families, friends, and professionals as the participant desires or requires.

(r) “Sentinel event” means an unexpected occurrence, including:

(1) The death of a participant from suicide or homicide; or

(2) A serious physical or psychological injury, or risk thereof, resulting from:

a. A sexual assault;

b. An unauthorized departure from a facility;

c. A medication error which results in paralysis, coma, permanent loss of function, or death;

d. A delay in the provision of departmental services resulting in a negative outcome; or

e. Abuse and/or neglect that results in paralysis, coma, permanent loss of function, or death, of a participant who:

1. Is receiving department funded services;

2. Has received department funded services within the preceding 30 days; or

3. Has been evaluated by a contract provider within the preceding 30 days.

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(s) "Targeted case management" means the collaborative process of assessment, planning, facilitation, advocacy, coordination, and monitoring that is accomplished with a person-centered process, and which:

(1) Assists participants to gain access to needed CFI waiver services, services contained in the medicaid state plan, and other medical, social, spiritual, vocational, educational, and community supports, regardless of the funding source; and

(2) Provides for coordination of participant service plans from all providers to assure adequacy and, appropriateness of care and cost effectiveness of planned services that yield positive outcomes.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.03 Eligibility.

(a) Targeted case management services shall be provided to all participants, except those excluded pursuant to the Laws of 2007, Chapter 263:108.

(b) Targeted case management services shall be available to participants who reside in hospitals or nursing facilities licensed in accordance with RSA 151, provided that such services:

(1) Do not exceed a total of 30 cumulative days of services provided prior to discharge to home from an aforementioned facility or combination of facilities; and

(2) Do not duplicate discharge planning services that the facility is normally expected to provide as part of inpatient services.

(c) Notwithstanding (a) above, the commissioner of the department shall grant waivers to allow case management services to be provided to the excluded beneficiaries in (a) above as necessary to protect their health and safety.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.04 Provider Agency Requirements.

(a) Case management agencies shall:

(1) Comply with the requirements contained in He-E 801.29, including the requirement to be enrolled as a medicaid provider; and

(2) Be licensed in accordance with requirements of state law, including RSA 151.

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(b) Case management agencies shall employ a full-time administrator responsible for the development and implementation of the policies of the case management agency and for compliance with applicable rules.

(c) Case management agencies shall establish and maintain agency written policies and procedures regarding the following areas, and shall ensure that they are properly followed and enforced:

- (1) Completion and documentation of a criminal background check for all employees pursuant to RSA 151:2-d;
- (2) A process for confirming that each employee is not on the NH central registry of abuse, neglect or exploitation pursuant to RSA 169-C:35 or BEAS state registry established pursuant to RSA 161-F:49;
- (3) Verification of discipline specific licensing for those employees whose profession requires licensing;
- (4) The requirements for the mandated reporting of abuse, neglect, or exploitation in accordance with RSA 161-F: 46;
- (5) The procedures for reported complaints, incidents, and sentinel events;
- (6) Staff orientation including, at a minimum, a review of:
 - a. The federal and state laws and rules governing the CFI program;
 - b. The local community service network;
 - c. The procedures for crisis intervention; and
 - d. The philosophy governing person-centered planning, as defined in He-E 805.02(q);
- (7) Staff development, including procedures for addressing performance or training needs;
- (8) Staff performance evaluations, including how performance or training needs will be addressed throughout the case manager's employment tenure;
- (9) A clinical supervision protocol which includes, at a minimum:
 - a. Monthly meetings between the case manager and his or her supervisor; and
 - b. As a focus of supervision, the review of participant records to ensure compliance with the requirements described in He-E 805.04(f) and He-E 805.05(b)-(d);
- (10) Participant complaints, including how participants are informed about the agency's policies and procedures;

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- (11) Evaluation of participant satisfaction with the agency and the case manager, and how a participant may request a change in case manager or case management agency;
 - (12) Procedures for protection of participant records that govern use of records, storage, removal, conditions for release of information, and compliance with the Health Insurance Portability and Accountability Act (HIPAA); and
 - (13) Procedures related to quality assurance and quality improvement.
- (d) Case management agencies shall accept assignments made, pursuant to He-E 805.07(b), according to the system maintained by the department's bureau of elderly and adult services (BEAS) unless there is a conflict of interest or the agency has informed BEAS in writing that it must be temporarily removed from the list of available agencies due to staffing shortages.
- (e) Case management agencies shall maintain access to a toll free number for all participants served and respond to calls as follows:
- (1) Responses to calls received on Monday through Friday shall be made within 24 hours; and
 - (2) Responses to calls received on Saturdays, Sundays, and holidays shall be made within 48 hours.
- (f) Case management agencies shall maintain an individual case record for each participant receiving case management services which includes:
- (1) A face sheet describing demographic and other important information, including:
 - a. The participant's name, date of birth, and address;
 - b. The participant's medicaid identification number; and
 - c. The name, phone number, and address of the participant's emergency contact person;
 - (2) The comprehensive assessment document, described in He-E 805.05(b) below;
 - (3) The comprehensive care plan, described in He-E 805.05(c) below;
 - (4) The CFI MEA assessment and MEA needs list or support plan;
 - (5) Medicaid financial eligibility information, including the cost share described in He-E 801.11;
 - (6) Release of information forms;
 - (7) Progress notes that reflect areas contained in the comprehensive care plan;
 - (8) All contact notes, including those required by He-E 805.05(d)(1) below;

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- (9) A written record of all monitoring and case management activities;
- (10) All pertinent correspondence relating to the participant's case management; and
- (11) Any and all electronic records.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.05 Required Case Management Services.

(a) For each participant who selects or is assigned to a case management agency, the agency shall designate a case manager to provide case management services.

(b) The designated case manager shall conduct a comprehensive assessment of a participant within 15 working days of the date on which the agency receives department notification of the assignment, which shall:

- (1) Utilize a formal assessment tool to evaluate the participant's status based on information gathered at a face-to-face meeting, and through other methods as needed; and
- (2) Culminate in a written document that describes the participant's abilities and needs in the following areas:
 - a. Biopsychosocial history;
 - b. Functional ability, including activities of daily living and instrumental activities of daily living;
 - c. Living environment, including the participant's in-home mobility, accessibility, and safety;
 - d. Social environment, including social/informal relationships and supports, activities and interests, such as avocational and spiritual;
 - e. Self-awareness, or the degree to which the participant is aware of his or her own medical condition(s), treatment(s), and medication regime;
 - f. Risk, including the potential for abuse, neglect, or exploitation by self or others, as well as health, social or behavioral issues that may indicate a risk;
 - g. Legal status, including guardianship, legal system involvement, and availability of advance directives, such as durable power of attorney;

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- h. Community participation, including the participant's need or expressed desire to access specific resources, such as the library, educational programs, restaurants, shopping, and medical providers; and
- i. Any other area identified by the participant as being important to his or her life.

(c) Within 20 working days of the date on which the agency receives BEAS notification of the assignment, the designated case manager shall develop a written comprehensive care plan for the participant, which shall:

- (1) Be a person-centered agreement;
- (2) Contain measurable objectives and goals, with timelines;
- (3) Contain the following, based on the participant's needs as identified in the comprehensive assessment document and the MED needs list or support plan:
 - a. Paid services to be provided under medicaid or other funding sources, including:
 - 1. The needs to be met by paid services;
 - 2. Service costs;
 - 3. Service funding source;
 - 4. Provider names; and
 - 5. The beginning and ending dates of each service, and the frequency of service provision;
 - b. Non-paid services or supports, including the needs to be met and the names of those individuals or groups providing such services or support;
 - c. Unfulfilled needs and gaps in services, including those that pose a risk to the participant's health and safety;
 - d. Any existing risks for abuse, neglect or exploitation, as defined in RSA 161-F:43;
 - e. A plan for mitigating any existing risks; and
 - f. An individualized contingency plan, as defined in He-E 805.02(I); and
- (4) Be updated with written documentation as follows:
 - a. At least annually for as long as the participant is receiving CFI services;
 - b. Whenever changes occur in the participant's medical condition and/or in the participant's needs and desires; and

- c. With progress notes reflecting each case management contact in (e)(1) below.
- (d) The designated case manager shall monitor the services provided to a participant, as follows:
 - (1) Conduct the case management contacts required for each participant, as follows:
 - a. Case management contacts shall include no less than one monthly telephonic contact and one face-to-face contact every 60 days; and
 - b. Each case management contact shall be documented in a contact note;
 - (2) Ensure that services are adequate and appropriate for the participant's needs, and are being provided, as described in the comprehensive care plan;
 - (3) Ensure that the participant is actively engaging in the services described in the comprehensive care plan;
 - (4) Ensure that the participant is satisfied with the comprehensive care plan; and
 - (5) Identify any changes in the participant's condition, discuss these changes with the participant in order to determine whether changes to the comprehensive care plan are needed, and make changes to the comprehensive care plan as needed.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.06 Qualification Requirements for Case Managers.

- (a) Case managers employed by case management agencies shall have the following minimum requirements:
 - (1) Have demonstrated knowledge of the local service delivery system and the resources available to participants;
 - (2) Have demonstrated knowledge of the development and provision of integrated, person-centered services; and
 - (3) Have a degree in a human-services related field and one year of supervised experience, or a similar combination of training and experience.
- (b) Case manager supervisors employed by case management agencies shall have the following minimum requirements:
 - (1) Have a bachelor's level degree; or
 - (2) Be a registered nurse with 2 years of related experience.

(c) Case management agencies shall not employ individuals who:

- (1) Have a felony conviction;
- (2) Have been found to have abused, neglected or exploited an individual based on a protective investigation completed by the BEAS in accordance with He-E 700 and an administrative hearing held pursuant to He-C 200, if such a hearing is requested; or
- (3) Are listed in the state of NH central registry of abuse, neglect or exploitation pursuant to RSA 169-C:35 or the BEAS state registry pursuant to RSA 161-F:49.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.07 Participant Selection of Case Management Agency.

(a) After being determined eligible for CFI services in accordance with He-E 801, the participant shall select a case management agency from a list provided by BEAS.

(b) If the participant does not choose a case management agency after being determined eligible for CFI services, then the participant shall be assigned to a case management agency through a system maintained by BEAS.

(c) The participant shall be informed that the case manager selected will also be responsible for coordinating mental health and developmental disability-related services if such services are needed by the participant.

(d) The participant shall be informed in writing of the case management agency to which he or she is assigned.

(e) The participant shall be informed in writing and orally of the process to request a change in case management agency:

- (1) At the time of eligibility determination and re-determination; and
- (2) By the case management agency during the assessment process.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.08 Payment for Services.

(a) Providers shall submit claims for payment to the department's fiscal agent.

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(b) Providers shall meet all NH medicaid provider requirements, including those regarding timely claims submission.

(c) Providers shall not bill the applicant if medicaid does not pay due to billing practices of the provider which result in non-payment for service.

(d) Reimbursement to providers shall be made in accordance with rates established pursuant to RSA 161:4, VI.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.09 Third Party Liability. All third party obligations shall be exhausted before medicaid may be billed.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.10 Quality Management.

(a) On a quarterly basis, case management agencies shall conduct a participant record review to evaluate the delivery of services identified in the comprehensive care plan to ensure that participants' needs are being met in the community, and shall document the results of the review in a quarterly quality management report, including:

- (1) The number of records reviewed;
- (2) A summary of the review results;
- (3) A description of any deficiencies identified;
- (4) The remedial action taken or planned to address the deficiencies identified in (3) including the dates action was taken or will be taken; and
- (5) A summary of unmet service needs.

(b) On a quarterly basis, case management agencies shall conduct a review of all reported complaints, incidents, and sentinel events related to the delivery of services identified in the comprehensive care plan, and shall document the results of the review in a quarterly quality management report, including:

- (1) The number of reported complaints, incidents and sentinel events;
- (2) A summary of the review results;
- (3) A description of the deficiencies identified; and

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- (4) The remedial action taken or planned to address the deficiencies identified in (3) including the dates action was taken or will be taken.
- (c) Case management agencies shall plan and take any remedial action necessary to address deficiencies in service delivery identified in the quarterly quality management reports in (a) and (b) above.
- (d) Case management agencies shall retain the quarterly quality management reports in (a) and (b) above for 2 years and make them available to the department upon request.
- (e) Case management agencies shall retain clinical records:
- (1) To support claims submitted for reimbursement for a period of at least 6 years from the date of service; or
 - (2) Until resolution of any legal action(s) commenced during the 6-year period.
- (f) Case management agencies shall be subject to monitoring visits by BEAS to ensure that services are provided in accordance with He-E 805.
- (g) Monitoring visits shall:
- (1) Be announced or unannounced;
 - (2) Occur at least annually;
 - (3) Include, but not be limited to:
 - a. A review of participant case records;
 - b. A review of the portion of employee records pertinent to the provider qualification requirements of He-805; and
 - c. A review of the quarterly quality management reports in (a) and (b) above and
 - (4) Be made during the agencies regular business hours.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

CHAPTER 151-E LONG-TERM CARE

151-E:1 Purpose. –

I. The purpose of this chapter is to provide medicaid eligible elderly and chronically ill adults with a continuum of care appropriate to their needs and affordable to the state and its taxpayers.

II. To a great extent, the current system relies on nursing facilities to provide care for this group. While the quality of this care is high, an increasingly elderly and disabled population and a constrained public financial resource base require the state to reevaluate how long-term care services are provided. Moreover, many long-term care recipients and potential recipients prefer to be cared for at home or in other settings less acute than a nursing facility. Because far more may be spent on nursing facility care than on home and community-based care, there is an inherent difference between the state's present long-term care system and what recipients prefer.

III. This chapter is an essential step toward rebalancing the long-term care system and expanding choices available to recipients. It increases the continuum of care by adding mid-level care, including but not limited to, assisted living and residential care services. Through an acuity-based reimbursement system, a comprehensive needs assessment process, and an information and assistance process, it provides those eligible for Medicaid nursing facility services the opportunity to choose more appropriate, less costly mid-level services and home and community-based care. In this way, the state intends to serve this increasing Medicaid eligible population more appropriately and more economically.

151-E:17 Availability of Targeted Management Services. – The department shall make available to and advise all Medicaid recipients who require a nursing facility level of care or are at risk of needing such care and who are patients in hospitals, rehabilitation hospitals, or nursing facilities of the availability of targeted case management services provided by independent case managers, to explore the feasibility of transitioning to home and community-based care.

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PART He-P 819 CASE MANAGEMENT AGENCIES

He-P 819.01 Purpose. The purpose of this part is to set forth the licensing requirements for all case management agencies (CMA) pursuant to RSA 151:5, XXII.

Source. #5633, eff 5-27-93; ss by #7006, INTERIM, eff 5-26-99, EXPIRED: 9-23-99

New. #10260, eff 1-25-13

He-P 819.02 Scope. This part shall apply to any agency, partnership, corporation, government entity, association or other legal entity providing case management services in a client's place of residence and operating as a case management agency, except:

- (a) All facilities listed in RSA 151:2, II(a)-(i);
- (b) All entities which are owned or operated by the state of New Hampshire, pursuant to RSA 151:2, II(i);
- (c) Self-employed individuals with no employees who provide case management services by private arrangement with a client(s);
- (d) All licensed healthcare entities, whether residential or non-residential, where case management is a component of the services provided, to include but not limited to hospitals, nursing homes, home health agencies, assisted living facilities, residential rehabilitation, residential psychiatric treatment, non-emergency walk-in care centers, ambulatory surgical centers, end stage renal dialysis centers, community residences, adult day care centers, and hospice care;
- (e) Community mental health programs approved in accordance with He-M 403, where case management is a component of the services provided; and
- (f) Area agencies designated in accordance with He-M 505, where case management is a component of the services provided.

Source. #10260, eff 1-25-13

He-P 819.03 Definitions.

- (a) "Abuse" means any one of the following:
 - (1) "Emotional abuse" means the misuse of power, authority, or both, verbal harassment, or unreasonable confinement which results or could result in the mental anguish or emotional distress of clients;
 - (2) "Physical abuse" means the misuse of physical force which results or could result in physical injury to clients; and
 - (3) "Sexual abuse" means contact or interaction of a sexual nature involving clients without their informed consent.
- (b) "Administrator" means the licensee or individual appointed by the licensee to be responsible for all aspects of the daily operation of the licensed premise.
- (c) "Agent" means an adult to whom authority to make health care decisions is delegated under an activated durable power of attorney for health care executed in accordance with RSA 137-

J.

(d) "Applicant" means an agency, partnership, corporation, government entity, association, or other legal entity seeking a license to operate a CMA pursuant to RSA 151:2 I, (f).

(e) "Assessment" means an evaluation of the client to determine the care and services that are needed.

(f) "Branch office" means a location physically separate from the primary location that provides client services under the administration and supervision of the primary location.

(g) "Bio-psychosocial history" means information about an individual's past and present functioning in the areas of:

- (1) Physical health and capabilities;
- (2) Psychological health including emotional and coping abilities;
- (3) Social environment, including interactive skills, activities and supports;
- (4) Decision making abilities;
- (5) Social and family interactions;
- (6) Employment and financial management;
- (7) Financial considerations;
- (8) Vocational interests and activities, including spiritual preferences; and
- (9) Other areas of significance, including, but not limited to, substance abuse or misuse, and involvement with the behavioral health care system, the developmental disability system or the legal system.

(h) "Care plan" means a written guide developed by the licensee, in consultation with the client, and the client's guardian, agent or personal representative, if any, as a result of the assessment process for the provision of care and services and which includes goals, objectives and timelines for their achievement.

(i) "Case management agency (CMA)" means an organization employing 2 or more people that, in consultation with the client in the client's place of residence, arranges for and coordinates the delivery of care and services to meet the physical, emotional, medical, nursing, financial, legal and social services needs of the client.

(j) "Case manager" means a person who provides case management services for an eligible individual and who is responsible for the ongoing assessment, coordination and monitoring of services to a client and is employed by a case management agency.

(k) "Case management supervision" means the provision of professional oversight and guidance of case manager performance by:

- (1) Monitoring and oversight of case manager interactions and courses of action with the individuals for whom he/she provides case management services;
- (2) Monitoring and oversight of a case manager's service implementation activities

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including a review of all complex clients at least once per quarter;

- (3) Written evaluation of a case manager's performance at least annually;
- (4) Identifying corrective action to improve a case manager's performance; and
- (5) Teaching and training case managers to enhance quality of case management service delivery as well as providing current Choices for Independence (CFI) program information.

(l) "Change of ownership" means the transfer in the controlling interest of an established CMA to any individual, agency, partnership, corporation, government entity, association or other legal entity.

(m) "Client" means any person admitted to or in any way receiving services from a CMA licensed in accordance with RSA 151 and He-P 819.

(n) "Client rights" means the privileges and responsibilities possessed by each client provided by RSA 151:21-b.

(o) "Client record" means the documentation of all care and services, which includes all documentation required by RSA 151 and He-P 819 and any other applicable federal and state requirements.

(p) "Commissioner" means the commissioner of the New Hampshire department of health and human services or his or her designee.

(q) "Days" means calendar days unless otherwise specified in the rule.

(r) "Deficiency" means any action, failure to act or other set of circumstances that causes a licensee to be out of compliance with RSA 151 or He-P 819.

(s) "Department" means the New Hampshire department of health and human services.

(t) "Direct care" means providing hands-on care or services to a client.

(u) "Directed plan of correction" means a plan developed and written by the department that specifies the necessary actions the licensee shall take to correct identified deficiencies.

(v) "Emergency plan" means a document outlining the responsibilities of personnel in an emergency.

(w) "Exploitation" means the illegal use of a client's person or property for another person's profit or advantage, or the breach of a fiduciary relationship through the use of a person or person's property for any purpose not in the proper and lawful execution of a trust, including, but not limited to, situations where a person obtains money, property, or services from a client through the use of undue influence, harassment, duress, or fraud.

(x) "Guardian" means a person appointed in accordance with RSA 464-A to make informed decisions relative to the client's health care and other personal needs.

(y) "Inspection" means the process followed by the department to determine an applicant's or a licensee's compliance with RSA 151 and He-P 819 or to respond to allegations of non-compliance with RSA 151 and He-P 819.

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(z) "License" means the document issued to an applicant or licensee of an CMA which authorizes operation in accordance with RSA 151 and He-P 819, and includes the name of the licensee, the name of the business, the physical address, the license category, the effective date and license number.

(aa) "License certificate" means the document issued by the department to an applicant or licensee that, in addition to the information contained on a license, includes the name of the administrator and the type(s) of services authorized that the CMA is licensed for.

(ab) "Licensed practitioner" means a:

- (1) Medical doctor;
- (2) Physician's assistant;
- (3) Advanced practice registered nurse (APRN);
- (4) Doctor of osteopathy; or
- (5) Doctor of naturopathic medicine.

(ac) "Licensed premises" means the building that comprises the physical location the department has approved for the licensee to conduct operations in accordance with its license. This term includes branch offices but does not include the private residences of a client receiving services from a CMA.

(ad) "Licensing classification" means the specific category of services authorized by a license.

(ae) "Neglect" means an act or omission, which results or could result in the deprivation of essential services necessary to maintain the mental, emotional or physical health and safety of a client.

(af) "Orders" means prescriptions, instructions for treatments, special diets or therapies given by a licensed practitioner, or other professional authorized by law.

(ag) "Owner" means any person, corporation, association, or any other legal entity, whether organized for profit or not, holding or claiming ownership of, or title to, a license.

(ah) "Personal representative" means a person designated in accordance with RSA 151:19 to assist the client for a specific, limited purpose or for the general purpose of assisting a client in the exercise of any rights.

(ai) "Personnel" means individual(s) who provide case management services to a client.

(aj) "Plan of correction (POC)" means a plan developed and written by the licensee, which specifies the actions that will be taken to correct identified deficiencies.

(ak) "Primary location" means the principle site for the CMA where the business office and administrative staff are located.

(al) "Procedure" means a licensee's written, standardized method of performing duties and providing services.

He-P 819.04 Initial License Application Requirements.

(a) Each applicant for a license shall comply with the requirements of RSA 151:4, I-III(a), and submit the following to the department:

(1) A completed application form entitled "Application for Residential or Health Care License," (4/4/12 edition) signed by the applicant or 2 of the corporate officers affirming the following:

"I affirm that I am familiar with the requirements of RSA 151 and the rules adopted thereunder and that the premises are in full compliance. I understand that providing false information shall be grounds for denial, suspension, or revocation of the license, and the imposition of a fine.";

(2) If applicable, proof of authorization from the New Hampshire secretary of state to do business in New Hampshire in the form of one of the following:

- a. "Certificate of Authority," if a corporation;
- b. "Certificate of Formation," if a limited liability company; or
- c. "Certificate of Trade Name," where applicable;

(3) The applicable fee, in accordance with RSA 151:5, payable in cash in the exact amount of the fee, or, if paid by check or money order, the exact amount of the fee made payable to the "Treasurer, State of New Hampshire";

(4) A resume identifying the qualifications of and copies of applicable licenses for the CMA administrator;

(5) For the proposed or existing licensed premises, not including a client's home, a local approval from the zoning officer verifying that the applicant complies with all applicable local zoning ordinances, which shall be obtained no more than 90 days prior to submission of the application; and

(6) The results of a criminal records check from the NH department of safety for the applicant(s), licensee and administrator.

(b) The applicant shall mail or hand-deliver the documents to:

Department of Health and Human Services
Health Facilities Administration
129 Pleasant Street
Concord, NH 03301

Source. #10260, eff 1-25-13

He-P 819.05 Processing of Applications and Issuance of Licenses.

(a) An application for an initial license shall be complete when the department determines that all items required by He-P 819.04(a) have been received.

(b) If an application does not contain all of the items required by He-P 819.04, the department shall notify the applicant in writing of the items required before the application can be

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(c) Any licensing fee submitted to the department in the form of a check or money order and returned to the state for any reason, shall be processed in accordance with RSA 6:11-a.

(d) Licensing fees shall not be transferable to any other application(s).

(e) Unless a waiver has been granted, the department shall deny a licensing request in accordance with He-P 819.17(c) after reviewing the information in He-P 819.04(a)(6) above if, after review, it determines that the applicant, licensee or administrator:

(1) Has been convicted of any felony in this or any other state;

(2) Has been convicted of a sexual assault, other violent crime, assault, fraud, abuse, neglect or exploitation;

(3) Has had a finding by the department or any administrative agency in this or any other state for assault, fraud, abuse, neglect or exploitation of any person; or

(4) Otherwise poses a threat to the health, safety or well-being of participants.

(f) An inspection shall be completed in accordance with He-P 819.09 prior to the issuance of a license.

(g) Following an inspection, a license shall be issued if the department determines that an applicant requesting an initial license is in full compliance with RSA 151 and He-P 819.

(h) All licenses issued in accordance with RSA 151 shall be non-transferable by person or location.

Source. #10260, eff 1-25-13

He-P 819.06 License Expirations and Procedures for Renewals.

(a) A license shall be valid on the date of issuance and expire the following year on the last day of the month it was issued unless a completed application for renewal has been received.

(b) Each licensee shall complete and submit to the department an application form pursuant to He-P 819.04 at least 120 days prior to the expiration of the current license.

(c) The licensee shall submit with the renewal application:

(1) The materials required by He-P 819.04(a)(1), and (3);

(2) The current license number;

(3) A request for renewal of any existing waiver previously granted by the department, in accordance with He-P 819.10(f) if the existing waiver was time limited by the department; and

(4) A list of any current employees for which a waiver was granted according to He-P 819.05(e) above.

(d) Following an inspection, a license shall be renewed if the department determines that the licensee:

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(1) Submitted an application containing all the items required by (c) above, prior to the expiration of the current license;

(2) If deficiencies were cited at the last licensing inspection or investigation, has submitted a POC that has been accepted by the department and implemented by the licensee; and

(3) Is found to be in compliance with RSA 151 and He-P 819 at the renewal inspection.

(e) Any licensee who does not submit a complete application for renewal prior to the expiration of an existing license shall be required to submit an application for initial license pursuant to He-P 819.04.

(f) If a licensee chooses to cease the operation of the CMA, the licensee shall submit written notification to the department at least 30 days in advance.

(g) Prior to issuing a license the department shall review any of the information submitted in accordance with He-P 819.04(a)(6) and deny a license renewal in accordance with He-P 819.05(e).

Source. #10260, eff 1-25-13

He-P 819.07 Branch Offices.

(a) CMAs may establish branch offices.

(b) The CMA shall notify the department in writing prior to operating at an additional location(s).

(c) The CMA shall submit to the department the information required by He-P 819.04(a)(5) for branch offices.

(d) Upon receipt of the information required by (b) and (c) above, the department shall issue a revised annual license certificate to reflect the addition of the branch offices provided the additions do not violate RSA 151 or He-P 819.

(e) All records, including those maintained at any branch office, shall be made available to the inspector at the primary location of the licensed premises at the time of inspection.

Source. #10260, eff 1-25-13

He-P 819.08 CMA Requirements for Organizational Changes.

(a) The CMA shall provide the department with written notice at least 30 days prior to changes in any of the following:

- (1) Ownership;
- (2) Primary physical location;
- (3) Address;
- (4) Branch locations;
- (5) Name; and
- (6) Services.

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(b) The CMA shall complete and submit a new application prior to operating for:

- (1) A change in ownership; or
- (2) A change in the physical location.

(c) When there is a change in address without a change in location, the CMA shall provide the department with a copy of the notification from the local, state or federal agency that requires the change.

(d) The CMA shall inform the department in writing as soon as possible prior to a change in administrator and provide the department with the following:

- (1) The information specified in He-P 819.04(a)(6);
- (2) A resume identifying the name and qualifications of the new administrator; and
- (3) Copies of applicable licenses for the new administrator.

(e) Upon review of the materials submitted in accordance with (d) above, the department shall make a determination as to whether the new administrator:

- (1) Does not have a history of any of the criteria identified in He-P 819.05(e); and
- (2) Meets the qualifications for the position as specified in He-P 819.15(a).

(f) If the department determines that the new administrator does not meet the qualifications of his or her position, it shall so notify the licensee in writing so that a waiver can be sought or the program can search for a qualified candidate.

(g) When there is a change in the name, the CMA shall submit to the department a copy of the certificate of amendment from the New Hampshire secretary of state, if applicable.

(h) When there is to be a change in the services provided, the CMA shall provide the department with a description of the service change.

(i) The department shall review the information submitted under (h) above and determine if the added services can be provided under the CMA's current license.

(j) An inspection by the department shall be conducted prior to operation when there is a change in the ownership, unless the current licensee has no outstanding administrative actions in process and there will be no changes made by the new owner in the scope of services provided.

(k) A new license shall be issued for a change in ownership or physical location.

(l) A revised license shall be issued for a change in name.

(m) A revised license certificate shall be issued for any of the following:

- (1) A change of administrator;
- (2) A change in the scope of services provided; or
- (3) When a waiver has been granted.

He-P 819.09 Inspections.

(a) For the purpose of determining compliance with RSA 151 and He-P 819, as authorized by RSA 151:6 and RSA 151:6-a, the licensee shall admit and allow any department representative at any time to inspect the following:

- (1) The licensed premises;
- (2) All programs and services provided by the CMA; and
- (3) Any records required by RSA 151 and He-P 819.

(b) The department shall conduct an inspection to determine full compliance with RSA 151 and He-P 819 prior to:

- (1) The issuance of an initial license;
- (2) A change in ownership except as allowed by He-P 819.08(j); or
- (3) The renewal of a license.

(c) In addition to (b) above the department shall conduct an inspection to verify the implementation of any POC accepted or issued by the department as part of an annual inspection, or as a follow-up inspection focused on confirming the implementation of a POC.

Source. #10260, eff 1-25-13

He-P 819.10 Waivers.

(a) Applicants or licensees seeking waivers of specific rules in He-P 819 shall submit a written request for a waiver to the commissioner that includes:

- (1) The specific reference to the rule for which a waiver is being sought;
- (2) A full explanation of why a waiver is necessary;
- (3) A full explanation of alternatives proposed by the applicant or license holder, which shall be equally as protective of public health and clients as the rule from which a waiver is sought; and
- (4) The period of time for which the waiver is sought if less than permanent.

(b) Waivers granted shall be permanent, except if the waiver is specific to a particular client, and subject to changes in the client's health status, in which case it shall be restricted by the department to a specified length of time.

(c) A request for waiver shall be granted if the commissioner determines that the alternative proposed by the applicant or licensee:

- (1) Meets the objective or intent of the rule;
- (2) Does not negatively impact the health or safety of the clients; and
- (3) Does not affect the quality of client services.

(d) The licensee's subsequent compliance with the alternatives approved in the waiver shall

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be considered equivalent to complying with the rule from which waiver was sought.

(e) Waivers shall not be transferable.

(f) When a licensee wishes to renew the waiver beyond the approved period of time, the licensee shall apply for a new waiver by submitting the information required by (a) above:

(1) When the licensee submits its application for license renewal pursuant to He-P 819.06(c); or

(2) At least 15 days prior to the expiration of the waiver if the waiver expires on a date other than the expiration date of the licensing certificate.

(g) The request to renew a waiver shall be subject to (b) through (f) above.

Source. #10260, eff 1-25-13

He-P 819.11 Complaints.

(a) The department shall investigate complaints that allege:

(1) A violation of RSA 151 or He-P 819;

(2) That an entity is operating as an CMA without being licensed; or

(3) That an entity is advertising or otherwise representing the CMA as having or performing services for which they are not licensed to provide, pursuant to RSA 151:2, III.

(b) When practicable the complaint shall be in writing and contain the following information:

(1) The name and address of the CMA, or the alleged unlicensed individual or entity;

(2) The name, address and telephone number of the complainant; and

(3) A description of the situation that supports the complaint and the alleged violation(s) of RSA 151 or He-P 819.

(c) For the licensed CMA, the department shall:

(1) Provide written notification of the results of the investigation to the licensee along with an inspection report if deficiencies were found as a result of the investigation; and

(2) Notify any other federal, state or local agencies of suspected violations of their statutes or rules based on the results of the investigation, as appropriate.

(d) If the department determines that the complaint is unfounded or does not violate any statutes or rules, the department shall so notify the unlicensed individual or licensee and take no further action.

(e) If the investigation results in deficiencies being cited, the licensee shall be required to submit a POC in accordance with He-P 819.12(c).

(f) For the unlicensed entity the department shall provide written notification to the owner or person responsible that includes:

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- (1) The date of inspection;
- (2) The reasons for the inspection; and
- (3) Whether or not the inspection resulted in a determination that the services being provided require licensing under RSA 151:2, I and RSA 151:5.

(g) In accordance with RSA 151:7-a, II, the owner or person responsible shall be allowed 7 days from the date of receipt of the notice required by (f) above to respond to a finding that they are operating without a license or submit a completed application for a license.

(h) If the owner of an unlicensed facility does not comply with (g) above, or if the department does not agree with the owner's response, the department shall:

- (1) Issue a written warning to immediately comply with RSA 151 and He-P 819; and
- (2) Provide notice stating that the individual has the right to appeal the warning in accordance with RSA 151:7-a, III.

(i) Any entity who fails to comply after receiving a warning as described in (h) above, shall be subject to an action by the department for injunctive relief under RSA 151:17.

(j) The fact that the department takes action for injunctive relief under RSA 151:17 shall not preclude the department from taking other action under RSA 151, He-P 819 or other applicable laws.

(k) Complaint investigation files shall be confidential in accordance with RSA 151:13, and shall not be disclosed publicly but shall be released by the department on written request only:

- (1) To the department of justice when relevant to a specific investigation;
- (2) To law enforcement when relevant to a specific criminal investigation;
- (3) When a court of competent jurisdiction orders the department to release such information; or
- (4) In connection with any adjudicative proceedings relative to the licensee.

Source. #10260, eff 1-25-13

He-P 819.12 Administrative Remedies.

(a) The department shall impose administrative remedies for violations of RSA 151, He-P 819 or other applicable licensing rules, including:

- (1) Requiring a licensee to submit a POC;
- (2) Imposing a directed POC upon a licensee;
- (3) Imposing fines upon an unlicensed individual, applicant or licensee;
- (4) Suspension of a license; or
- (5) Revocation of a license.

(b) When administrative remedies are imposed, the department shall provide a written notice,

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as applicable, which:

- (1) Identifies each deficiency;
 - (2) Identifies the specific remedy(s) that has been proposed; and
 - (3) Provides the licensee with the following information:
 - a. The right to a hearing in accordance with RSA 541-A and He-C 200 prior to imposition of a fine; and
 - b. The automatic reduction of a fine by 25% if the fine is paid within 10 days of the date on the written notice from the department and the deficiency has been corrected, or a POC has been accepted and approved by the department;
- (c) A POC shall be developed and enforced in the following manner:
- (1) Upon receipt of a notice of deficiencies, the licensee shall submit a POC containing:
 - a. How the licensee intends to correct each deficiency;
 - b. What measures will be put in place, or what system changes will be made to ensure that the deficiency does not recur; and
 - c. The date by which each deficiency shall be corrected;
 - (2) The licensee shall submit a POC to the department within 21 days of the date on the letter that transmitted the inspection report, unless the licensee requests, either verbally or in writing, and the department agrees, to extend that deadline, based on the following criteria:
 - a. The licensee demonstrates that he or she has made a good faith effort to develop and submit the POC within the 21 day period but has been unable to do so; and
 - b. The department determines that the health, safety or well-being of a client will not be jeopardized as a result of granting the extension;
 - (3) The department shall review and accept each POC that:
 - a. Achieves compliance with RSA 151 and He-P 819;
 - b. Addresses all deficiencies and deficient practices as cited in the inspection report;
 - c. Prevents a new violation of RSA 151 or He-P 819 as a result of the implementation of the POC; and
 - d. Specifies the date upon which the deficiencies will be corrected;
 - (4) If the POC is acceptable, the department shall issue a license certificate or provide written notification of acceptance of the POC, whichever is applicable;
 - (5) If the POC is not acceptable:
 - a. The department shall notify the licensee in writing of the reason for rejecting

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the POC;

b. The licensee shall develop and submit a revised POC within 14 days of the date of the written notification from the department that states the original POC was rejected unless, within the 14 day period, the licensee requests an extension, either via telephone or in writing, and the department grants the extension, based on the following criteria:

1. The licensee demonstrates that he or she has made a good faith effort to develop and submit the POC within the 14 day period but has been unable to do so; and

2. The department determines that the health, safety or well being of a client will not be jeopardized as a result of granting the extension;

c. The revised POC shall comply with (1) above and be reviewed in accordance with (3) above; and

d. If the revised POC is not acceptable to the department, or is not submitted within 14 days of the date of the written notification from the department that states the original POC was rejected, the licensee shall be subject to a directed POC in accordance with (d) below and a fine in accordance with (f)(9) below;

(6) The department shall verify the implementation of any POC that has been submitted and accepted by:

a. Reviewing materials submitted by the licensee;

b. Conducting a follow-up inspection; or

c. Reviewing compliance during the next annual inspection;

(7) Verification of the implementation of any POC shall only occur after the date of completion specified by the licensee in the plan; and

(8) If the POC or revised POC has not been implemented by the completion date at the time of the next inspection the licensee shall be:

a. Notified by the department in accordance with He-P 819.12(b); and

b. Issued a directed POC in accordance with (d) below and shall be subject to a fine in accordance with (f)(10) below.

(d) The department shall develop and impose a directed POC that specifies corrective actions for the licensee to implement when:

(1) As a result of an inspection, deficiencies were identified that require immediate corrective action to protect the health and safety of the clients and personnel;

(2) A revised POC is not submitted within 14 days of the written notification from the department; or

(3) A revised POC submitted by the licensee or administrator has not been accepted.

(e) If at the time of the next inspection the directed POC referenced in (d) above has not been

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- (1) Impose a fine;
 - (2) Deny the application for a renewal of a license; or
 - (3) Revoke the license in accordance with He-P 819.13(b)(6).
- (f) The department shall impose fines as follows:
- (1) For a failure to cease providing unlicensed services after being notified by the department of the need for a license, in violation of RSA 151:2, the fine shall be \$2000.00 for an applicant or unlicensed provider;
 - (2) For a failure to cease operations after a denial of a license or after receipt of an order to cease and desist immediately, in violation of RSA 151:2 and RSA 541-A:30, the fine for an applicant or unlicensed provider or licensee shall be \$2000.00;
 - (3) For advertising services or otherwise representing themselves as having a license to provide services that they are not licensed to provide, in violation of RSA 151:2, III, the fine for an applicant, licensee or unlicensed provider shall be \$500.00;
 - (4) For a failure to comply with the directives of a warning issued by the department in violation of RSA 151:7-a and He-P 819.11(i), the fine for an unlicensed provider or licensee shall be \$500.00;
 - (5) For a failure to submit a renewal application for a license prior to the expiration date, in violation of He-P 819.06(b), the fine shall be \$100.00;
 - (6) For a failure to notify the department prior to a change of ownership, in violation of He-P 819.08(a)(1), the fine shall be \$500.00;
 - (7) For a failure to notify the department prior to a change in the physical location, in violation of He-P 819.08(a)(2), the fine shall be \$500.00;
 - (8) For a failure to allow access by the department to the CMA's premises, programs, services or records, in violation of He-P 819.09(a), the fine for an applicant or licensee shall be \$2000.00;
 - (9) For a failure to submit a POC or revised POC, within 21 or 14 days, respectively, of the date on the letter that transmits the inspection report, in violation of He-P 819.12(c)(2) and (5)(b), the fine for a licensee shall be \$100.00 unless an extension has been granted by the department;
 - (10) For a failure to implement any POC that has been accepted or issued by the department, in violation of He-P 819.12(c)(8), the fine for a licensee shall be \$1000.00;
 - (11) For a failure to establish, implement or comply with licensee policies, after being notified in writing by the department of the need to establish, implement or comply with licensee policies, as required by He-P 819.14(e), the fine for a licensee shall be \$500.00;
 - (12) For falsification of information contained on an application or on any records required to be maintained for licensing, in violation of He-P 819.14(g), the fine shall be

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\$500.00 per offense;

(13) For employing an administrator or other personnel who do not meet the qualifications for the position, in violation of He-P 819.15(a), the fine for a licensee shall be \$500.00;

(14) When an inspection determines that a violation of RSA 151 or He-P 819 has the potential to jeopardize the health, safety or well being of a client, in addition to any other enforcement actions taken by the department, the fines assessed shall be as follows:

a. If the same deficiency is cited within 2 years of the original deficiency the fine shall be double the initial fine but not to exceed \$2000.00; or

b. If the same deficiency is cited a third time within 2 years of being fined in a. above the fine for a licensee shall be triple the initial fine but not to exceed \$2000.00;

(15) Each day that the individual or licensee continues to be in violation of the provisions of RSA 151 or He-P 819 shall constitute a separate violation and shall be fined in accordance with He-P 819.12(f); and

(16) If the applicant or licensee is making good faith efforts to comply with (4), (11) or (15) above, the department shall not issue a daily fine.

(g) Payment of any imposed fine to the department shall meet the following requirements:

(1) Payment shall be made in the form of check or money order made payable to the "Treasurer, State of New Hampshire" or cash in the exact amount due; and

(2) Cash, money order, or certified check shall be required when an applicant or licensee has issued payment to the department by check, and such check was returned for insufficient funds.

Source. #10260, eff 1-25-13

He-P 819.13 Enforcement Actions and Hearings.

(a) Prior to imposing a fine, denying, revoking or suspending a license, the department shall send to the applicant or licensee a written notice that sets forth:

(1) The reasons for the proposed action;

(2) The action to be taken by the department; and

(3) The right of an applicant or licensee to a hearing in accordance with RSA 151:8 or RSA 541-A:30, III, as applicable.

(b) The department shall deny an application or revoke a license if:

(1) An applicant or a licensee violated RSA 151 or He-P 819, which violations have the potential to harm to a client's health, safety or well being.

(2) An applicant or a licensee has failed to pay a fine imposed under administrative remedies;

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- (3) An applicant or a licensee has had a check returned to the department for insufficient funds and has not re-submitted the outstanding fee in the form of cash, money order or certified check;
 - (4) After being notified of and given an opportunity to supply missing information, an applicant or licensee fails to submit an application that meets the requirements of He-P 819.04;
 - (5) An applicant, licensee or any representative or employee of the applicant or licensee:
 - a. Provides false or misleading information to the department;
 - b. Prevents or interferes, or fails to cooperate with any inspection or investigation conducted by the department; or
 - c. Fails to provide requested files or documents to the department;
 - (6) The licensee failed to implement or continue to implement a POC that has been accepted or imposed by the department in accordance with He-P 819.12(c)(3) and (d);
 - (7) The licensee is cited a third time under RSA 151 or He-P 819 for the same violations within the last 5 inspections;
 - (8) A licensee, including corporation officers or board members, has had a license revoked and submits an application during the 5-year prohibition period specified in (j) below;
 - (9) Upon inspection, the applicant's premise is not in compliance with RSA 151 or He-P 819;
 - (10) The department makes a determination that one or more of the factors in He-P 819.05(e) is true; or
 - (11) The applicant or licensee fails to employ a qualified administrator.
- (c) An applicant or licensee shall have 30 days after receipt of the notice of enforcement action to request a hearing to contest the action.
- (d) If a written request for a hearing is not made pursuant to (c) above, the action of the department shall become final.
- (e) The department shall order the immediate suspension of a license and the cessation of operations when it finds that the health, safety or well being of clients is in jeopardy and requires emergency action in accordance with RSA 541:A-30, III.
- (f) If an immediate suspension is upheld, the licensee shall not resume operating until the department determines through inspection that compliance with RSA 151 and He-P 819 is achieved.
- (g) Hearings under this section shall be conducted in accordance with RSA 541-A and He-C 200.
- (h) RSA 541 shall govern further appeals of department decisions under this section.

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(i) When a CMA's license has been denied or revoked, the applicant, licensee or administrator shall not be eligible to reapply for a license or be employed as an administrator for 5 years if the enforcement action pertained to their role in the CMA.

(j) The 5 year period referenced in (i) above shall begin on:

(1) The date of the department's decision to revoke or deny the license, if no request for a hearing is filed; or

(2) The date a final decision upholding the action of the department is issued, if a request for a hearing is made and a hearing is held.

Source. #10260, eff 1-25-13

He-P 819.14 Duties and Responsibilities of All Licensees.

(a) The CMA shall not provide direct care to any client unless it is also:

(1) Certified by the department as an other qualified agency in accordance with RSA 161-H and He-E 601; or

(2) Licensed by the department as a home care service provider or a home health care provider in accordance with RSA 151 and He-P 822 or He-P 809, respectively.

(b) The licensee shall comply with all federal, state and local laws, rules, codes and ordinances, as applicable.

(c) The licensee shall comply with the home care clients' bill of rights as set forth in RSA 151:21-b.

(d) The licensee shall define, in writing, the scope and type of services to be provided by the CMA.

(e) The licensee shall develop and implement written policies and procedures governing the operation and all services provided by the CMA to include but not limited to:

(1) Complaint policy;

(2) Documentation and records management;

(3) Release of information;

(4) Case management supervision protocol;

(5) Evaluation, training and competency of personnel;

(6) Case management practice and services; and

(7) Quality improvement program, as required by He-P 819.18.

(f) All policies and procedures shall be reviewed annually and revised as needed.

(g) The licensee or any personnel shall not falsify any documentation or provide false or misleading information to the department.

(h) The licensee shall not:

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- (1) Advertise or otherwise represent the program as operating a CMA, unless it is licensed; and
 - (2) Advertise that it provides services that it is not authorized to provide.
- (i) The licensee shall comply with all conditions of warnings and administrative remedies issued by the department, and all court orders.
- (j) Licensees shall:
- (1) Initiate action to maintain the CMA in full compliance at all times with all relevant health and safety requirements contained in applicable federal, state and local laws, rules, regulations, and ordinances;
 - (2) Appoint an administrator; and
 - (3) Implement any POC that has been accepted or issued by the department.
- (k) The licensee shall consider all clients to be competent and capable of making health care decisions unless the client:
- (1) Has a guardian appointed by a court of competent jurisdiction; or
 - (2) Has a durable power of attorney for health care that has been activated.
- (l) A licensee shall provide a client or their guardian or agent, if any, with a copy of his or her client record pursuant to the provisions of RSA 151:21-b, II(i), upon request.
- (m) All records required for licensing shall be legible, current, accurate and available to the department during an inspection or investigation conducted in accordance with RSA 151:6 and RSA 151:6-a.
- (n) Any licensee that maintains electronic records shall develop written policies and procedures designed to protect the privacy of clients and personnel that, at a minimum, include:
- (1) Procedures for backing up files to prevent loss of data;
 - (2) Safeguards for maintaining the confidentiality of information pertaining to clients and staff; and
 - (3) Systems to prevent tampering with information pertaining to clients and staff.
- (o) Client records shall be safeguarded against loss, damage or unauthorized use by being stored in locked containers, cabinets, rooms or closets except when being used by the CMA's personnel.
- (p) Client records shall be retained for a minimum of 4 years after discharge.
- (q) Prior to the CMA ceasing operation, it shall arrange for the storage of and access to client records for 4 years after the date of closure, which shall be made available to the department and past clients upon request.
- (r) In addition to the posting requirements specified in RSA 151:29, the licensee shall post the following documents in a public area:

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- (1) The current license certificate issued in accordance with RSA 151:2;
 - (2) All inspection reports issued in accordance with He-P 819.09(b) and (c) and He-P 819.11(c), for the previous 12 months;
 - (3) A copy of the home care clients' bill of rights specified by RSA 151:21-b; and
 - (4) A copy of the licensee's complaint procedure, including the address and phone number of the department to which complaints may also be made, which shall also be posted on the CMA's website if available.
- (s) The licensee shall admit and allow any department representative to inspect the CMA and all programs and services that are being provided at any time for the purpose of determining compliance with RSA 151 and He-P 819 as authorized by RSA 151:6 and RSA 151:6-a.
- (t) At the time of admission the licensee shall give a client and his or her guardian, agent, or personal representative, if applicable, a listing of all CMA's charges and identify what services are included in the charge.
- (u) The licensee shall give a client a written notice before any increase is imposed in the cost or fees for any CMA services.

Source. #10260, eff 1-25-13

He-P 819.15 Required Services.

- (a) The licensee shall provide an administrator who:
- (1) Is at least 21 years of age;
 - (2) Has one of the following combinations of education and experience:
 - a. A bachelor's degree from an accredited institution in business or a health care field such as nursing or social work and at least 2 years of related experience; or
 - b. Is a registered nurse (RN), licensed in New Hampshire, with at least 2 years of related experience;
 - (3) Is responsible for the day to day operation of the CMA services; and
 - (4) Hires staff necessary to assist in maintaining regulatory compliance.
- (b) Case managers shall be responsible:
- (1) For the completion of an assessment that includes a biopsychosocial history;
 - (2) For the development of a care plan in conjunction with the client and his or her agent, if applicable;
 - (3) For the coordination of services identified in the care plan and ensuring that providers hold all required licenses or registrations, as applicable.
 - (4) For the monitoring of services to ensure that services identified in the care plan are provided according to the timeframes and frequencies identified in the care plan and are meeting the client's needs;

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- (5) To document changes in a client's needs and to develop recommendations for changes in the care plan as appropriate;
- (6) For conducting a risk assessment for any client whose condition, behavior or other circumstances represent a risk to the individual, person(s) providing services and/or others; and
- (7) For documenting all case management services provided and their outcomes.

Source. #10260, eff 1-25-13

He-P 819.16 Client Services.

(a) At the time of admission, personnel of the CMA shall:

(1) Provide, both orally and in writing, to the client, guardian, agent and personal representative, as applicable:

- a. A copy of the home care clients' bill of rights;
- b. The CMA's complaint procedure and rules; and
- c. Documentation to verify receipt of these policies and rules; and

(2) Collect and record the following information:

- a. Client's name, home address and home telephone number;
- b. Client's date of birth;
- c. Name, address and telephone number of an emergency contact;
- d. Name of client's primary care provider with the address and telephone number;
- e. Copies of all legal directives such as durable power of attorney, legal guardian or living will; and
- f. Written and signed consent for the delivery of services and the release of information.

(b) Each client shall have an initial assessment prior to the development of the care plan.

(c) Each client shall have a review of needs whenever the case manager, client or guardian determine that the services provided are no longer required or not meeting the client's needs.

(d) The care plan shall be developed by the case manager and the client or client's personal representative.

(e) For each client accepted for care and services by the CMA, a current and accurate record shall be maintained that includes, at a minimum:

- (1) The written confirmation required by (a)(1) above;
- (2) The identification data required by (a)(2) above;
- (3) Consent and medical release forms, as required by (a)(2)f. above;

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- (4) The record of assessments and reviews as required by (b) and (c) above;
- (5) All care plans, including documentation that the client or person legally responsible participated in the development of the care plan if they choose to;
- (6) A copy, initialed by the client and/or the client's guardian or personal representative, of all charges and services to be provided as required by He-P 819.14(r); and
- (7) Documentation of all contacts with the client and/or the client's guardian or personal representative, with service providers identified in the client's care plan, and with anyone else involved with the client's care plan.

Source. #10260, eff 1-25-13

He-P 819.17 Personnel.

- (a) The licensee shall develop a job description for each position in the CMA containing:
 - (1) Duties of the position; and
 - (2) Education and experience requirements of the position.
- (b) For all applicants for employment, the licensee shall:
 - (1) Obtain and review a criminal records check from the New Hampshire department of safety in accordance with RSA 151:3-c;
 - (2) Review the results of the criminal records check in accordance with (c) below;
 - (3) Verify that the potential employee is not listed on the State Registry maintained by the department's bureau of elderly and adult services (BEAS) per RSA 161-F:49;
 - (4) Require the employee to submit the results of a physical examination or pre-employment health screening performed by a licensed nurse or a licensed practitioner and 2 step tuberculosis testing, Mantoux method, or other method approved by the Centers for Disease Control, conducted not more than 12 months prior to employment;
 - (5) Allow the employee to work while waiting for the results of the second step of the TB test when the results of the first test are negative for TB; and
 - (6) Comply with the requirements of the Centers for Disease Control "Guidelines for Preventing the Transmission of Tuberculosis in Health Facilities Settings," 2005 edition (available as noted in Appendix A), if the person has either a positive TB test, or has had direct contact or potential for occupational exposure to M. tuberculosis through shared air space with persons with infectious tuberculosis.
- (c) Unless a waiver is granted in accordance with (d) below, the licensee shall not offer employment for any position if the individual:
 - (1) Has been convicted of a felony in this or any other state;
 - (2) Has been convicted for sexual assault, other violent crime, assault, fraud, abuse, neglect or exploitation;

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(3) Has been found by the department or any administrative agency in this or any other state for assault, fraud, abuse, neglect or exploitation or any person; or

(4) Otherwise poses a threat to the health, safety or well being of clients.

(d) The department shall grant a waiver of (c) above if, after reviewing the underlying circumstances, it determines that the person does not pose a threat to the health, safety or well being of clients.

(e) Waivers granted under (d) above shall be permanent as long as the individual is employed by the facility.

(f) Personnel shall not be permitted to maintain their employment if they have been convicted of a felony, sexual assault, other violent crime, assault, fraud, abuse, neglect or exploitation of any person in this or any other state by a court of law or had a complaint investigation for abuse, neglect, or exploitation adjudicated and founded by the department unless a waiver has been granted by the department.

(g) All personnel shall:

(1) Meet the requirements of the position as listed in the job description required by (a) above;

(2) Be licensed, registered or certified as required by state statute; and

(3) Receive an orientation within the first 3 business days of work that includes:

a. The CMA's policies on client rights and responsibilities and complaint procedures as required by RSA 151:20;

b. The duties and responsibilities of the position they were hired for;

c. The CMA's policies, procedures and guidelines;

d. The CMA's emergency plans; and

e. Mandatory reporting requirements such as those found in RSA 161-F:42-57 and RSA 169-C:29.

(h) All personnel shall complete annual continuing education, which shall include a review of the CMA's policies and procedures relative to client rights and complaint procedures.

(i) Current, separate and complete personnel files shall be maintained and stored in a secure and confidential manner at the licensed premises for all personnel of the CMA.

(j) The personnel file required by (i) above shall include the following:

(1) A completed application for employment or a resume;

(2) A signed statement acknowledging the receipt of the CMA's policy setting forth the client's rights and responsibilities, and acknowledging training and implementation of the policy as required by RSA 151:20;

(3) Record of satisfactory completion of the orientation program required by (g)(3) above;

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- (4) A copy of each current New Hampshire license, registration or certification in health care field, if applicable;
- (5) Documentation that the required TB test results or radiology reports of chest x-rays, if required, have been completed by the appropriate health professionals;
- (6) Documentation of annual continuing education as required by (h) above;
- (7) Documentation of the BEAS State Registry check and the criminal record check; and
- (8) A statement that shall be signed at the time the initial offer of employment is made and then annually thereafter by all personnel stating that they:
 - a. Do not have a felony conviction in this or any other state;
 - b. Have not been convicted of a sexual assault, other violent crime, assault, fraud, abuse, neglect or exploitation;
 - c. Have not had a finding by the department or any administrative agency in this or any other state for assault, fraud, abuse, neglect or exploitation of any person; and
 - d. Do not pose a threat to the health, safety or well-being of a client.

(k) An individual need not re-disclose any of the matters in (j)(8) above if the documentation is available and the department has previously reviewed the material and determined that the individual can continue employment.

Source. #10260, eff 1-25-13

He-P 819.18 Quality Improvement.

- (a) The CMA shall develop and implement a quality improvement program that reviews policies and services and maximizes quality by preventing or correcting identified problems.
- (b) As part of its quality improvement program, a quality improvement committee shall be established containing a minimum of the administrator and one employee.
- (c) The quality improvement committee shall:
 - (1) Determine the indicators to be monitored and ensure that indicators reflect the clinical requirements of He-P 819;
 - (2) Determine the frequency with which information will be reviewed;
 - (3) Evaluate the information that is gathered;
 - (4) Develop and implement the action necessary to correct identified problems; and
 - (5) Evaluate the effectiveness of the corrective actions.
- (d) The quality improvement committee shall meet at least annually and record the minutes of each meeting.
- (e) Documentation of all quality improvement activities, including minutes of meetings, shall

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be maintained on-site for at least 2 years.

He-P 819.19 Emergency and Fire Safety.

(a) The licensee shall comply with all applicable federal, state and local laws, rules, codes and ordinances, including, but not limited to, the business chapter of NFPA 101 as adopted by the commissioner of the department of safety in Saf-C 6000, for:

- (1) Building;
- (2) Health, including waste disposal and water;
- (3) Fire; and
- (4) Zoning.

(b) An emergency and fire safety program shall be developed and implemented to provide for the safety of personnel.

Source. #10260, eff 1-25-13

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171-A:12 Individual Service Agreement. –

I. There shall be an individual service agreement for every client in the service delivery system who receives services. A service coordinator chosen by the client shall develop a preliminary written individual service agreement based upon a comprehensive screening evaluation established under RSA 171-A:6 for such client within 14 days after the initial service planning meeting. The individual service agreement shall be continually reviewed by the area agency and shall be modified if necessary. The commissioner shall adopt rules pursuant to RSA 541-A relative to the development of such individual service agreements.

II. Each individual service agreement shall include but not be limited to:

- (a) A statement of the nature of the specific strengths, interests, capacities, disabilities, and specific needs of the client;
- (b) A description of intermediate and long-range habilitation and treatment goals chosen by the individual and his or her guardian with a projected timetable for their attainment;
- (c) A statement of specific services to be provided and the amount, frequency, and duration of each service;
- (d) Specification of the providers to furnish each service identified in the agreement; and
- (e) Criteria for transfer to less restrictive settings for habilitation, including criteria for termination of service and a projected date for termination of service from the service.

DEVELOPMENTAL DISABILITIES SERVICES

He-M 503.08 Service Coordination.

(a) The service coordinator shall be a person chosen by the individual, guardian, or representative who meets the criteria in He-M 506.03 (b)-(g) and He-M 503.08 (e)-(f) below.

(b) The area agency shall advise the individual and guardian or representative verbally and in writing within 5 days of the determination of eligibility and each year prior to the annual service planning meeting under He-M 503.09 and He-M 503.10 that he or she has a right to choose his or her own service coordinator, including one who is not employed by the area agency.

(c) On an annual basis, the area agency shall evaluate the individual's, guardian's, or representative's satisfaction with the individual's service coordinator.

(d) The service coordinator shall:

Advocate on behalf of individuals for services to be provided in accordance with He-M 503.07 (b);

(1) Coordinate the service planning process in accordance with He-M 503.07, He-M 503.09, and He-M 503.10;

(2) Describe to the individual, guardian, or representative service provision options such as participant directed and managed services;

(3) Monitor and document services provided to the individual;

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(5) Ensure continuity and quality of services provided;

(6) Ensure that service documentation is maintained pursuant to He-M 503.10 (c), (h)(1), and (m)(2)-(3);

(7) Determine and implement necessary action and document resolution when goals are not being addressed, support services are not being provided in accordance with the service agreement, or when health or safety issues have arisen;

(8) Convene service planning meetings at least annually and whenever:

a. The individual, guardian, or representative is not satisfied with the services received;

b. There is no progress on the goals after follow-up interventions;

c. The individual's needs change;

d. There is a need for a new provider; or

e. The individual, guardian, or representative requests a meeting;

(9) Document service coordination visits and contacts pursuant to He-M 503.09 (n) and He-M 503.10 (m) (2)-(4);

(10) In advance of the annual service planning meeting, either during the quarterly meeting held prior to the expiration of the service agreement or at least 45 days prior to the expiration of the service agreement:

a. Ensure that all needed evaluations, screenings or assessments, such as the SIS, HRST, assistive technology evaluation, risk assessments, behavior plans and other clinical or health evaluations are updated and, if necessary, performed and that information from said evaluations, screenings and assessments is discussed and shared with the individual, guardian or representative (the SIS and the HRST are available as noted in Appendix A);

b. Identify risk factors and plans to minimize them;

c. Assess the individual's interest in, or satisfaction with, employment; and

d. Discuss and assess the individual's progress on goals and preparing for the development of new goals to be included in the new service agreement; and

(11) Assist the individual, guardian, or representative to maintain the individual's public benefits.

(e) A service coordinator shall not:

(1) Be a guardian or representative of the individual whose services he or she is coordinating;

(2) Have a felony conviction;

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(3) Have been found to have abused or neglected an adult with a disability based on a protective investigation performed by the bureau of elderly and adult services in accordance with He-E 700 and an administrative hearing held pursuant to He-C 200, if such a hearing is requested;

(4) Be listed in the state registry of abuse and neglect pursuant to RSA 169-C:35 or RSA 161-F:49; or

(5) Have a conflict of interest concerning the individual, such as providing other direct services to the individual.

(f) If the service coordinator chosen by the individual, guardian, or representative is not employed by the area agency or its subcontractor:

(1) The service coordinator and area agency shall enter into an agreement which describes:

- a. The role(s) set forth in He-M 503.08 for which the service coordinator assumes responsibility;
- b. The reimbursement, if any, provided by the area agency to the service coordinator;
- c. The oversight activities to be provided by the area agency; and
- d. Compliance with (e) above;

(2) If the area agency determines that the service coordinator is not acting in the best interest of the individual or is not fulfilling his or her obligations as described in the letter of agreement, the area agency shall revoke the designation of the service coordinator with a 30-day notice and designate a new service coordinator, with input from the individual, guardian, or representative, pursuant to He-M 503.08 (a); and

(3) If the area agency determines that a service coordinator chosen by the individual, guardian, or representative is posing an immediate and serious threat to the health or safety of the individual, the area agency shall terminate the designation of the service coordinator immediately upon issuance of written notice specifying the reasons for the action and designate a new service coordinator, with input from the individual, guardian, or representative, pursuant to He-M 503.08 (a).

(g) The individual, guardian, or representative may appeal the area agency's decision under (f) (2) or (3) above about a service coordinator pursuant to He-M 503.17. At the time it provides notice under (f) (2) or (3) above, the area agency shall advise the individual, guardian, or representative verbally and in writing of his or her appeal rights under He-M 503.17.

(h) The role of service coordinator may, by mutual agreement, be shared by an employee of the area agency and another person. Such agreements shall be in writing and clearly indicate which functions each service coordinator will perform.

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(i) For individuals who receive services from both the developmental services and behavioral health services systems, service coordination shall be billed only by the area agency or behavioral health agency that is the primary service provider, pursuant to He-M 426.15 (a)(6).

ACQUIRED BRAIN DISORDER SERVICES

He-M 522.09 Service Coordination.

(a) The service coordinator shall be a person chosen by the individual, guardian, or representative who meets the criteria in He-M 506.03(b)-(g) and He-M 522.09(e)-(f) below.

(b) The area agency shall advise the individual and guardian or representative in writing within 5 days of the determination of eligibility and each year prior to the annual service planning meeting under He-M 522.10 and He-M 522.11 that he or she has a right to choose his or her own service coordinator, including one who is not employed by the area agency.

(c) For those individuals not eligible for medicaid home- and community-based care services pursuant to He-M 517, the service coordinator shall:

- (1) Hold a planning session to identify service needs and goals and appropriate community resources;
- (2) Make appropriate referrals to community agencies; and
- (3) Advocate on behalf of the individual for services to be provided in accordance with He-M 522.

(d) For those individuals eligible under He-M 517.03, the service coordinator shall:

- (1) Advocate on behalf of individuals for services to be provided in accordance with He-M 522.08(b);
- (2) Coordinate the service planning process in accordance with He-M 522.08, He-M 522.10, and He-M 522.11;
- (3) Describe to the individual, guardian, or representative service provision options such as participant directed and managed services;
- (4) Monitor and document services provided to the individual;
- (5) Ensure continuity and quality of services provided;
- (6) Ensure that service documentation is maintained pursuant to He-M 522.11 (c), (h)(1) and (m)(2)-(3);

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- (7) Determine and implement necessary action and document resolution when goals are not being addressed, support services are not being provided in accordance with the service agreement, or health or safety issues have arisen;
- (8) Convene service planning meetings at least annually and whenever:
- a. The individual, guardian, or representative is not satisfied with the services received;
 - b. There is no progress on the goals after follow-up interventions;
 - c. The individual's needs change;
 - d. There is a need for a new provider; or
 - e. The individual, guardian, or representative requests a meeting;
- (9) Document service coordination visits and contacts pursuant to He-M 522.10(n) and He-M 522.11 (m)(2)-(4);
- (10) In advance of the annual service planning meeting, either during the quarterly meeting held prior to the expiration of the service agreement or at least 45 days prior to the expiration of the service agreement:
- a. Ensure that all needed evaluations, screenings, or assessments, such as the SIS, HRST, assistive technology evaluation, risk assessments, behavior plans, and other clinical or health evaluations are updated and, if necessary, performed and that information from said evaluations, screenings, and assessments is discussed and shared with the individual, guardian, or representative;
 - b. Identify risk factors and plans to minimize them;
 - c. Assess the individual's interest in, or satisfaction with, employment; and
 - d. Discuss and assess the individual's progress on goals and preparing for the development of new goals to be included in the new service agreement; and
- (11) Assist the individual, guardian, or representative to maintain the individual's public benefits.
- (e) A service coordinator shall not:
- (1) Be a guardian or representative of the individual whose services he or she is coordinating;
 - (2) Have a felony conviction;

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(3) Have been found to have abused or neglected an adult with a disability based on a protective investigation performed by the bureau of elderly and adult services in accordance with He-E 700 and an administrative hearing held pursuant to He-C 200, if such a hearing is requested;

(4) Be listed in the state registry of abuse and neglect pursuant to RSA 169-C:35 or RSA 161-F:49; or

(5) Have a conflict of interest concerning the individual, such as providing other direct services to the individual.

(f) If the service coordinator chosen by the individual, guardian, or representative is not employed by the area agency or its subcontractor:

(1) The service coordinator and area agency shall enter into an agreement which describes:

- a. The role(s) set forth in He-M 522.09 for which the service coordinator assumes responsibility;
- b. The reimbursement, if any, provided by the area agency to the service coordinator;
- c. The oversight activities to be provided by the area agency; and
- d. Compliance with (e) above;

(2) If the area agency determines that the service coordinator is not acting in the best interest of the individual or is not fulfilling his or her obligations as described in the letter of agreement, the area agency shall revoke the designation of the service coordinator with a 30-day notice and designate a new service coordinator, with input from the individual, guardian, or representative, pursuant to (a) above; and

(3) If the area agency determines that a service coordinator chosen by the individual, guardian, or representative is posing an immediate and serious threat to the health or safety of the individual, the area agency shall terminate the designation of the service coordinator immediately upon issuance of written notice specifying the reasons for the action and designate a new service coordinator, with input from the individual, guardian, or representative, pursuant to (a) above.

(g) The individual, guardian, or representative may appeal the area agency's decision under (f)(2) or (3) above about a service coordinator pursuant to He-M 522.18. At the time it provides notice under (f)(2) or (3) above, the area agency shall advise the individual, guardian, or representative in writing of his or her appeal rights under He-M 522.18.

(h) The role of service coordinator may, by mutual agreement, be shared by an employee of the area agency and another person. Such agreements shall be in writing and clearly indicate which functions each service coordinator will perform.

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(i) For individuals who receive services from both the developmental services and behavioral health services systems, service coordination shall be billed only by the area agency or behavioral health agency that is the primary service provider, pursuant to He-M 426.15(a)(6).

IN HOME SUPPORTS

He-M 524.07 Coordination of In-Home Supports.

(a) Once an individual, family, and representative, choose to participate and the individual is authorized pursuant to He-M 524.13 to receive services, a service coordinator shall be:

- (1) Chosen or approved by the individual or representative; and
 - (2) Designated by the area agency.
- (b) The service coordinator shall:
- (1) Maximize the extent to which an individual, family, and representative participate in the service planning process by:
 - a. Explaining the service planning process;
 - b. Eliciting information regarding the preferences, goals, and service needs of the individual and his or her family;
 - c. Reviewing issues to be discussed during service planning meetings; and
 - d. Inviting and assisting the family, representative, and individual, if age appropriate, to determine the following elements in the service planning process:
 1. The number and length of meetings;
 2. The location and time of meetings;
 3. The meeting participants; and
 4. The topics to be discussed;
 - (2) Facilitate the development of a service agreement; and
 - (3) Document the service agreement.
- (c) If the individual or representative selects a service coordinator who is not employed by the area agency or a subcontract agency, the service coordinator and area agency shall enter into an agreement which describes:
- (1) The specific responsibilities of the service coordinator

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- (2) The reimbursement to the service coordinator; and
- (3) The oversight activities to be provided by the area agency.

WAIVER PAYMENT

He-M 517.05 Covered Services.

(a) All services provided in accordance with the home and community-based care waiver shall be specifically tailored to, and provided in accordance with, the individual's needs, interests, competencies, and lifestyle as described in the individual's service agreement.

(b) Services provided pursuant to He-M 517 shall be designed to maintain and enhance each individual's natural supports.

(c) The services identified in (d)-(n) below shall be fundable in accordance with the home and community-based care waiver if such services are identified within an individual's service agreement or IFSP.

(d) Service coordination services shall:

(1) Be provided pursuant to He-M 503.09 – He-M 503.11 or He-M 522.10 – He-M 522.12;

(2) Include the following:

a. Monthly contacts, at a minimum, with the individual or other people who support or serve the individual, unless more frequent contacts are indicated by the service agreement;

b. Quarterly visits with the individual at the individual's residence or site of service, except when a different frequency is required subsequent to provision of participant directed and managed services pursuant to (n) below;

c. Quarterly determination of the individual's satisfaction with services through contact with the individual and his or her:

1. Family;

2. Guardian;

3. Friends; or

4. Service providers, as applicable to the individual's services;

d. Coordination and facilitation of all supports and services delineated in the service agreement;

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- e. Development and revision of the service agreement;
 - f. Monitoring, ongoing review and follow-up of all service agreement services; and
 - g. Referral to the bureau for the assessment of the individual's continued need for waived services pursuant to He-M 517.08; and
- (3) Be reimbursed at a monthly rate.

Committee to Study the Disparity in Reimbursement among Organizations that Provide Case Management under Social Security Act Section 1915(c) Waiver Programs

**Robin Cooper, Director of Technical Assistance
National Association of State Directors of Developmental Disabilities Services (NASDDDS)**

**Deborah Scheetz, Director of Long Term Supports and Services
Department of Health and Human Services (DHHS) – New Hampshire**

12/18/2019 – 10:00 am – 12:00 am

Ms. Cooper will address the following questions with the Committee:

Medicaid and Case Management for People with Developmental Disabilities: Structure, Practice, and Issues

National Association of State Directors of Developmental Disabilities Services - NASDDDS April 2019

- **Is there a federal regulation for case management for HCBS?**

Yes—the Medicaid admin, TCM and waiver regulations apply if you want to use Medicaid

**Home and Community Based Services (HCBS) waiver
Core services definition waiver technical guide, p.105**

- Evaluation and/or re-evaluation of level of care;
- Assessment and/or reassessment of the need for waiver services;
- Development and/or review of the service plan;
- Coordination of multiple services and/or among multiple providers;
- Linking waiver participants to other federal, state, and local programs;
- Monitoring the implementation of the service plan and participant health and welfare,
- Addressing problems in service provision;
- Responding to participant crises; and
- For waivers with cost or service duration limits, monitoring to detect and resolve situations when the needs of an individual might exceed the limit(s) to ensure health and welfare of waiver participants

**Targeted Case Management (TCM)
42 CFR §440.169.**

- D. The assistance that case managers provide in assisting eligible individuals obtain services includes -
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:
 - i. Taking client history.
 - ii. Identifying the needs of the individual, and completing related documentation.

- iii. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.
2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:
 - i. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.
 - ii. Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.
 - iii. Identifies a course of action to respond to the assessed needs of the eligible individual.
3. Referral and related activities.
4. Monitoring and follow-up activities.
5. Assuring:
 - i. Services are being furnished in accordance with the individual's care plan.
 - ii. Services in the care plan are adequate.
 - iii. There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
6. Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.¹

Administrative Case Management

42 CFR §433.15(b)(7)

Medicaid administrative activities refer to those costs that are "as found necessary by the Secretary for the proper and efficient administration of the state plan."² The Secretary of Health and Human Services has final determination of which activities are allowable. In addition to case management activities, some common activities that fall under administrative claiming include:

- Medicaid eligibility determination,
- Medicaid intake processing,
- the prior authorization of Medicaid services (to the extent that a state requires this activity to be conducted in advance of furnishing a service),
- preadmission screening or level of care evaluations for persons being admitted to an institutional setting,
- Medicaid outreach activities, and
the day-by-day costs incurred in operating the state Medicaid agency (SMA).³

¹ Excerpts from: 42 CFR §440.169.

² 42 CFR §433.15(b)(7).

³ See www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD122094.pdf.

- **What is the best practice for a scope of services or governance for case management for HCBS?**

The activities should reflect two spheres—the individual supports, outcome and quality and system monitoring

Agent of the person but also an agent of the “state”—carrying out state policies and practices that improve the lives of the individuals serviced

- **Does case management need to, or should it be, the same across all HCBS waivers? Is this defined in federal regulation?**

Not required nor defined I state regulation—and there is no requirement that CM be the same, particularly the qualifications.

Case managers supporting seniors need different skill and knowledge to perform their job say from CMs serving adult with ASD and criminal justice involvement! May have a basic set of core competencies with disability-specific skill sets

- **Is case management typically billed at a monthly, daily, or other unit?
Monthly and 15 minutes**

From Medicaid and Case Management monograph

DD case management 47 states responding

| TIME | TC M | HCBS Waiver | 1115 | Admin | (b)/(c) |
|--------------------|------|-------------|------|-------|---------|
| 5 minute | 2 | 0 | 0 | 0 | 0 |
| 15 minute | 10 | 3 | 0 | 0 | 1 |
| Hourly | 0 | 1 | 1 | 0 | 0 |
| Daily | 0 | 0 | 0 | 0 | 0 |
| Weekly | 1 | 2 | 0 | 0 | 0 |
| Monthly | 8 | 13 | 0 | 0 | 1 |
| Fixed Fee Contract | 0 | 0 | 0 | 1 | 0 |
| Other | 2 | 2 | 1 | 5 | 1 |

- **Does 24/7, 365 support belong with the Organized Health Care Delivery System (OHCDS), Case Management, or can it be done by either?**

If you mean that the A is a reasonable place for 24/7 on-call responsibility, that might be okay. In this sense they act as a safety net and are for example the entity responsible for tracking abuse or are the authorizing agency for emergency services...24/7 responsibility would be defined in the scope of duties and compensated accordingly on a Medicaid admin cost allocation plan

24/7 is also typically a case management agency/provider requirement as well—individual should be able to access their case manager in an emergency—but if you do not want this, then there must be a very clear and well-defined and well-understood point of contact in an emergency... This means, families, individuals, providers, --and this may mean more than one contact point, say A and CM agency

Wednesday, December 18, 2019– Committee on Case Management Rates

Senator Rosenwald and members of the committee:

I am speaking to highlight information that was not included in the December 3, 2019 presentation to the legislature by DHHS regarding case management rates in New Hampshire's 1915 (c) Medicaid Waiver programs.

While the discussion focused on case management rates a larger scope needs to be included in the discussion to fully appreciate and disclose the financial advantages that some providers have over others. Because of these advantages and an inherent anti-competitive structure to the Area Agency "system", independent case management agencies like Life Coping are being undermined to the detriment of consumer choice by the General Management Fee structure that we do not have the benefit of.

It was mentioned by DHHS staff on 12/3/19 that "No one is giving us more money". The fact of the matter is that Area Agencies who compete with non area agency, independent and conflict free case management agencies, like Life Coping, are annually budgeted more money through another mechanism.

This mechanism is the "General Management Fee (GM)" ranging from 3% to 12% that is assessed and paid to the Area Agency for each client served under the developmental disabilities 1915 (c) waiver. The waiver funding managed by the ten regional AA's will have increased 102 % from 2009 to 2021 from \$161,943,992 to \$327,350,806. This illustrates a key competitive and structural disadvantage that all non AA providers of case management face vis a vis their AA counterparts.

At the same time that the Bureau of Developmental Disabilities has been mandated by the Center for Medicare and Medicaid Services (CMS) to implement conflict free case management, the entities like Life Coping that could accomplish this are being weakened by the increasing AA funding subsidies from their GM fees. There is not a level playing field.

Other clarifications from the meeting on 12/3/19:

- Rates for case management for independent case management for DD clients are dictated by the AA not "negotiated"
- Community Partners (see letter) wrote that "it has been recommended by the DHHS, that we use the reimbursement rate of the Choices for Independence Program. Therefore the rate we would contract for your services will be \$191.97"
- Life Coping DOES provide 24/7 coverage of our clients via answering service dispatching messages.
- AA Agency paid for 7 days of service. Non AA providers paid for only 5 days
- Area Agencies DO receive a "fee" from beneficiary social security income to be representative payee. This is not an "unpaid" service.

Thank you for the opportunity to speak this morning.

Jebb Curelop
Life Coping Inc.

Comparison Developmentally Disabled and Elderly Medicaid Home and Community Based Care Waiver Budgets 2009-2021

| SFY | Developmentally Disabled Area Agency | Elderly CFI Waiver |
|---------------------|--------------------------------------|--------------------|
| 2009 | 161,943,992 | 54,319,842 |
| 2010 | 163,198,591 | 60,595,420 |
| 2011 | 191,007,314 | 64,417,211 |
| 2012 | 194,601,181 | 50,933,790 |
| 2013 | 199,286,914 | 58,098,004 |
| 2014 | 202,257,096 | 60,582,533 |
| 2015 | 232,587,182 | 59,318,489 |
| 2016 | 224,512,579 | 53,367,360 |
| 2017 | 234,387,960 | 53,901,034 |
| 2018 | 250,066,010 | 55,547,596 |
| 2019 | 260,862,930 | 55,547,596 |
| 2020 | 311,381,853 | 67,615,133 |
| 2021 | 327,350,806 | 72,092,558 |
| Increase 2009-20021 | 102% | 32% |

| Nursing Home Budget | CFI + Nursing Home Budgets |
|---------------------|----------------------------|
| 2020 | 268,813,054 |
| 2021 | 273,290,479 |



Community Partners
113 Crosby Road, Suite 1
Dover, NH 03820
Phone: (603) 516-9300
Fax: (603)743-3244

A United Way
Partner Agency

May 7, 2019

Ellen J. Curelop, President
Life Coping, Inc.
159 Main Dunstable Road – Suite 207
Nashua, NH 03060

Dear Ms. Curelop;

Many thanks for your letter of April 11, 2019 regarding Life Coping's interest in providing case management services for individuals at Community Partners. As you know, Life Coping has been providing case management services for a number of years and we have always felt that it has been a positive relationship that has served people who want that choice well. We will ensure that Life Coping's name is provided to families and will assist them in contacting you directly for any referral information.

One distinction henceforth for any new referrals, our rate for reimbursement for case management services will be changed to reflect the direction of the implementation of the State's Corrective Action Plan. It has been recommended by the DHHS, that we use the reimbursement rate of the Choices For Independence program. Therefore the rate we would contract for your services will be \$191.97/month.

Currently Life Coping provides case management service for five individuals. We will not be changing the rates at this time for these individuals, which is \$257.33/month.

Please recognize as further guidance and implementation unfolds, we will revisit both the decisions referenced above.

I will ask Pamela Dushan, our Director of Case Management to reach out to you in the near future to be sure that our communication is effective and ongoing. We want to have our list of potential case management vendors available for the families served through our agency. Many thanks for your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian Collins".

Brian Collins, Executive Director
Community Partners

cc: Commissioner Jeffrey A. Meyers

Community Partners
Behavioral Health & Developmental Services of Strafford County, Inc.

Debra Martone

From: Carolyn Virtue <carolyn@granitecm.us>
Sent: Saturday, January 04, 2020 6:40 AM
To: Cindy Rosenwald
Cc: Debra Martone; senclegg@aol.com; jcurelop@lifecoping.org
Subject: NE CM Rates
Attachments: WebPage.pdf

Good Morning Senator;

Happy New Year!

When we spoke in December, you had asked me about case management rates paid by our neighboring states (which CMS directs states to include for consideration in their rate setting methodologies). Please see the below data for VT, ME and MA. I am working on a formal document of my comments for submission to all members prior to the next meeting of the Study Commission.

Thank you, Carolyn

Vermont:

| | | | | | | |
|-------|-----|-----|----------|----------|---|----------|
| T1017 | T19 | S25 | 20040101 | 23821231 | N | \$36.00 |
| T1017 | T16 | S29 | 20050701 | 23821231 | N | \$24.09 |
| T1017 | T16 | S26 | 20071001 | 23821231 | N | \$216.67 |
| T2022 | T20 | 060 | 20121001 | 23821231 | N | \$320.00 |
| T2022 | T21 | 060 | 20121001 | 23821231 | N | \$320.00 |
| T2022 | T23 | S04 | 20121001 | 23821231 | N | \$320.00 |
| T2023 | 036 | S53 | 20161001 | 23821231 | N | \$400.00 |
| T2023 | T47 | S53 | 20161001 | 23821231 | N | \$400.00 |

MASSACHUSETTS: \$241.22 per month

(4) Approved Rates. The approved rate is the lower of the provider's charge or amount accepted as payment from another payer or the rate listed in 101 CMR 417.03(4).

| Service | Unit | Rate |
|---|----------------------|----------|
| Enhanced Community Options Program (ECOP) Direct Services | Per client per month | \$731.91 |
| Home Care Program Services Direct Services | Per client per month | \$318.70 |
| Congregate Housing Services Coordination | Per client per month | \$210.95 |
| Basic Home Care Case Management | Per client per month | \$137.74 |
| ECOP Case Management | Per client per month | \$241.22 |
| Protective Services | Per client per month | \$388.63 |

| | | |
|----------------------------|-------------------------------|---------|
| Protective Services Intake | Per protective service report | \$68.47 |
| Supportive Senior Housing | | |

| | |
|--------------------|----------|
| Per site per month | \$12,014 |
|--------------------|----------|

| | | |
|---------------------------|----------------------|---------|
| Money Management Services | Per client per month | \$63.51 |
| Guardianship Services | Per client per month | |

| |
|----------|
| \$587.62 |
|----------|

Enhanced Community Options Program (ECOP) Direct Services. A program administered by ASAPs for frail elders who are clinically eligible for nursing facility services under MassHealth and who meet criteria set forth by EOEA. ECOP provides a broad range of community services for these elders to remain in the community that includes services available under the Home Care Program.

Maine: \$21.09 per 15 minute unit

Carolyn A Virtue

Granite Case Management
Cell: (603) 848-7345

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State of Maine

Department of Health & Human Services
 Section 13 - Targeted Case Management Rates/Fee Schedule
 Effective January 1, 2019 - December 31, 2019

| Procedure Code | Modifier | Code Description | Unit of Service | 8/1/2018 Rate | 7/1/2019 Rate |
|----------------|----------|--|-----------------|---------------|---------------|
| T1017 | UD | Case Management Services for Children with Developmental Disabilities | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | UC | Case Management Services for Children with Behavioral Health Disorders | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | UB | Case Management Services for Children with Chronic Medical Care Needs | 15 Minutes | \$21.99 | \$21.95 |
| G9012 | HI | Case Management Services for Adults with Developmental Disabilities | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | HF | Case Management Services for Adults with Substance Abuse Disorders | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | | Case Management Services for Adults with HIV | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | U5 | Case Management Services for Members Experiencing Homelessness | 15 Minutes | \$21.99 | \$21.95 |
| G9012 | U5 | Case Management Services for Members Experiencing Homelessness (Government Agencies) | 15 Minutes | \$21.99 | \$21.95 |

Modifier:
 HF - Substance Abuse Program
 HI - Developmental Disability Program
 UB - Target Case Management Svc <21 MOD
 UC - Target Case Management Svc <21 MOD
 UD - Target Case Management Svc <21 MOD
 U5 - Targeted Case Management Services

Debra Martone

From: Carolyn Virtue <carolyn@granitecm.us>
Sent: Wednesday, January 08, 2020 3:14 PM
To: Cindy Rosenwald; john.reagan@leg.state.nh.us; Martha Hennessey; katherine.rogers@leg.state.nh
Cc: senclegg@aol.com; Bob Giuda; Debra Martone; HCBS@cms.hhs.gov; ROBOSDMCH@cms.hhs.gov; OCOM@dhhs.nh.gov; Henry.Lipman@dhhs.nh.gov; Christine.Tappan@dhhs.nh.gov; Deborah.Scheetz@dhhs.nh.gov
Subject: Committee to Study Waiver CM Rate Disparity
Attachments: CM Rate Comparrison 1 2020.pdf

Senator Cindy Rosenwald
Senator John Reagan
Representative Erin Hennessey,
Representative Katherine Rogers

Dear Chairman Rosenwald and Honorable Members of the:

COMMITTEE TO STUDY THE DISPARITY IN REIMBURSEMENT AMONG ORGANIZATIONS THAT PROVIDE CASE MANAGEMENT UNDER SOCIAL SECURITY ACT SECTION 1915(c) WAIVER PROGRAMS HB4 - Chapter 346:381 - Laws of 2019. (the Committee)

This Committee was established because within the NH Department of Health and Human Services (the department) there exists a disparity in the 1915 (c) Waiver case management rates.

We sincerely appreciate the time this committee is expending to benchmark NH's 1915 (c) waiver case management rates as required by the Center for Medicare and Medicaid Services (CMS).

The CMS documents referenced herein can be found at: <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-training-series/index.html>

In an effort to develop accurate and complete information for the Committee assessment of the case management rate disparity, the following highlights and commentary are in response to various documents and testimony provided to the Committee to date.

CMS directs states to have "a consistent rate paid to all providers for the same service" and that rates be consistent for "similar services within your programs".

The aforementioned was verified by the department's expert Ms. Robin Cooper during the 12/18/2019 meeting. The Choices For Independence (CFI) Waiver management rate is far below the Developmental Disability (DD), Acquired Brain Disorder (ABD) and In Home Supports (IHS) Waiver case management rates.

All four waivers are operated under the 1915 (c) waiver authority. While there are slight variances in the programs, the case management provided in each of the waivers is done so under the same federal definitions and guidance.

The CFI case management duties as defined in statute and rule are far greater than the DD, ABD and IHS duties as defined in statute and rule (refer to department's document submissions for this study).

Any claim made to the contrary should be not accepted as fact until fully vetted.

A clear and definitive rate disparity exists, which should be addressed forthwith to bring the programs into compliance with federal guidance on rate setting.

The department has brought the Conflict Free Case Management Plan of Correction (12/13/2016 - ongoing) into this rate discussion. Of note, the Plan of Correction does not apply to the CFI Waiver as the CFI waiver is in compliance with the conflict free case management and direct bill requirements.

The corrections required by CMS are: development of a "direct bill" process for the ABD, DD and IHS waivers, CMS did not require the department to include rate setting in the the plan of correction. A process to develop a means to direct bill case management service and a process to set a rate are two separate and distinct activities. Combining these separate activities, only serves to confuse both the direct bill and the rate setting issues. Further, presenting information which is not applicable to this study, has caused unnecessary confusion. The department added rate setting to the timeline in 2018.

CMS directed states to separate administrative activities from case management service activities in 2008: "States must identify the activities claimed as administration and compare the activities to the definition of case management services. If these activities are a case management service, then the service must be claimed as medical assistance. If the activities are for the proper and efficient administration of the State Plan, then reimbursement would be claimed as administration." - CMS-2237-IFC - 4/18/08".

NH complied with the above directive at the time it was issued. The practice of billing for administrative services under the medical service code for targeted case management (T2022, T2023, T2025) has NOT been identified as requiring correction in the current Conflict Free Case Management Corrective Action Plan.

The Corrective Action Plan and the associated activities the department is engaged in relative to mitigating conflict and setting up a direct bill process, has no bearing on the rate disparity discussion.

The department has brought the area agency status of "organized health care delivery system" into the rate study discussion. What may not be clear is - as such, the area agencies have separate and distinct duties, defined in statute, rule and by contract (references not provided by the department to date), for which the area agencies are paid an administrative fee (not provided to date). An administrative, fee paid for administrative duties, which are seperate and distinct from case management.

The "organized health care delivery system" status of the are agencies has NOTHING to do with the case management rate set for the case management services currently provided. Administrative duties are strictly barred from being included in case management service provision. Any adjustments needed for administrative duties under the plan of correction should be made to the administrative rate.

The rates set in each waiver for case management are for case management. There is nothing in the documents submitted by DHHS to this study committee suggesting otherwise.

The case management rates paid under T2022, T2023, T2025 are reimbursement for case management services, the rate should NOT include administrative activities and there is no evidence provided suggesting it does. Should this be incorrect it would raise fraudulent billing concerns and exposure for recoupment, which would need to be addressed forthwith.

The CFI Waiver case management is billed in 15 minute increments, 5 days per week. The statute and rules which define the CFI case management service, require the service to be provided monthly and as needed.

The CFI Waiver case management rate should be set as it is required to be provided by applicable regulations, MONTHLY. A monthly CFI Waiver case management rate will bring the services into compliance with federal coding requirements.

As discussed during the meeting on 12/18/2019, the CFI Waiver case management is available 7 days per week by the two of the enrolled providers present. This is evidenced by documented communication with department staff as needed on weekends to address client issues. To be clear, the CFI case management is BILLED 5 days per week and is available and often PROVIDED 7 days per week.

The DD, ABD and IHS Waiver case management is billed at a monthly rate. The statute and rules which define the service vary dependent on the specific waiver, require the case management services to be provided monthly, at most (ABD has a quarterly requirement). The CFI Waiver case management requirements are equal or greater.

The DHHS assertion that DD, ABD, and IHS Waiver case management is currently required in statute or rule to be provided 7 days per week is false. Furthermore, the statute and rule references the department provides for the 7 day per week requirement for DD, ABD and IHS can be found exactly or similarly in the references the department cites for authority for the provision of CFI waiver case management. DD, ABD, and IHS Waiver case management is not readily available 7 days per week to consumers, nor is currently consistently provided in that manner by all area agencies. The area agencies differ greatly. Some may have contracted service providers with on call staff, but this is NOT case management, these direct service providers are specifically excluded from providing case management service.

All case management should be available 7 days per to protect the health, welfare and safety of the beneficiaries.

The case management provided in NH's FOUR 1915 (c) waivers is very similar, if not identical.

On September 1, 2010 CMS issued a State Medicaid Directors Letter (SMD #: 10-017 ACA#: 7) in regard to the National Correct Coding Initiative (NCCI).

The CFI waiver case management rate should have been addressed at this time, it was ignored. Of note: the NH DHHS Department of Integrity and improvement regularly sends letters to clients stating they received case management 5 days per week for the identified review period. This causes confusion and agita. Informing recipients to ignore these important communications defies the purpose of sending the notices and it diminishes effectiveness of the integrity program.

The department was asked to provide a comparison of the regulatory authority governing the case management for **each** waiver:

- The department submitted the document titled "Case Management for the Bureau of Developmental Services - Laws and Rules" which combines the regulations for ABD, IHS and DD Waiver case management. Although some of the included regulations applied to only one waiver, the department made no differentiation as to which regulations applied to the individual services. 9 Pages of requirements for the ABD, DD, and IHS Waiver case management services.
- The department submitted the document titled "Case Management for the Bureau of Elderly and Adult Services - Laws and Rules" as the requirements for CFI Case Management. The document is incomplete, it does not contain the enabling statutes (RSA 151-E:1 and 151-E:17 or the licensure rule (He-P 819) requirement. 17 Pages of requirements without the enabling statute and a complete rule reference for the CFI case management service.

The correctness of the rate history document submitted by DHHS ("CM Rates for DLTSS CFI, DD, ABD & IHS Waivers 12-2-19 2") is in question. The ABD case management has been published at a higher than what is being reported in the department's submission for this study.

While the CFI Waiver case management rate has NOT been adequately addressed by any standard, the duties and responsibilities the agencies are required by rule to perform, have been added to every time the department opens an He-E 800 Rule.

The He-E 805 was added as a new rule in 2008 greatly expanding the scope of service provided. No consideration has been given to the cost of these mandates over the years, nor has the rate been adjusted for responsibilities added by the department or the legislature through statute or rule.

CMS directs states to factor the Bureau of Labor Statistics Wage Data when rate setting. The pay rate BLS reports as Median, \$65,320 could not be supported by the current CFI Rate, contrary to the rate paid in the ABD, DD and IHS which could support the rate.

This is based on the average caseload for all four waivers of 45 cases.

Bureau of Labor Statistics:

The May 2018 Occupational Employment Statistics data were released on March 29th, 2019.

<https://www.bls.gov/ooh/management/social-and-community-service-managers.htm>

Quick Facts: Social and Community Service Managers
2018 Median Pay
\$65,320 per year
\$31.41 per hour
Typical Entry-Level Education
Bachelor's degree
Work Experience in a Related Occupation
Less than 5 years

CMS directs states to factor the Bureau of Labor Statistics Consumer Price Index (CPI) Data when rate setting.

BLS CPI Inflation Calculator: <https://data.bls.gov/cgi-bin/cpicalc.pl?cost1=8.35&year1=200001&year2=201911>

CPI for the CFI CM Rate:

(Utilizing the data submitted by BEAS to this committee):

\$8.35 in 3/2004 has the same buying power as \$11.46 in 11/2019

CPI for the CFI CM Rate:

(Utilizing the rate experience):

\$8.35 in 1/2000 has the same buying power as \$12.72 in 11/2019

CMS directs states to factor the rates paid for similar services in neighboring states. (NH's rates for 1915 (c) waiver case management are lower than our neighboring states.)

Vermont Case Management Rates:

T1017 (15 Minute Unit) - \$24.09 - 36.00

T2022 (Monthly) - \$320.00

T2023 (Monthly) - \$400.00

Maine Case Management Rate:

T1017 (15 Minute Unit) - \$21.09

Massachusetts Case Management Rate:

ECOP Case Management, Per client per month - \$241.22*

Enhanced Community Options Program (ECOP) Direct Services. A program administered by ASAPs for frail elders who are clinically eligible for nursing facility services under MassHealth and who meet criteria set forth by EOEAE. ECOP provides a broad range of community services for these elders to remain in the community that includes services available under the Home Care Program.

*This is the Massachusetts Case Management Rate for the Elderly and Adult Waiver - Similar to NH's CFI Waiver. I was unable to locate the rate for other populations.

Senator Reagan asked me why the CFI case management had in essence been ignored. I did not have a good response at the time.

Having given this very interesting question much thought I reply - in addition to the obvious budgetary issue of the state of NH, the **CFI Waiver case management is an orphan.**

The CFI waiver has a rate setting methodology for *CFI Waiver services*, in the waiver. *CFI Waiver case management is NOT a CFI Waiver service*, the CFI case management is a state plan service. No methodology utilized for state plan services rate setting has been applied to the CFI case management rate. There is no clear designated responsibility for the CFI Waiver case management rate setting within the department, resulting in the disparity.

Please see a side by side comparison attached below. I do hope this adds some clarity to the rate disparity discussion. Please do not hesitate to contact me directly, should you have questions or require clarification.

I sincerely appreciate your consideration of the case management rate disparity and your efforts to resolve the inequities.

Thank you,
Carolyn A Virtue
Granite Case Management
Cell: (603) 848-7345

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NH 1915 (c) Waiver Comparisons

CFI Case Management DD Case Management ABD Case Management IHS Case Management Similarity/Difference

| HCBS Waiver Name | NH Choices for Independence (0060.R07.00) | 1915 (c) | NH Developmental Disabilities Waiver (0053.R06.00) a | 1915 (c) | NH BDS Acquired Brain Disorder Services (4177.R05.00) | NH In Home Supports for Children w/DD (0397.R03.00) | Similarity/Difference |
|--|---|--|---|---|---|---|--|
| HCBS Waiver Authority | 1915 (c) | 1915 (c) | 1915 (c) | 1915 (c) | 1915 (c) | 1915 (c) | IDENTICAL |
| HCPCS Code (Federally Required Medicaid Service Identifier Code) | T1016 | T1016 | T1016 | T1016 | T1016 | T1016 | IDENTICAL |
| Face to Face Visit Requirement | Every 60 Days | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Not Specified | CFI CM Mandated 6 Face to Face visits per year. DD NO mandate for Face to Face Visit |
| Telephone Contact | Monthly and PRN | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Not Specified | CFI telephone contact is greater. |
| NH Admin Rule References | He-E 801; He-E 805 | He-M 503 | He-M 517 | He-M 524 | He-M 524 | | |
| He-P 819 Case Management License Required to deliver service. | Yes | NO | NO | NO | NO | | |
| Populations served | Recipients in need of LTSS who are adults or frail elders - ALL diagnosis, including ABD and DD | Recipients in need of LTSS with Developmental Disabilities | Recipients in need of LTSS Acquired Brain Disorder (ABD) | Recipients in need of enhanced personal care, consultations, environmental and vehicle mods, family support/service coordination, respite care for individuals w/autism, ID, DD ages 0-21 | Recipients in need of enhanced personal care, consultations, environmental and vehicle mods, family support/service coordination, respite care for individuals w/autism, ID, DD ages 0-21 | | CFI covers all adult populations, including those with ABD and DD. |
| Rate | \$8.86 per diem, 5 days per week | DHHS does NOT PUBLISH DD rates or provide them on request - 2014 Rate is reported here. \$267.35 per month | \$349 per month | DHHS does NOT PUBLISH DD rates or provide them on request. | DHHS does NOT PUBLISH DD rates or provide them on request. | | Disparity |
| Monthly Reimbursement | \$191.96 | \$257.35 | \$349.00 | \$349.00 | | | Disparity |

Federal regulations require parity in reimbursement of identical services (\$1902(a)(30)(A) of the Social Security Act; 42 CFR 447.201-202)

The CFI CM rate disparity treats one group of Medicaid beneficiaries differently than another group which does not comply with federal law (42 CFR 435.923).

Committee to Study the Disparity in Reimbursement among Organizations that Provide Case Management under Social Security Act Section 1915(c) Waiver Programs

**Robin Cooper, Director of Technical Assistance
National Association of State Directors of Developmental Disabilities Services (NASDDDS)**

**Deborah Scheetz, Director of Long Term Supports and Services
Department of Health and Human Services (DHHS) – New Hampshire**

12/18/2019 – 10:00 am – 12:00 am

Ms. Cooper will address the following questions with the Committee:

Medicaid and Case Management for People with Developmental Disabilities: Structure, Practice, and Issues

National Association of State Directors of Developmental Disabilities Services - NASDDDS April 2019

- **Is there a federal regulation for case management for HCBS?**

Yes—the Medicaid admin, TCM and waiver regulations apply if you want to use Medicaid

**Home and Community Based Services (HCBS) waiver
Core services definition waiver technical guide, p.105**

- Evaluation and/or re-evaluation of level of care;
- Assessment and/or reassessment of the need for waiver services;
- Development and/or review of the service plan;
- Coordination of multiple services and/or among multiple providers;
- Linking waiver participants to other federal, state, and local programs;
- Monitoring the implementation of the service plan and participant health and welfare,
- Addressing problems in service provision;
- Responding to participant crises; and
- For waivers with cost or service duration limits, monitoring to detect and resolve situations when the needs of an individual might exceed the limit(s) to ensure health and welfare of waiver participants

**Targeted Case Management (TCM)
42 CFR §440.169.**

- D. The assistance that case managers provide in assisting eligible individuals obtain services includes -
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:
 - i. Taking client history.
 - ii. Identifying the needs of the individual, and completing related documentation.

- iii. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.
 2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:
 - i. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.
 - ii. Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.
 - iii. Identifies a course of action to respond to the assessed needs of the eligible individual.
 3. Referral and related activities.
 4. Monitoring and follow-up activities.
 5. Assuring:
 - i. Services are being furnished in accordance with the individual's care plan.
 - ii. Services in the care plan are adequate.
 - iii. There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 6. Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.¹

Administrative Case Management

42 CFR §433.15(b)(7)

Medicaid administrative activities refer to those costs that are "as found necessary by the Secretary for the proper and efficient administration of the state plan."² The Secretary of Health and Human Services has final determination of which activities are allowable. In addition to case management activities, some common activities that fall under administrative claiming include:

- Medicaid eligibility determination,
- Medicaid intake processing,
- the prior authorization of Medicaid services (to the extent that a state requires this activity to be conducted in advance of furnishing a service),
- preadmission screening or level of care evaluations for persons being admitted to an institutional setting,
- Medicaid outreach activities, and
the day-by-day costs incurred in operating the state Medicaid agency (SMA).³

¹ Excerpts from: 42 CFR §440.169.

² 42 CFR §433.15(b)(7).

³ See www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD122094.pdf.

- **What is the best practice for a scope of services or governance for case management for HCBS?**

The activities should reflect two spheres—the individual supports, outcome and quality and system monitoring

Agent of the person but also an agent of the “state”—carrying out state policies and practices that improve the lives of the individuals serviced

- **Does case management need to, or should it be, the same across all HCBS waivers? Is this defined in federal regulation?**

Not required nor defined in state regulation—and there is no requirement that CM be the same, particularly the qualifications.

Case managers supporting seniors need different skill and knowledge to perform their job say from CMs serving adult with ASD and criminal justice involvement! May have a basic set of core competencies with disability-specific skill sets

- **Is case management typically billed at a monthly, daily, or other unit?
Monthly and 15 minutes**

From Medicaid and Case Management monograph

DD case management 47 states responding

| TIME | TC M | HCBS Waiver | 1115 | Admin | (b)/(c) |
|--------------------|------|-------------|------|-------|---------|
| 5 minute | 2 | 0 | 0 | 0 | 0 |
| 15 minute | 10 | 3 | 0 | 0 | 1 |
| Hourly | 0 | 1 | 1 | 0 | 0 |
| Daily | 0 | 0 | 0 | 0 | 0 |
| Weekly | 1 | 2 | 0 | 0 | 0 |
| Monthly | 8 | 13 | 0 | 0 | 1 |
| Fixed Fee Contract | 0 | 0 | 0 | 1 | 0 |
| Other | 2 | 2 | 1 | 5 | 1 |

- **Does 24/7, 365 support belong with the Organized Health Care Delivery System (OHCDS), Case Management, or can it be done by either?**

If you mean that the A is a reasonable place for 24/7 on-call responsibility, that might be okay. In this sense they act as a safety net and are for example the entity responsible for tracking abuse or are the authorizing agency for emergency services...24/7 responsibility would be defined in the scope of duties and compensated accordingly on a Medicaid admin cost allocation plan

24/7 is also typically a case management agency/provider requirement as well—individual should be able to access their case manager in an emergency—but if you do not want this, then there must be a very clear and well-defined and well-understood point of contact in an emergency... This means, families, individuals, providers, --and this may mean more than one contact point, say A and CM agency

Wednesday, December 18, 2019– Committee on Case Management Rates

Senator Rosenwald and members of the committee:

I am speaking to highlight information that was not included in the December 3, 2019 presentation to the legislature by DHHS regarding case management rates in New Hampshire's 1915 (c) Medicaid Waiver programs.

While the discussion focused on case management rates a larger scope needs to be included in the discussion to fully appreciate and disclose the financial advantages that some providers have over others. Because of these advantages and an inherent anti-competitive structure to the Area Agency "system", independent case management agencies like Life Coping are being undermined to the detriment of consumer choice by the General Management Fee structure that we do not have the benefit of.

It was mentioned by DHHS staff on 12/3/19 that "No one is giving us more money". The fact of the matter is that Area Agencies who compete with non area agency, independent and conflict free case management agencies, like Life Coping, are annually budgeted more money through another mechanism.

This mechanism is the "General Management Fee (GM)" ranging from 3% to 12% that is assessed and paid to the Area Agency for each client served under the developmental disabilities 1915 (c) waiver. The waiver funding managed by the ten regional AA's will have increased 102 % from 2009 to 2021 from \$161,943,992 to \$327,350,806. This illustrates a key competitive and structural disadvantage that all non AA providers of case management face vis a vis their AA counterparts.

At the same time that the Bureau of Developmental Disabilities has been mandated by the Center for Medicare and Medicaid Services (CMS) to implement conflict free case management, the entities like Life Coping that could accomplish this are being weakened by the increasing AA funding subsidies from their GM fees. There is not a level playing field.

Other clarifications from the meeting on 12/3/19:

- Rates for case management for independent case management for DD clients are dictated by the AA not "negotiated"
- Community Partners (see letter) wrote that "it has been recommended by the DHHS, that we use the reimbursement rate of the Choices for Independence Program. Therefore the rate we would contract for your services will be \$191.97"
- Life Coping DOES provide 24/7 coverage of our clients via answering service dispatching messages.
- AA Agency paid for 7 days of service. Non AA providers paid for only 5 days
- Area Agencies DO receive a "fee" from beneficiary social security income to be representative payee. This is not an "unpaid" service.

Thank you for the opportunity to speak this morning.

Jebb Curelop
Life Coping Inc.

Comparison Developmentally Disabled and Elderly Medicaid Home and Community Based Care Waiver Budgets 2009-2021

| SFY | Developmentally Disabled Area Agency | Elderly CFI Waiver |
|---------------------|--------------------------------------|--------------------|
| 2009 | 161,943,992 | 54,319,842 |
| 2010 | 163,198,591 | 60,595,420 |
| 2011 | 191,007,314 | 64,417,211 |
| 2012 | 194,601,181 | 50,933,790 |
| 2013 | 199,286,914 | 58,098,004 |
| 2014 | 202,257,096 | 60,582,533 |
| 2015 | 232,587,182 | 59,318,489 |
| 2016 | 224,512,579 | 53,367,360 |
| 2017 | 234,387,960 | 53,901,034 |
| 2018 | 250,066,010 | 55,547,596 |
| 2019 | 260,862,930 | 55,547,596 |
| 2020 | 311,381,853 | 67,615,133 |
| 2021 | 327,350,806 | 72,092,558 |
| Increase 2009-20021 | 102% | 32% |

| Nursing Home Budget | CFI + Nursing Home Budgets |
|---------------------|----------------------------|
| 2020 | 268,813,054 |
| 2021 | 273,290,479 |



Community Partners
113 Crosby Road, Suite 1
Dover, NH 03820
Phone: (603) 516-9300
Fax: (603)743-3244

A United Way
Partner Agency

May 7, 2019

Ellen J. Curelop, President
Life Coping, Inc.
159 Main Dunstable Road – Suite 207
Nashua, NH 03060

Dear Ms. Curelop;

Many thanks for your letter of April 11, 2019 regarding Life Coping's interest in providing case management services for individuals at Community Partners. As you know, Life Coping has been providing case management services for a number of years and we have always felt that it has been a positive relationship that has served people who want that choice well. We will ensure that Life Coping's name is provided to families and will assist them in contacting you directly for any referral information.

One distinction henceforth for any new referrals, our rate for reimbursement for case management services will be changed to reflect the direction of the implementation of the State's Corrective Action Plan. It has been recommended by the DHHS, that we use the reimbursement rate of the Choices For Independence program. Therefore the rate we would contract for your services will be \$191.97/month.

Currently Life Coping provides case management service for five individuals. We will not be changing the rates at this time for these individuals, which is \$257.33/month.

Please recognize as further guidance and implementation unfolds, we will revisit both the decisions referenced above.

I will ask Pamela Dushan, our Director of Case Management to reach out to you in the near future to be sure that our communication is effective and ongoing. We want to have our list of potential case management vendors available for the families served through our agency. Many thanks for your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian Collins".

Brian Collins, Executive Director
Community Partners

cc: Commissioner Jeffrey A. Meyers

Community Partners
Behavioral Health & Developmental Services of Strafford County, Inc.

Debra Martone

From: Carolyn Virtue <carolyn@granitecm.us>
Sent: Saturday, January 04, 2020 6:40 AM
To: Cindy Rosenwald
Cc: Debra Martone; senclegg@aol.com; jcurelop@lifecoping.org
Subject: NE CM Rates
Attachments: WebPage.pdf

Good Morning Senator;

Happy New Year!

When we spoke in December, you had asked me about case management rates paid by our neighboring states (which CMS directs states to include for consideration in their rate setting methodologies). Please see the below data for VT, ME and MA. I am working on a formal document of my comments for submission to all members prior to the next meeting of the Study Commission.

Thank you, Carolyn

Vermont:

| | | | | | | |
|-------|-----|-----|----------|----------|---|----------|
| T1017 | T19 | S25 | 20040101 | 23821231 | N | \$36.00 |
| T1017 | T16 | S29 | 20050701 | 23821231 | N | \$24.09 |
| T1017 | T16 | S26 | 20071001 | 23821231 | N | \$216.67 |
| T2022 | T20 | 060 | 20121001 | 23821231 | N | \$320.00 |
| T2022 | T21 | 060 | 20121001 | 23821231 | N | \$320.00 |
| T2022 | T23 | S04 | 20121001 | 23821231 | N | \$320.00 |
| T2023 | 036 | S53 | 20161001 | 23821231 | N | \$400.00 |
| T2023 | T47 | S53 | 20161001 | 23821231 | N | \$400.00 |

MASSACHUSETTS: \$241.22 per month

(4) Approved Rates. The approved rate is the lower of the provider's charge or amount accepted as payment from another payer or the rate listed in 101 CMR 417.03(4).

| Service | Unit | Rate |
|---|----------------------|----------|
| Enhanced Community Options Program (ECOP) Direct Services | Per client per month | \$731.91 |
| Home Care Program Services Direct Services | Per client per month | \$318.70 |
| Congregate Housing Services Coordination | Per client per month | \$210.95 |
| Basic Home Care Case Management | Per client per month | \$137.74 |
| ECOP Case Management | Per client per month | \$241.22 |
| Protective Services | Per client per month | \$388.63 |

| | | |
|----------------------------|-------------------------------|---------|
| Protective Services Intake | Per protective service report | \$68.47 |
| Supportive Senior Housing | | |

| | |
|--------------------|----------|
| Per site per month | \$12,014 |
|--------------------|----------|

| | | |
|---------------------------|----------------------|---------|
| Money Management Services | Per client per month | \$63.51 |
| Guardianship Services | Per client per month | |

| |
|----------|
| \$587.62 |
|----------|

Enhanced Community Options Program (ECOP) Direct Services. A program administered by ASAPs for frail elders who are clinically eligible for nursing facility services under MassHealth and who meet criteria set forth by EOEA. ECOP provides a broad range of community services for these elders to remain in the community that includes services available under the Home Care Program.

Maine: \$21.09 per 15 minute unit

Carolyn A Virtue

Granite Case Management
Cell: (603) 848-7345

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State of Maine

Department of Health & Human Services
 Section 13 - Targeted Case Management Rates/Fee Schedule
 Effective January 1, 2019 - December 31, 2019

| Procedure Code | Modifier | Code Description | Unit of Service | 8/1/2018 Rate | 7/1/2019 Rate |
|----------------|----------|--|-----------------|---------------|---------------|
| T1017 | UD | Case Management Services for Children with Developmental Disabilities | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | UC | Case Management Services for Children with Behavioral Health Disorders | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | UB | Case Management Services for Children with Chronic Medical Care Needs | 15 Minutes | \$21.99 | \$21.95 |
| G9012 | HI | Case Management Services for Adults with Developmental Disabilities | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | HF | Case Management Services for Adults with Substance Abuse Disorders | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | | Case Management Services for Adults with HIV | 15 Minutes | \$21.99 | \$21.95 |
| T1017 | U5 | Case Management Services for Members Experiencing Homelessness | 15 Minutes | \$21.99 | \$21.95 |
| G9012 | U5 | Case Management Services for Members Experiencing Homelessness (Government Agencies) | 15 Minutes | \$21.99 | \$21.95 |

Modifier:
 HF - Substance Abuse Program
 HI - Developmental Disability Program
 UB - Target Case Management Svc <21 MOD
 UC - Target Case Management Svc <21 MOD
 UD - Target Case Management Svc <21 MOD
 U5 - Targeted Case Management Services

Debra Martone

From: Carolyn Virtue <carolyn@granitecm.us>
Sent: Wednesday, January 08, 2020 3:14 PM
To: Cindy Rosenwald; john.reagan@leg.state.nh.us; Martha Hennessey; katherine.rogers@leg.state.nh
Cc: senclegg@aol.com; Bob Giuda; Debra Martone; HCBS@cms.hhs.gov; ROBOSDMCH@cms.hhs.gov; OCOM@dhhs.nh.gov; Henry.Lipman@dhhs.nh.gov; Christine.Tappan@dhhs.nh.gov; Deborah.Scheetz@dhhs.nh.gov
Subject: Committee to Study Waiver CM Rate Disparity
Attachments: CM Rate Comparrison 1 2020.pdf

Senator Cindy Rosenwald
Senator John Reagan
Representative Erin Hennessey,
Representative Katherine Rogers

Dear Chairman Rosenwald and Honorable Members of the:

COMMITTEE TO STUDY THE DISPARITY IN REIMBURSEMENT AMONG ORGANIZATIONS THAT PROVIDE CASE MANAGEMENT UNDER SOCIAL SECURITY ACT SECTION 1915(c) WAIVER PROGRAMS HB4 - Chapter 346:381 - Laws of 2019. (the Committee)

This Committee was established because within the NH Department of Health and Human Services (the department) there exists a disparity in the 1915 (c) Waiver case management rates.

We sincerely appreciate the time this committee is expending to benchmark NH's 1915 (c) waiver case management rates as required by the Center for Medicare and Medicaid Services (CMS).

The CMS documents referenced herein can be found at: <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-training-series/index.html>

In an effort to develop accurate and complete information for the Committee assessment of the case management rate disparity, the following highlights and commentary are in response to various documents and testimony provided to the Committee to date.

CMS directs states to have "a consistent rate paid to all providers for the same service" and that rates be consistent for "similar services within your programs".

The aforementioned was verified by the department's expert Ms. Robin Cooper during the 12/18/2019 meeting. The Choices For Independence (CFI) Waiver management rate is far below the Developmental Disability (DD), Acquired Brain Disorder (ABD) and In Home Supports (IHS) Waiver case management rates.

All four waivers are operated under the 1915 (c) waiver authority. While there are slight variances in the programs, the case management provided in each of the waivers is done so under the same federal definitions and guidance.

The CFI case management duties as defined in statute and rule are far greater than the DD, ABD and IHS duties as defined in statute and rule (refer to department's document submissions for this study).

Any claim made to the contrary should be not accepted as fact until fully vetted.

A clear and definitive rate disparity exists, which should be addressed forthwith to bring the programs into compliance with federal guidance on rate setting.

The department has brought the Conflict Free Case Management Plan of Correction (12/13/2016 - ongoing) into this rate discussion. Of note, the Plan of Correction does not apply to the CFI Waiver as the CFI waiver is in compliance with the conflict free case management and direct bill requirements.

The corrections required by CMS are: development of a "direct bill" process for the ABD, DD and IHS waivers, CMS did not require the department to include rate setting in the the plan of correction. A process to develop a means to direct bill case management service and a process to set a rate are two separate and distinct activities. Combining these separate activities, only serves to confuse both the direct bill and the rate setting issues. Further, presenting information which is not applicable to this study, has caused unnecessary confusion. The department added rate setting to the timeline in 2018.

CMS directed states to separate administrative activities from case management service activities in 2008: "States must identify the activities claimed as administration and compare the activities to the definition of case management services. If these activities are a case management service, then the service must be claimed as medical assistance. If the activities are for the proper and efficient administration of the State Plan, then reimbursement would be claimed as administration." - CMS-2237-IFC - 4/18/08".

NH complied with the above directive at the time it was issued. The practice of billing for administrative services under the medical service code for targeted case management (T2022, T2023, T2025) has NOT been identified as requiring correction in the current Conflict Free Case Management Corrective Action Plan.

The Corrective Action Plan and the associated activities the department is engaged in relative to mitigating conflict and setting up a direct bill process, has no bearing on the rate disparity discussion.

The department has brought the area agency status of "organized health care delivery system" into the rate study discussion. What may not be clear is - as such, the area agencies have separate and distinct duties, defined in statute, rule and by contract (references not provided by the department to date), for which the area agencies are paid an administrative fee (not provided to date). An administrative, fee paid for administrative duties, which are seperate and distinct from case management.

The "organized health care delivery system" status of the are agencies has NOTHING to do with the case management rate set for the case management services currently provided. Administrative duties are strictly barred from being included in case management service provision. Any adjustments needed for administrative duties under the plan of correction should be made to the administrative rate.

The rates set in each waiver for case management are for case management. There is nothing in the documents submitted by DHHS to this study committee suggesting otherwise.

The case management rates paid under T2022, T2023, T2025 are reimbursement for case management services, the rate should NOT include administrative activities and there is no evidence provided suggesting it does. Should this be incorrect it would raise fraudulent billing concerns and exposure for recoupment, which would need to be addressed forthwith.

The CFI Waiver case management is billed in 15 minute increments, 5 days per week. The statute and rules which define the CFI case management service, require the service to be provided monthly and as needed.

The CFI Waiver case management rate should be set as it is required to be provided by applicable regulations, MONTHLY. A monthly CFI Waiver case management rate will bring the services into compliance with federal coding requirements.

As discussed during the meeting on 12/18/2019, the CFI Waiver case management is available 7 days per week by the two of the enrolled providers present. This is evidenced by documented communication with department staff as needed on weekends to address client issues. To be clear, the CFI case management is BILLED 5 days per week and is available and often PROVIDED 7 days per week.

The DD, ABD and IHS Waiver case management is billed at a monthly rate. The statute and rules which define the service vary dependent on the specific waiver, require the case management services to be provided monthly, at most (ABD has a quarterly requirement). The CFI Waiver case management requirements are equal or greater.

The DHHS assertion that DD, ABD, and IHS Waiver case management is currently required in statute or rule to be provided 7 days per week is false. Furthermore, the statute and rule references the department provides for the 7 day per week requirement for DD, ABD and IHS can be found exactly or similarly in the references the department cites for authority for the provision of CFI waiver case management. DD, ABD, and IHS Waiver case management is not readily available 7 days per week to consumers, nor is currently consistently provided in that manner by all area agencies. The area agencies differ greatly. Some may have contracted service providers with on call staff, but this is NOT case management, these direct service providers are specifically excluded from providing case management service.

All case management should be available 7 days per to protect the health, welfare and safety of the beneficiaries.

The case management provided in NH's FOUR 1915 (c) waivers is very similar, if not identical.

On September 1, 2010 CMS issued a State Medicaid Directors Letter (SMD #: 10-017 ACA#: 7) in regard to the National Correct Coding Initiative (NCCI).

The CFI waiver case management rate should have been addressed at this time, it was ignored. Of note: the NH DHHS Department of Integrity and improvement regularly sends letters to clients stating they received case management 5 days per week for the identified review period. This causes confusion and agita. Informing recipients to ignore these important communications defies the purpose of sending the notices and it diminishes effectiveness of the integrity program.

The department was asked to provide a comparison of the regulatory authority governing the case management for **each** waiver:

- The department submitted the document titled "Case Management for the Bureau of Developmental Services - Laws and Rules" which combines the regulations for ABD, IHS and DD Waiver case management. Although some of the included regulations applied to only one waiver, the department made no differentiation as to which regulations applied to the individual services. 9 Pages of requirements for the ABD, DD, and IHS Waiver case management services.
- The department submitted the document titled "Case Management for the Bureau of Elderly and Adult Services - Laws and Rules" as the requirements for CFI Case Management. The document is incomplete, it does not contain the enabling statutes (RSA 151-E:1 and 151-E:17 or the licensure rule (He-P 819) requirement. 17 Pages of requirements without the enabling statute and a complete rule reference for the CFI case management service.

The correctness of the rate history document submitted by DHHS ("CM Rates for DLTSS CFI, DD, ABD & IHS Waivers 12-2-19 2") is in question. The ABD case management has been published at a higher than what is being reported in the department's submission for this study.

While the CFI Waiver case management rate has NOT been adequately addressed by any standard, the duties and responsibilities the agencies are required by rule to perform, have been added to every time the department opens an He-E 800 Rule.

The He-E 805 was added as a new rule in 2008 greatly expanding the scope of service provided. No consideration has been given to the cost of these mandates over the years, nor has the rate been adjusted for responsibilities added by the department or the legislature through statute or rule.

CMS directs states to factor the Bureau of Labor Statistics Wage Data when rate setting. The pay rate BLS reports as Median, \$65,320 could not be supported by the current CFI Rate, contrary to the rate paid in the ABD, DD and IHS which could support the rate.

This is based on the average caseload for all four waivers of 45 cases.

Bureau of Labor Statistics:

The May 2018 Occupational Employment Statistics data were released on March 29th, 2019.

<https://www.bls.gov/ooh/management/social-and-community-service-managers.htm>

Quick Facts: Social and Community Service Managers
2018 Median Pay
\$65,320 per year
\$31.41 per hour
Typical Entry-Level Education
Bachelor's degree
Work Experience in a Related Occupation
Less than 5 years

CMS directs states to factor the Bureau of Labor Statistics Consumer Price Index (CPI) Data when rate setting.

BLS CPI Inflation Calculator: <https://data.bls.gov/cgi-bin/cpicalc.pl?cost1=8.35&year1=200001&year2=201911>

CPI for the CFI CM Rate:

(Utilizing the data submitted by BEAS to this committee):

\$8.35 in 3/2004 has the same buying power as \$11.46 in 11/2019

CPI for the CFI CM Rate:

(Utilizing the rate experience):

\$8.35 in 1/2000 has the same buying power as \$12.72 in 11/2019

CMS directs states to factor the rates paid for similar services in neighboring states. (NH's rates for 1915 (c) waiver case management are lower than our neighboring states.)

Vermont Case Management Rates:

T1017 (15 Minute Unit) - \$24.09 - 36.00

T2022 (Monthly) - \$320.00

T2023 (Monthly) - \$400.00

Maine Case Management Rate:

T1017 (15 Minute Unit) - \$21.09

Massachusetts Case Management Rate:

ECOP Case Management, Per client per month - \$241.22*

Enhanced Community Options Program (ECOP) Direct Services. A program administered by ASAPs for frail elders who are clinically eligible for nursing facility services under MassHealth and who meet criteria set forth by EOEAE. ECOP provides a broad range of community services for these elders to remain in the community that includes services available under the Home Care Program.

*This is the Massachusetts Case Management Rate for the Elderly and Adult Waiver - Similar to NH's CFI Waiver. I was unable to locate the rate for other populations.

Senator Reagan asked me why the CFI case management had in essence been ignored. I did not have a good response at the time.

Having given this very interesting question much thought I reply - in addition to the obvious budgetary issue of the state of NH, the **CFI Waiver case management is an orphan.**

The CFI waiver has a rate setting methodology for *CFI Waiver services*, in the waiver. *CFI Waiver case management is NOT a CFI Waiver service*, the CFI case management is a state plan service. No methodology utilized for state plan services rate setting has been applied to the CFI case management rate. There is no clear designated responsibility for the CFI Waiver case management rate setting within the department, resulting in the disparity.

Please see a side by side comparison attached below. I do hope this adds some clarity to the rate disparity discussion. Please do not hesitate to contact me directly, should you have questions or require clarification.

I sincerely appreciate your consideration of the case management rate disparity and your efforts to resolve the inequities.

Thank you,
Carolyn A Virtue
Granite Case Management
Cell: (603) 848-7345

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NH 1915 (c) Waiver Comparisons

CFI Case Management DD Case Management ABD Case Management IHS Case Management Similarity/Difference

| HCBS Waiver Name | NH Choices for Independence (0060.R07.00) | 1915 (c) | NH Developmental Disabilities Waiver (0053.R06.00) a | NH BDS Acquired Brain Disorder Services (4177.R05.00) | NH In Home Supports for Children w/DD (0397.R03.00) | Similarity/Difference |
|--|---|--|---|---|---|--|
| HCBS Waiver Authority | 1915 (c) | 1915 (c) | 1915 (c) | 1915 (c) | 1915 (c) | IDENTICAL |
| HCPCS Code (Federally Required Medicaid Service Identifier Code) | T1016 | T1016 | T1016 | T1016 | T1016 | IDENTICAL |
| Face to Face Visit Requirement | Every 60 Days | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Not Specified | CFI CM Mandated 6 Face to Face visits per year. DD NO mandate for Face to Face Visit |
| Telephone Contact | Monthly and PRN | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Quarterly Contact (90 Days) Face to Face OR Telephone Contact | Not Specified | CFI telephone contact is greater. |
| NH Admin Rule References | He-E 801; He-E 805 | He-M 503 | He-M 517 | He-M 524 | | |
| He-P 819 Case Management License Required to deliver service. | Yes | NO | NO | NO | | |
| Populations served | Recipients in need of LTSS who are adults or frail elders - ALL diagnosis, including ABD and DD | Recipients in need of LTSS with Developmental Disabilities | Recipients in need of LTSS Acquired Brain Disorder (ABD) | Recipients in need of enhanced personal care, consultations, environmental and vehicle mods, family support/service coordination, respite care for individuals w/autism, ID, DD ages 0-21 | | CFI covers all adult populations, including those with ABD and DD. |
| Rate | \$8.86 per diem, 5 days per week | DHHS does NOT PUBLISH DD rates or provide them on request - 2014 Rate is reported here. \$267.35 per month | \$349 per month | DHHS does NOT PUBLISH DD rates or provide them on request. | | Disparity |
| Monthly Reimbursement | \$191.96 | \$257.35 | \$349.00 | Disparity | | Disparity |

Federal regulations require parity in reimbursement of identical services (\$1902(a)(30)(A) of the Social Security Act; 42 CFR 447.201-202)

The CFI CM rate disparity treats one group of Medicaid beneficiaries differently than another group which does not comply with federal law (42 CFR 435.923).

APPENDIX B

Agendas

**COMMITTEE TO STUDY THE DISPARITY IN REIMBURSEMENT
AMONG ORGANIZATIONS THAT PROVIDE CASE MANAGEMENT
UNDER SOCIAL SECURITY ACT SECTION 1915(c) WAIVER
PROGRAMS**

HB 4, Chapter 346:381, Laws of 2019

ORGANIZATIONAL MEETING

October 29, 2019

1:00 pm

SH 103

-
1. Welcome and Introduction of Committee Members
 2. Elect a Chairperson
 3. Overview of Committee Duties as Established in Legislation
 4. Identify Key Stakeholders to Testify at Future Meetings
 5. Set Future Meeting Dates
 6. Any Other Business That Needs to be Covered
 7. Adjournment

Report Due: February 15, 2020

**COMMITTEE TO STUDY THE DISPARITY IN REIMBURSEMENT
AMONG ORGANIZATIONS THAT PROVIDE CASE MANAGEMENT
UNDER SOCIAL SECURITY ACT SECTION 1915(c) WAIVER
PROGRAMS**

HB 4, Chapter 346:381, Laws of 2019

REGULAR MEETING

December 3, 2019

1:00 pm

SH 103

-
1. Call Meeting to Order
 2. Approval of Minutes of October 29, 2019 Meeting
 3. DHHS Presentation: Comparing 1915(c) References in Waiver, Statute, Rules and Comparing Rates
 4. Discussion of Requested Input from National Partner (Subsequent Meeting)
 5. Action Items
 6. Set Future Meeting Dates
 7. Any Other Business That Needs to be Covered
 8. Adjournment

Report Due: February 15, 2020

**COMMITTEE TO STUDY THE DISPARITY IN REIMBURSEMENT
AMONG ORGANIZATIONS THAT PROVIDE CASE MANAGEMENT
UNDER SOCIAL SECURITY ACT SECTION 1915(c) WAIVER
PROGRAMS**

HB 4, Chapter 346:381, Laws of 2019

REGULAR MEETING

December 18, 2019

10:00 am

SH 103

-
1. Call Meeting to Order
 2. Approval of Minutes of December 3, 2019 Meeting
 3. Conference Call: Robin Cooper, National Association of State Directors
of Developmental Disabilities Services
 4. Discussion
 5. Action Items
 6. Set Future Meeting Dates
 7. Any Other Business That Needs to be Covered
 8. Adjournment

Report Due: February 15, 2020

**COMMITTEE TO STUDY THE DISPARITY IN REIMBURSEMENT
AMONG ORGANIZATIONS THAT PROVIDE CASE MANAGEMENT
UNDER SOCIAL SECURITY ACT SECTION 1915(c) WAIVER
PROGRAMS**

HB 4, Chapter 346:381, Laws of 2019

REGULAR MEETING

January 13, 2020

1:00 p.m.

SH 103

-
1. Call Meeting to Order
 2. Approval of Minutes of December 3, 2019 Meeting
 3. Discussion
 4. Set Future Meeting Dates
 5. Adjournment

Report Due: February 15, 2020

**COMMITTEE TO STUDY THE DISPARITY IN REIMBURSEMENT
AMONG ORGANIZATIONS THAT PROVIDE CASE MANAGEMENT
UNDER SOCIAL SECURITY ACT SECTION 1915(c) WAIVER
PROGRAMS**

HB 4, Chapter 346:381, Laws of 2019

REGULAR MEETING

January 27, 2020

1:00 p.m.

SH 103

-
1. Call Meeting to Order
 2. Approval of Minutes of January 13, 2020 Meeting
 3. Discussion/Vote on Final Report
 4. Adjournment

Report Due: February 15, 2020

APPENDIX C

Meeting Minutes

Committee to Study the Disparity in Reimbursement Among Organizations that Provide Case Management Under Social Security Act Section 1915 (c) Waiver Programs”

Committee to Study the Disparity in Reimbursement Among Organizations that Provide Case Management Under Social Security Act Section 1915 (c) Waiver Programs”

Meeting Tuesday, Oct 29, 2019 1PM Room 103 State House

Attending: Sen Rosenwald, Rep Hennessey and Rep Rogers
Not Attending: Sen Reagan

Called to order by Sen Rosenwald at 1PM

- Introductions
- Election of Chair: Motion by Rep Rogers, Seconded by Rep Hennessey for Sen Rosenwald to serve as Chairman. Unanimously approved. Sen Rosenwald nominated Rep Rogers for Clerk, unanimously approved.

Sen Rosenwald stated that this study committee was brought forward by Sen Guida late in the budget process at the request of Ms Virtue asking him why some organizations that do same programs as others are not reimbursed in the same manner as others - looked at this simply as a money issue not policy but simply as a money bill and the task is the disparity in reimbursement for the same work and why that would be and what we could do about that. The Committee is to look at CFI, DD and the acquired brain programs, three is a quorum so we can take action today and the report deadline is February 15, 2020.

A homework assignment is to look at DHHS for the next meeting in December and would like to discuss who to hear from at future meeting besides the DHHS-think the independent case managers, the case managers, the area agencies, NH Heathy families (represented in the audience) , clients possibly, and other suggestions.

Sen. Rosenwald passed out an outline out of what we could ask DHHS to help the Committee with on the report - Titled "DHHS to Report"

Committee to Study the Disparity in Reimbursement Among Organizations that Provide Case Management Under Social Security Act Section 1915 (c) Waiver Programs"

Carolyn Virtue from Granite Case mgt - "T1016" is HC is a HC kick code the T is primarily for Medicaid billing so it is HCPCS that is the set of codes that medicaid comes to

Sen Rosenwald - there is a limit in the number of days that can be billed - any limits the amount would be helpful

Deb Sheetz (DHHS)-in preparation we have already built a spreadsheet and we are in alignment with this there is one thing I would like to suggest the area agency system it also asked us to look at services and not have to go thru the bill and we are looking at the process what the roll of case mgt is and what the roll of case mgt is what we have done is what is called the area agency delivery system rate it may make sense to have technical assistance from our national organization because it could impact how we look at comparators

Rosenwald - who

National - NASDI I can ask them to join us by telephone and they can walk thru and answer questions

Rosenwald - lets pin that and decide at our next meeting

Virtue - if the DHHS position is some service other than case mgt has been being billed historically by waiver you might want to look at what your financial exposure might be from CMS if that code was billed for more than that service if there was admin services were billed differently that would need to be returned

Rosenwald - our charge is not to look backward but forward our hope is to not look down that rabbit hole because that is not our charge our focus is case mgt payments

Deb Sheetz (DHHS)-that is an opportunity to explain a little better more we want to have case mgt explain regardless of what waiver and our work with CMS brings us towards that goal

Committee to Study the Disparity in Reimbursement Among Organizations that Provide Case Management Under Social Security Act Section 1915 (c) Waiver Programs”

Rosenwald - as long as we stay focused on case mgt.

Deb Sheetz) — there is a difference in how delivery is structured there is an assumption that area agencies is structured for CMI waiver there is no organized system where it designates within DD and does take into account the rates

Rosenwald - even thou some aa has providers on staff and some don't

Rosenwald's - so that might be something to consider but isn't that a conflict

Deb Sheetz (DHHS)-that is a correction mgt. plan

Rosenwald - it would be more like an independent mgt. system and only reimbursed only for the case mgt.

Deb Sheetz (DHHS)-they can provide case mgt and may not provide both to the individual CMS recognized that and approved a law that said AA may not provide both the of the individual

Rosenwald - so but when someone becomes eligible for one of these waiver programs the CSI waiver the DHHS says call one of these agencies call them are the Area Agencies included in that list

Deb Sheetz (DHHS)-under the CSI - we have 7 independent agencies the individual can choose area agencies were the designated but CMS are requiring an individual are not required to go to Area Agencies Starting August 2021

Rosenwald-we should put that discussion with the technical support not next meeting but the one after that

Deb Sheetz DHHS - I can forward a link to the correct conflict of interest link (see Below)

Committee to Study the Disparity in Reimbursement Among Organizations that Provide Case Management Under Social Security Act Section 1915 (c) Waiver Programs”

Per the “Committee to Study the Disparity in Reimbursement Among Organizations that Provide Case Management Under Social Security Act Section 1915 (c) Waiver Programs” request, please find the link to the Department of Health and Human Service’s web site page specific to the Corrective Action Plan (CAP) for Conflict of Interest (COI) relative to three of the state’s 1915 (c) Home and Community Based Services (HCBS) Waivers through the Center for Medicare and Medicaid (CMS). The three 1915 (c) waivers under this CAP are: Developmental Disability, Acquired Brain Disorder, and Children’s In-Home Services.

<https://www.dhhs.nh.gov/dcbcs/bds/coi-cap.htm>Links to the CMS approved New Hampshire CAP Template and CAP Work Plan are as follows:

<https://www.dhhs.nh.gov/dcbcs/bds/documents/nhcaptemplate.pdf>

<https://www.dhhs.nh.gov/dcbcs/bds/documents/nhcaptimeline.pdf>

Rosenwald - next meeting Dec 3 at 1pm in SH Room 103

Meeting was Adjourned at 1:27pm

Committee to study Reimbursement among Organizations that Provide
Case Management Under Social Security Act Section 1915(C) Waiver
Programs (HB 4, Chapter 346:381, Laws of 2019)

Tuesday, December 3, 2019 1PM,
State House Room 103

Members Present: Chairman Sen Cindy Rosenwald, Rep Erin Hennessey,
Rep Katherine Rogers

Members Absent : Sen John Reagan

1. Chairman Rosenwald Called the meeting to order at 1:05PM and
announced no quorum was present so we will not take up previous minutes
but Rep Hennessey arrived at 1:06pm setting up a quorum

2. Approval of minutes of October 29, 2019 meeting - motion by Rep
Rogers, Seconded by Rep Hennessey

3. DHHS Presentation: Comparing 1915 (C) References in Waiver, Statute,
Rules and Comparing Rates by Sandy Hunt Bureau Chief at
Developmental Services & Wendy Altman Bureau Chief Elderly and Adult
Services

Written Materials Handed out:

1915 waivers

Method we are able to support in communities as option to
institutional Services

Developmental disabilities

Acquired brain disorder

Children with developmental disabilities all three managed by
Developmental disabilities Bureau

Choices for independence waiver for elderly and with disabilities
Managed by BDAS

Committee to study Reimbursement among Organizations that Provide Case Management Under Social Security Act Section 1915(C) Waiver Programs (HB 4, Chapter 346:381, Laws of 2019)

Tuesday, December 3, 2019 1PM,
State House Room 103

Question at hand is around case Management rates within the division there are a number of case Management codes we developed a number of spread sheets

Case Management by waivers - Jen Doig Manager of the Division - walked the committee thru spreadsheet on waiver

Started with CYI waiver with procedure code and what it stands for what the unit is paid for by unit or by month, identify which waiver Bucketed by - currently for asked Management \$8 a day for case Management is \$45 a day, normally for CFI 5 days a week normally not on call for weekends, in rules section and in state plan (two word docs in packet with waiver rules and language) HE- E-805.04.

Lines 9 & 10 - targeted case mgt. and family support Coord part of BDS people that are not on the waiver but medicaid eligible before they become waiver eligible the dollars come out of the budget ABD and MCAID - \$257.35 per month - CFI is \$8.86 per unit but with DD those are done on the month basis

Sen Rosenwald - so you can get services on the weekend but not if you are old

Sen Rosenwald - how did we get to a limit of 5 days per week

DHHS - these two systems arrived independently over time by the way that they were built the area Agency system is referred to as an organized health care delivery system and designated by the state as a safety net and available 365 days a year

The CFI is not an organized health care delivery system it is a health care Management system resulting in a good level of care but creates a conflict of interest we are trying to unpack what needs to be done by a area agency

Committee to study Reimbursement among Organizations that Provide Case Management Under Social Security Act Section 1915(C) Waiver Programs (HB 4, Chapter 346:381, Laws of 2019)

Tuesday, December 3, 2019 1PM,
State House Room 103

outside of case Management it is complicated because they are a safety net.

Sen Rosenwald - but on the CFI waiver they are entitled as a nursing home but they are not and it saves us but there are weekends

DHHS - I would suggest they are getting services 7 days of a week because OIT depends on their individual plans - responses of call received on Sunday's and Saturday shall be responded to within 48 hours these individuals are being cared for but their case managers are not on call

Melissa Nemeth - Atty Div of Long term support services Attorney
Second sheet is the history of the rates from 7/6 at \$8.35 eleven years later up to \$8.86 not at \$8.8 that is very completing in terms of the rate structure

Rep Hennessey - which organization wanted to look at the disparity of these rates

Sen Rosenwald - the case managers

Rep Hennessey - do they want to do it 24/7 and get paid

Sen Rosenwald - I think they want to get paid better they said to us we are doing the same work and getting paid differently

DHHS - they are doing very similar work but if you look at the model of the area agency work that is case mgt. plus the role of the delivery system. We need to take a look at that

Sen Rosenwald - you are going to have to look at how you pay the area agencies for case mgt and get that approved by CFI

Committee to study Reimbursement among Organizations that Provide Case Management Under Social Security Act Section 1915(C) Waiver Programs (HB 4, Chapter 346:381, Laws of 2019)

Tuesday, December 3, 2019 1PM,
State House Room 103

DHHS - we have been separating out the roles and responsibilities with the area agencies and we hope to better align the case management moving forward and case mgt. would be better allocated

Sen Rosenwald - why wouldn't you just pay case mgt. the same rate

DHHS - that might be where we wind up but it took 30 years to get where we are to today so we want to do this very carefully we need to work with the system to define what is case mgt. moving forward and what is the role of the designated area agency

Rep Hennessey - when you unpack it and come up with a new case mgt. number if is potential that number goes below the \$8.86

DHHS - we are not sure where is end up we may find there are things that are not captured in CFI and we may end up modifying case mgt. and look at the compensation relative to that.

Sen Rosenwald - so people on the waiver have a choice of case mgt. so does the DHHS say you are free to go here but they don't have the same services

DHHS - if you are on the waivers you go to the area agency's up to now the majority house the area agency under the corrective action plan people will have a choice so we are in the process of piloting this now

Sen Rosenwald - why wouldn't you automatically say these groups are doing the same work and get paid the same

DHHS - we need to go thru the process

Sen Rosenwald - What do you not get if you are case meet vs health care delivery system

DHHS - recovery cost for magi ingot transfers

Committee to study Reimbursement among Organizations that Provide Case Management Under Social Security Act Section 1915(C) Waiver Programs (HB 4, Chapter 346:381, Laws of 2019)

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Waitlist mgt.
Benefit mgt.
Monitoring utilization
Budget tracking
Quality
NCI quality data
Recover cost billing - clinical services
Actual day to day interaction as a client
Very similar from consumer perspective

Sen Rosenwald - some administrative overhead to the rate with area agency

Rep Hennessey - you mention quality do the nurses have quality audit they have to keep figures on

DHHS - we designate area agency and part of what we look at - people are not missing a lot but the systems are build differently they were designated by the state do do certain functions so the state is doing eligibility and intake and are designated by the state to do those functions and the questions is who would do those functions and we go thru designations each five years to see who does this we tell the Federal govt. that everyone will have a service agreement each year so we report to CMS and the area agencies do a lot of work for the state to report to CMS we wanted the families to do a lot of the work locally thru the CFIs have service link.

Sen Rosenwald - so the area agencies do all of the eligibility determination

DHHS - in conjunction we do the final approval but the area agencies do the intake and the agreements at which point a service agreement will be generated the Medicaid part of it goes thru the DHHS it is the waiver that is different

Committee to study Reimbursement among Organizations that Provide Case Management Under Social Security Act Section 1915(C) Waiver Programs (HB 4, Chapter 346:381, Laws of 2019)

Tuesday, December 3, 2019 1PM,
State House Room 103

Rep Hennessey - the DD client rate is what

DHHS - it is an negotiated rate

DHHS - CMS wants a single case mgt. rate for all waivers we need to go thru that I would hope there is some level of similarity - I think we are going to get there working with the case managers and hopefully it is the same rate among the waivers.

Sen Rosenwald - DD clients will be able to choose to stay with area agencies 7 days a week or case Mgr 5 days a week

DHHS - will be required to be 7 days a week under negotiated rate

DHHS - these negotiated rates are done in good faith and not taking rate unless they are comfortable with the rate

Heidi Kroll - life coping group - JeB there is an organized system btw all the eligibility has come thru the level of care of nursing home level from there the client assigned to case mgt. agency and find the providers and amend the care plan oversight they the state and BDAS and annual reviews and also the program integrity also involved in any claims and questions of billing while we don't have an area agency system we do have local district office and service alliance thru-out the state there was also no mention of in

terms of the all of those functions the area agencies receive a general management fee is a lot of compensation they receive a percentage of everyone's budget we do not have that in CFI general mgt. fee has been part of our discussion and that part however is still being discussed and that wasn't mentioned and that is a very important part of how the area agencies are compensated. The growth in the budget there is only so much money but the growth has been 102% increase from 2009 to 2012 by comparison the CFI budget was relatively flat in the same time period 32% increase we are the second oldest state in the US why this disparity in the budget if the discussion is there is only so much money with all of that

Committee to study Reimbursement among Organizations that Provide Case Management Under Social Security Act Section 1915(C) Waiver Programs (HB 4, Chapter 346:381, Laws of 2019)

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increase they are going to get an increase there is another mechanism in the Area Agencies to provide increase to Area Agencies that we do not have at CFI.

Sen Rosenwald - how much is this mgt. fee in the aggregate?

DHHS - keep in mind area agencies I think the GM would be about 3% the area agencies also have the option to subcontract with other agencies that could be 9% that totals 12% on average the area agencies gets 3% the vendor gets 9% then it is determined what the person will need. Case mgt. is one service. I think the purpose is disparity among case mgt. rates that is one service available thru each waiver within will include one line item for case mgt. It has been a real challenge to ask area agencies to say how much it costs to provide case mgt. keep in mind case mgt. is a line item of that budget nothing is keeping independent case mgt. agencies from providing those other services there is a lot of other functions

Sen Rosenwald - that is our focus - but the analogy is a gender pay gap.

DHHS - it depends on what those functions are but the independent case Managers are not a Health care Management system

Sen Rosenwald - shouldn't we be able to agree the same work gets paid the same amount - but the Dept doesn't seem to want to commit to that

DHHS - but what we are doing is going thru the process to determine that the work is the same - there is a bucket of money and everyone is trying to determine what is the work and is it the same and some independent CSI Managers are saying they can't stand up 7 days a week

Sen Rosenwald - if it mattered to have 7 day a week you would have to pay them to do so

Committee to study Reimbursement among Organizations that Provide Case Management Under Social Security Act Section 1915(C) Waiver Programs (HB 4, Chapter 346:381, Laws of 2019)

Tuesday, December 3, 2019 1PM,
State House Room 103

4. Discussion of Requested Input from National Partner (subsequent Meeting)
NASDDS.

5. Action Items

6. Set Future Meeting Dates

Tues, Dec 17 at 10 or Wed, Dec 18 at 10 depending on when phone call with national partner can be arraigned .

7. Any Other Business That Needs to be Covered

NZI Obinelo - VP Individual and Family Services at Gateway in Nashua - differences btw CFI vs Area agency when you are looking at differences when that client or guardian is in need of Sunday night because of residential placement or need in court the area agency is on at that moment they can't sit for 48 hours and things are built into the infrastructure they are able to provide at that moment because the area

agency is on for the needs of that individual we have a number of people that are dally diagnosed and area agencies are trying to provide training from their staff to deal with this. There is a difference between what is needed by CFI support and what case managers are able to provide for their clients and what they are dealing with there is only certain parts of what they are needing there is not those funds the same way as thru the area agency it is important to make the distinction between what case mgt. is able to offer and even the eligibility is different as you are looking at that is offered thru the waivers there is different kind of case Management in each.

8. Adjournment

Committee to study Reimbursement among Organizations that Provide
Case Management Under Social Security Act Section 1915(C) Waiver
Programs (HB 4, Chapter 346:381, Laws of 2019)

Tuesday, December 3, 2019 1PM,
State House Room 103

Report Due; February 15, 2020

Committee to Study the Disparity in Reimbursement among Organizations that provide case Management under social security act section 1915(C) Waiver Programs

HB 4 Chapter 346:381, Laws of 2019

REGULAR MEETING

December 18, 2019

10AM

SH 103

Members Present: Sen Rosenwald, Sen Reagan, Rep Hennessey, Rep Rogers

1. Call Meeting to Order by Sen Rosenwald at 10AM
2. Approval of Minutes of December 3, 2019 meeting
Correct Page 4 bottom sentence should read "recovery cost for managing transfers"
Motion by Rep Hennessey, seconded by Rep Rogers, to adopt as corrected., passed without dissent
3. Conference Call: Robin Cooper, National Association of State Directors of Developmental Disabilities of State Directors of Developmental Disabilities Services

Response to some questions posed: Is there a federal Reg for case mgt. for home and community based services - yes

Three streams of fed medicaid money and various citations they indicate
They are similar, flexible and wide range anything directly for the person can work with non Medicaid entities and receive money and there is flexibility in home and community based states have the authority to modify the definition and seek approval, targeted case mgt. 42-CFR- 440-169 targeted case mgt. regulations - CMS tends to follow the targeted when they look at home based regulations

Rosenwald - do states define both of these

Cooper - yes they do with both they're are things you can not do all Medicaid regs have overarching set of rules administrative case mgt. is a different beast 42CFR433.15-c7.

Targeted and home base are direct to the individual

Administrative is a whole different set of rules and processes - you can only claim time spent on delivering case mgt. to an eligible individual and only in relation to case services for example.

There are pluses and minuses in all these streams

Rosenwald - when states define both home and community and targeted case mgt. are the states definitions all over the map or do most have the same definition

Cooper - they have comparable or similar definition across states -there is a whole wheelhouse that tend to be case mgt. When case mgt. is contracted there is some services that are held back by the state generally.

Rosenwald - NH's definition is not the same as is the DD definition is NH an outlier

Cooper - no not at all. There may be a range of services that are similar but there may be some that are similar but you might want to have some that are distinctive to the population they share a core section. Some states may require they are 24/7 for certain populations and not for others. There is a lot of ability to craft the definition for the population you are serving.

Cooper- I was asked what is the best practices scope of services for home and community based services - there is some debate about the scope - one is the individual to access high services given your needs but another part sphere on behalf of the system to provide information on how things are functioning and carry out some of the regulations and responsibilities of the state - I.e. People remain eligibility four Medicaid that is a system requirement - so there is the two spheres - keep the lights on - people are receiving the Services and the quality - oriented towards the system on behalf of the person and the other is directly for the person. There is no one right answer it depends on your system structure which dictates the scope of your responsibilities.

Rosenwald - some of this is not defined as case mgt.

Cooper - some would be the responsibility of area agency

Rosenwald - in states with that set up is there a separate negotiated fee

Cooper - a cost allocated administrative fee - what are they doing on behalf of Medicaid recipients - the Area Agency have the responsibilities to meet the Medicaid recipients spending on the program and a process called a cost allocation plan and a time study down on a quarterly basis tied to the proper and efficiency deliver of the Medicaid process . There are sometime a transaction fee paid. If you want to maximize the use of that federal funds there are a number of pathways to use.

Rep Hennessey - are there things we are not doing in NH to maximize our federal funds -

Cooper - some of the ways you do things have to change not that try couldn't do them they just have to change you had a good idea here no harm no foul were appropriately looking to garnered funds the issue is what pathway what process

Rosenwald - are we maximizing our funds on targeted

Cooper - the targeted case mgt. is broader that the administrative option I encourage the targeted it is broader the scope of what you can claim is less under administrative they all need to be Medicaid only -you are doing the right thing now

Rosenwald - the reason we are here is that organizations inside and outside of DD system are doing same work but being reimbursed differently

Cooper - the rates can be different but need to story why - geographic and scope of responsibilities or qualifications can be addressed you have to account for the difference but the rates - you must be able to say why you can't say the rates were negotiated at that rate

Deb Sheets - one of the things that came up was why a CFI Mgr would be paid differently than a CFI with an agency like a daily rate of 8.86 vs an area agency a monthly rate at 200+ when the perception was they are all in the community and need the support we talked about the two systems are very different and the CFI was based on DHHS keeping some authority what concerning with corrective action plan was case mgt rates look similar I think it might be helpful if you put corrective action plan would be closer for person receiving corrective action plan - could you give some framework around that - what other states have done

Cooper - can have different cases and intensity of support needs - if pop serving is more complex - do understand why if system must be available on 24/7 basis

Rosenwald - except they are that is problem

Cooper - if they are that is a problem sometimes it is interesting when you look at yearly cost is one significantly lower than the other sometimes the per diem is set so would be the same

Rosenwald - we looked at that and took the daily rate at 25 days they were limited to 192.71 so it is pretty significantly different I =f someone in long term care they call their case mgr but they are not compensated

Deb Sheets - I want to stand up for all our case mgr do and it varies for provider to provider some will work on a weekend and many do act as a safety net but there are some that because of how structured the Dept has to pick up the slack

Carolyn Virtue - the DHHS certainly are now going to acknowledge we are available on the weekends that we have spoken to them the two providers in the CFI vouchers answer their phones 24/7 we address the needs but what I will say is the remaining providers are DD agencies

Deb Sheets - the current rules put it at 5 days a week

Virtue - the responsibilities of the CFI case mgt. up to 62 pages and the Area Agencies are 9 pages what we are talking about here are the justifications and responsibilities far exceed what the DHHS provided you combined. I have mastered required provided we are payed less with equally prepared staff there is a rate disparity here and CMS does not allow this

Rosenwald administrative reimbursement is that the 3% that goes to the area agency

Sheets - if I could back into what Carolyn said I am really am terribly uncomfortably comparing systems when they were built differently there is 11 pages of rules and 60 pages of rules

Rosenwald - it seems to me what we are talking about here is the person centered part of case Management - it should look the same and should be reimbursed the same - the part that client sees to me it should look the same to them

- the structure matters - if you can show the rings driving the cost are the same that's ok - it's a little bit two kinds of apples

Cooper - as long as the scope of responsibilities look the same

Cary Firmer - Granite State Case Management - working off a 1988 rate with a 5% rate increase that had been cut so not working on a sustainable model - how rate structures have been increasing in other areas or states

Cooper - the rates anywhere do not truly equal costs = many states are doing a rate-refresh on their rates - CMS is asking how the rates have been developed

Rosenwald - so its responsibilities, scope and qualifications
If someone who is in either system they have a choice to where to get there case mgt. but if picking in the home and com based cared system they are not getting paid for 7 days a week

Cooper - It's looking at the cost centers and what it takes to deliver these services

Sheets - this plays into the corrective action plan in the future state we will have a rate

Rosenwald - but if under the CFI and

Wendy - changes under the corrective action plan if someone eligible and getting services under CFI waiver they can't ask anyone but but a CFI case waiver to provide case mgt.

Gateways, Community Partners, and Community Crossroads doing it now and 2 are in recess to become a CFI pathway as well and any that are not Area Agencies could enroll in the future under the corrective action plan for the three DD waivers. They can do that today if they have a contract to do so.

Reagan - why would they do that for 40% less money

Sheets - Some are doing so after a contract is negotiated in the future there will be a uniform contract price that is where our corrective action plan will take us

Rosenwald - I am happy to hear you say that because previously. You have said you hoped it would look similar.

Sheets - we are still determining what goes into the role and scope for the waiver for those case mgt there could be a difference in scope. It takes time to do this so you do not destabilize you system that is why I don't want to say that yet.

Cooper - Most common use of service is 15 minutes a month - or monthly is most common and then you have a fixed fee contract for managed care for example Most states do have a 24/7 covered or a emergency call in number some states have a regional office but I am used to seeing at least in DD at 24/7 availability

Sheets - I appreciate this dialogue because if you are on waver with agency this is available but if not in many case it is the home care worker or you end up in the ER or you end up in a nursing facility earlier or in many case the DDHHS picks this up I want to raise up the work the case mgt work the agencies do

Reagan - are your contracts uniform

Sheets. Our area agency contract - are and stipulate 24/7 our CFI are not and not always have 24/7 and I would yield to Carolyn

Rosenwald - and there is a cap correct

Carolyn - they are set up for 5 days and 15 minutes unites but the understanding is when you have the client however in 2008 CMS came out and said you cannot bill like this any longer and we should have been switched to a monthly rate and it has her been addressed

Sheets - I would like to give Robin an opportunity to comment

Cooper - That got reminded a lot of it billing 145 minutes seems rude to me because case mgt. is running all the time so to me it makes sense to have a payment to keep the lights on all the time but you earn it weather you make one or two contact with the individual you might have a week you spend 25 hour with that person monthly makes a lot of sense

Rosenwald - and that seems to be the direction we are going in

Cooper - HIPPA came in and everything got mushed in it all got sorted out and said that was not health related etc.

Sheets. This is something we are examine again it raised questions we are in the process of doing this no we als need to look at the Financial Side of thing as well

Rosenwald - that increase to the Area Agencies the 3% baked in is larger and the independent do not get the budget increase in value as well

Jeb Curelop - Life Coping Independent Agency Services - We provide for DD client when we are a client is different depending on the area agencies we are dealing with we are looking for basic equity out=r one issue is being discussed is what the area agency gets from each individual budget they have a general Management fee between 3-12% which have increased in last year's it is another mechanism for increasing to area agencies - there needs to be a distinction about that - if up until now area agencies have been charging a general Management fee and in addition they are taking a part of the pan agent fee how is that going to be reconciled

Rosenwald - a little beyond the scope

Cooper - this is a methodology to see these fees are proper and underwood there are some issues and I know that is part of the corrective action plan as well

4. Discussion

Sheets - part of this work is helping us to discover things we end to improve on the CFI waiver as we move forward including the safety net and the discrepancies in the 2008 guidance I want to make sure there is an understanding there is a while there that the case mgr are picking up

Carolyn - the course action applies only to the BDAS waiver I would be very concern that the CFI piece would not get adequate air time additionally we had an expert but her expertise is in not in the CFI waiver which is why this study was formed I would just say we need to look at the CFI waiver as well

Rosenwald - our charge is not to set rotates but to look at the same work not different work
So what is the DHHS timing

Sheets - August of 2021 has to be in place I had sent you a link of the full timeline for DD it has recently been updated I would like to indicate whenever you go thru a corrective plan with CMS we are responsible for home and community base actions and it does call attention to CFI

Rosenwald our report is due Feb 15 so what is DHHS timeline in relation

Sheet - we are aiming for second or third week of January for DD system that is what we are putting out for the area agencies and aRobin's area agencies is not just DD - it is January unless we see any slips

5. Action Items

6. Set Future Meeting Dates - Next meeting at Monday, January 13, 2020 at 1PM, SH Room 103

7. Any other Business That Needs to be Covered

8. Adjournment Sen Rosenwald closed the meeting at 11:33AM

Comm to study the disparity in reimbursement among org that provide case mgt under social security act section 1915 (c) waiver programs

Monday Jan 13, 2020. 1PM

Members present, Sen Cindy Rosenwald, Sen Jon Reagan, Rep Katherine

Members Absent: Rep Erin Hennessey

Sen Rosenwald called the meeting to order at 1pm

Approval of Dec 18, 1919 meeting motion by Sen Reagan, seconded by Rep Rogers approved unanimously

Sen Rosenwald called on Deb to respond to three questions that were teed - up to the DHHS

1. Is there a fed regulation which re: rate parity for life services in the waiver and state plan with similar responsibilities as evidenced by the DHHS document submission

A - there is no specific regulation but there is some guidance that they might be paid similarly within a specific waiver within a suicided rate range and we were provided with rate methodologies which will be provided to the committee

But no specific regulation only guidance - a plethora of guidance

2.is there a fed Reg which requires states to treat different groups of beneficiaries equally

No not under the waivers all are tailored to the target population served

For state plans services all based on medical necessity your recent of services will be based on your need for state plan services a few state plan services are also based on medical necessity and meeting the target group eligibility for the services'

3. If one single case management rate for providers of duties is defined similarity or greater than state statue or rules is drastically different than all others the waivers and the state plan does a disparity exist if so does a disparity exist?

If the state can account for a difference than it is acceptable CMS has approved the state's current rates

Discussion of findings - Sen Rosenwald stated she wanted to talk about what we had learned and what might be in their presentation

Sen Rosenwald said she had been struck by the fact there is a difference in the difference in compensation btw area agencies and independent case managers - I think we have to keep our focus on what we are authorized to look at - thinking about case mgt. on the 4 waivers there seems to be still an inconsistency in the definition of what is actually case mgt. at the same time

DHHS has said you need to have conflict free case mgt. by August of 2021 they are working with the stake holders to define case mgt. which is not the same as all the other administrative fees as all the others. I think I heard that case mgt. will have one definition and will have one payment - am I quoting you correctly

Deb - correct - if the services they are coordinating are they different and equitable I think we can get there

Rosenwald - because the people on the different waivers can get case mgt. from 4 systems it seems like the scope and Systeem would have to be the same to be fair s- someone that picked from one system wouldn't be different than someone who stayed within the system /

Deb - this gets down to what are the qualifications for a DD waiver and a CFI waiver - If we determine if you get case mgt. 24/7 you should get compensated for that.

Rosenwald - how can you justify having different qualifications for people who can qualify for Different systems

Deb - some might be considered more medically complex -

Reagan - State of Maine every different service is at the same rate

Deb - because they have defined the same we are trying to get case mgt. defined the same across all four different waivers

Discussion of rate setting ensued among committee and DHHS

Carolyn Virtue = there is no licensure for individuals in NH there is facility licensure under 151 and only the CFI Mgr are required to hold so they have higher requirements that DD it seems that Area agencies are saying they have higher qualified staff that independent which is not true any licensed social worker working as a case mgr would seem outside the scope of their practice this whole study of DHHS to be based on the premise that the area agencies are better and do more but if you look at the documents submitted by the DHHS that is not true another key point is case mgt. is billed to the state plan so it is a state plan Service so the language of like plans to like providers does apply to CFI so if the DHHS position is so convoluted that is doesn't end apply then let's reapply and take it out of the plain of correction and make the plan comparable to other state services

Jeb - the licensure of the social workers in NH is only for clinical but not for social workers like in Massachusetts we do for nurses we have many who work for us we have many with masters in social work I have noticed that many area agencies do not I have noticed the I depended have more higher level of training than area Agencies -

Cary form Granite Case mgt. - we are over complicating this come back to same work for same pay there are already portions under the last budget resolution I though we were here to get CFI rate to equitable position so to suggest to get everything to the same port and redefine is getting us of the mark - if you do that the delivery network is already challenged now

Rosenwald - our charge is about disparity in rates - I don't think we are only lookin at that one one

Alex - don't think anyone at area agencies that do not have at least a BA

Rosenwald - I would hope DHHS would have a recommendation before we did but they won't we know they have to have it implemented at the next budget but the DHHS is going to start working in the next few months on the next budget - you have to know what you are doing by the first of March so the timing is correct but I think there are possibly two divergent paths - one rate across all four waivers or a case mgt description for each waiver and the same for who is delivering it and that is probably where you are but I am not hearing a commitment to that and one rate

Deb - I can commit to that

Reagan - I can't make sense of that how does that make sense of the level of service

Rosenwald - if we Recommendation was that DHHS define case mgt for the waivers and the person got the same reimbursement regardless from where that case mgt came from does that seem fair?

Are report is not due until Feb 15 I think we should have a meeting two weeks from today that will include minutes, agenda and all correspondence, etc with basically a recommendation that similar experience work will be paid the same and that is the expectation. We could meet on the 27 and either make changes or improve the report and if the DHHS is not back in March then you will be looking at legislation.

Set future meeting dates - Jan 27 at 1pm

Sen Rosenwald adjourned the meeting at 1:54pm

Committee to Study the Disparity in Reimbursement among Organizations that provide case Management under Social Security Act Section 1915(C) Waiver Programs

January 27, 2020

Members Present: Rosenwald, Reagan, Rogers

Members Absent: Hennessey

1. Meeting Called to Order by Sen Rosenwald at 1PM

2. Approval of Minutes of January 13, 2020 Meeting:
Motion by Sen Reagan, second by Rogers , approved unanimously

3. Discussion/ Vote on Final Report
Final report drafted by Sen Rosenwald with tables attached as provided by Alex Koutroubas - from Community Supported Networks INC .

(Report will be attached to minutes)

Rosenwald thanked all involved and stated she learned a lot and said that the resolution has to be in time for the next budget and we will expect the DHHS to keep us informed as to the problem in this area

Reagan agreed to the sentiments

Rogers asked also to keep members informed as to the progress of the situation and its resolution.

Rosenwald said will be looking at the old BES Audit and will be meeting on that

Reagan motion to adopt, Rogers second, report unanimously adopted.

4. Adjournment
Chairman Rosenwald Adjourned the committee at 1:04PM

5. Report Due: February 15, 2020

APPENDIX D

Additional Documentation

Practices by Region for after-hours and/or weekend services for Case Management

Region 1:

- Families and contracted home provides are given the emergency phone numbers of service coordinators and housing coordinators for 24/7 access.
- Mental Health emergency services system has access to electronic medical records 24/7, should a MH emergency arise with a client receiving developmental services.
- We are now looking to start offering the option of forwarding our developmental services office calls that come in after hours to the answering service that we already use for MH in addition to our current practice. This would be an enhancement.

Region 2: (sent on-call procedure document)

- The on-call Family Service Coordinator will work in conjunction with other PathWays employees and community resources to provide support.
- Family Services office hours are 8:00am to 5:00pm, Monday through Friday. An on-call system is in place to receive emergency calls 24 hours a day, seven days a week.
- The auto attendant system for all main office phones includes instructions to direct any emergency call to the pager system for after hours.
- The on-call Family Service Coordinator attends the pager and cell phone when the office is closed.
- The on-call Family Service Coordinator will respond to emergency situations appropriately and will document each call and intervention in the on-call log. The on-call Family Services Coordinator will return a page within 15 minutes and will respond in person, when necessary, within 1 hour.
- Family Services Coordination maintains a rotating weekly on-call schedule. The schedule will include the name and dates of the on-call person, his/her home phone number, and the service coordination pager number. The schedule is distributed to agency employees as well as appropriate representatives of any provider agencies.

Region 3: (sent on-call procedure document)

- If the situation occurs after hours, the individual/family/provider/agency staff/other will initiate the On-Call response by calling the Main Office Telephone Number:
 - The Answering Service will obtain necessary information including the person's name and contact information, a brief outline of the emergency, and determination of what the living situation is.
- The Answering Service calls the Resource Coordinator (RC) On-Call Telephone Number. If no response, a message is left for the RC with a repeat call in 15 minutes. If no response after 15 minutes, the Answering Service will contact the Director of Resource Coordination. If no response, a message is left with a repeat call in 15 minutes. If no response, the Answering Service will proceed by following the Agency's Telephone List.
- When the RC On-Call receives a message and speaks to the Answering Service, the person receiving the call is to assess the situation and assist in the following manner (if applicable):
 - Insure proper authorities have been notified, insure safety of others, insure that the individual's rights have not been violated, identify available resources, give direction as to follow-up and other assistance as needed

- Immediately notify the Director of Resource Coordination if the situation involves the health or safety of the individual, police involvement or if action is required by the RC On-Call or the individual's RC. If the situation is resolved (and does not involve an above situation), email a brief description of the situation/outcome to the appropriate RC and copy the Director of Resource Coordination.

Region 4: (sent on-call procedure document)

- Always a case manager on call for emergencies with administrator back up.
- Non-emergencies are referred to next business day follow-up

Region 5: (sent on-call procedure document)

- The individual or provider calls MDS.
- The MDS on call/answering service picks up and asks who he or she is looking to speak with- service coordination or ISO (direct service provider).
- The on call service calls the service coordinator on call. They must **RESPOND TO ON CALL SERVICE WITHIN 10 MINUTES** of getting the message. If the on call service isn't able to reach the ASC on call, they will then call the ASC back up on call person- Typically the ASC Supervisor.
- That person calls back the caller directly.

Region 6: (sent on-call procedure document)

- The on-call service, which is accessed by calling our main number, will call the on-call cell phone first.
 - If there is no answer, the service will wait and call again.
 - If no one answers a second time, the on-call service will call the secondary number listed on the schedule for the assigned SC.

If no one answers the secondary number, the on-call service will call the next person on the on-call rotation.

Region 7: (sent on-call procedure document)

- **On-call hours:** 4:30pm – 8:00am Monday – Friday & 4:30pm Friday – 8:00am Monday & Holidays
- If emergency occurs during business hours call CM directly. If no answer, dial 0 and ask for assistance in contacting CM or Office Coverage CM.
- **Contact numbers:** Area Agency # will go directly to answering service who contacts on-call CM during non-business hours: 206-2700. Or call Case Manager direct line and dial 0. This will transfer line to main number/answering service who contacts on-call CM during non-business hours.

Region 8: (sent on-call procedure document)

- The individual or provider calls the office number. There is an on-call option that forwards the call to the service coordinator on call at that time.
- On-call Service Coordinator is available to receive calls to the agency at his/her work-issued cell phone number. The Service Coordinator on call will bring his/her work computer home to access phone numbers and records as necessary.

- The Service Coordinator will take the appropriate information down from the call. They will immediately contact their Director or Team Manager. If he/she is unavailable, they will notify the CEO or Director.

Region 9:

- Agency Emergency Services clinicians are available 24/7
- After-hours calls are routed to answering service, who gathers data from the caller about the situation.
- Emergencies are routed to the service coordinator on-call, or the service coordination supervisor if no response.

Region 10: (sent on-call policy document)

- Service coordinators on-call on a rotating basis to cover 24/7 access.

**REGION II AREA AGENCY
PATHWAYS OF THE RIVER VALLEY**

FAMILY SERVICES ON-CALL SYSTEM

POLICY: It is the policy of PathWays of the River Valley to maintain an on-call system that provides individual and family assistance for emergencies after hours and on holidays and weekends. The on-call Family Service Coordinator will work in conjunction with other PathWays employees and community resources to provide support and assistance as appropriate to individuals and families.

PROCEDURE:

Family Services office hours are 8:00am to 5:00pm, Monday through Friday. The office is closed for agency recognized holidays and weekends. An on-call system is in place to receive emergency calls 24 hours a day, seven days a week.

During regular office hours each Family Services Coordinator is responsible for support of individuals with whom he/she normally works. After regular hours all emergency calls will be addressed as follows:

- The auto attendant system for all main office phones includes instructions to direct any emergency call to the pager system.
- The on-call Family Service Coordinator attends the pager and cell phone when the office is closed.
- The on-call Family Service Coordinator will respond to emergency situations appropriately and will document each call and intervention in the on-call log. This includes responding in person to emergencies when necessary or at the request of the Director of the program. Responses made in person are to be made in a reasonable amount of time. The on-call Family Services Coordinator will return a page within 15 minutes and will respond in person, when necessary, within 1 hour.
- The on-call Family Service Coordinator will leave a voice mail message before the next working day to notify the primary Family Service Coordinator that a call was received. It is the responsibility of the primary service coordinator to review the incident with the on-call service coordinator and to follow up as needed. This includes notifying the Forensic Coordinator when appropriate.
- The on-call Family Service Coordinator is also responsible for immediately contacting the Family Services Director in the event of serious emergency situations including hospitalizations, police involvement, fire, ambulance

services, death, lost or missing individuals, and significant behavioral incidents resulting in damage or injury. The Family Services Director will contact the Senior Director of Family Services who will inform the Chief Executive Officer as needed. The Chief Executive Officer is to be contacted if a Director or the Senior Director cannot be reached.

The on-call resource book is the responsibility of the on-call Family Service Coordinator. He/she is responsible for replacing outdated pages whenever new information sheets or lists are provided. This book needs to be available during working hours for other Family Service Coordinators to review as needed. It is the responsibility of the on-call Family Service Coordinator to pick up the pager and resource book from the previous on-call Family Service Coordinator.

It is the responsibility of the Primary Family Service Coordinator to ensure that current information is provided for the resource book and to provide updates as appropriate to the on-call Family Service Coordinator so that they can respond appropriately in emergency situations. The Primary Family Service Coordinator will provide immediate updates by voicemail to the on-call Family Service Coordinator and the paperwork will be faxed by an administrative support person as appropriate.

The resource book will include, but is not limited to, the following information:

- On-call log
- Demographic information
- Supervision or support protocols
- Advanced Directive guidelines
- Agency policies as needed
- Community referral resources and emergency numbers
- On-call rotation schedules for all pertinent programs/services

All Family Services Coordinators are responsible for updating information in the on-call resource book promptly.

Family Services Coordination maintains a rotating weekly on-call schedule. This rotation begins at 5:00pm on Friday and ends the following Friday at 8:00am. The schedule will include the name and dates of the on-call person, his/her home phone number, and the service coordination pager number. The schedule is distributed to agency employees as well as appropriate representatives of any provider agencies. The Family Services Directors must approve any changes to the on-call schedule. It is the responsibility of the on-call Family Services Coordinator to notify other agency personnel of these changes once approved.

Lakes Region Community Services

NAME OF PROCEDURE: RESOURCE COORDINATOR ON-CALL POLICY

DATE WRITTEN: 11/20/1986

DATE REVISED: 12/4/2003, 3/2011, 5/2015

DATE APPROVED BY MANAGEMENT TEAM: 6/14/2004, 4/2011; 6/1/2015

DATE APPROVED BY BOARD: 10/13/2004 (Board approval not required for revisions)

PAGE: 1 of 4

POLICY/PURPOSE:

It is the policy of Lakes Region Community Services (LRCS) to provide 24-hour emergency On-Call Coverage to individuals/families. There shall be a Resource Coordinator (RC) On-Call assigned after business hours, during holidays and weekends to provide support and crisis response as indicated.

SCOPE:

This policy applies to On-Call Coverage for Resource Coordination.

AUTHORITY:

- He-M 503 - Eligibility and the Process of Providing Services
- He-M 522 - Eligibility Determination and Service Planning for Individuals with Acquired Brain Disorder

DEFINITIONS:

Timeframe:

It is the expectation that the RC On-Call will address an individual's concern immediately upon notification of a problem/emergency call from the answering service outside business hours.

Crisis Situation:

A crisis is a concern or event which requires immediate action; including, but not limited to: any health related situation that requires immediate medical response or police involvement.

PROCEDURE:

Lakes Region Community Services

NAME OF PROCEDURE: RESOURCE COORDINATOR ON-CALL POLICY

DATE WRITTEN: 11/20/1986

DATE REVISED: 12/4/2003, 3/2011, 5/2015

DATE APPROVED BY MANAGEMENT TEAM: 6/14/2004, 4/2011; 6/1/2015

DATE APPROVED BY BOARD: 10/13/2004 (Board approval not required for revisions)

PAGE: 2 of 4

If the situation occurs after hours, the individual/family/provider/agency staff/other will initiate the On-Call response by calling the Main Office Telephone Number:

1. The Answering Service will obtain the following information:
 - Individual/family/provider/agency staff person's name and telephone number where he/she can be reached
 - Brief outline of the problem/emergency
 - Determination of what the living situation is (family, shared family living, staffed residence or independently)
2. The Answering Service calls the RC On-Call Telephone Number. If no response, a message is left for the RC with a repeat call in 15 minutes.
 - If no response after 15 minutes, the Answering Service will contact the Director of Resource Coordination. If no response, a message is left with a repeat call in 15 minutes.
 - If no response, the Answering Service will proceed by following the Agency's Telephone List.
3. When the RC On-Call receives message and speaks to the Answering Service, the person receiving the call is to assess the situation and assist in the following manner (if applicable):
 - Insure proper authorities have been notified
 - Insure safety of others
 - Insure that the individual's rights have not been violated
 - Identify available resources
 - Give direction as to follow-up and other assistance as needed
4. Immediately notify the Director of Resource Coordination if the situation involves the health or safety of the individual, police involvement or if action is required by the RC On-Call or the individual's RC. If the situation is resolved (and does not involve an above situation), email a brief description of the situation/outcome to the appropriate RC and copy the Director of Resource Coordination.

Note: In the event of death, police involvement or hospitalization of an individual, the RC and the Director of Resource Coordination shall always be contacted. The Director of Resource Coordination shall immediately notify the Executive Director.

Lakes Region Community Services

NAME OF PROCEDURE: RESOURCE COORDINATOR ON-CALL POLICY

DATE WRITTEN: 11/20/1986

DATE REVISED: 12/4/2003, 3/2011, 5/2015

DATE APPROVED BY MANAGEMENT TEAM: 6/14/2004, 4/2011; 6/1/2015

DATE APPROVED BY BOARD: 10/13/2004 (Board approval not required for revisions)

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5. If death or police involvement, the RC On-Call will respond in person at the discretion of the Director of Resource Coordination.

Note: In the event of a hospitalization of an individual, the RC On-Call will contact the hospital and/or the individual's support person/program manager to determine if the RC needs to be present and who will physically respond to the hospital if needed. If the person has a legal guardian, they will be contacted by the RC On-Call for notification and/or touch base regarding the situation.

6. The RC On-Call will have the On-Call Binder with them and refer to as appropriate to include:
 - a. On-Call Procedure-Guidelines
 - b. Protocols / DNR Orders
 - c. Serious Injury or Apparent Death of an Agency Client Procedure
 - d. Incident and Reporting Procedure
 - e. Program and staff home telephone numbers (including Self Directed Services, Residential Homes and Home Assist Program contacts)

SELF-INJURY, BODILY HARM OR SUICIDE THREAT:

1. RC receives notification from the Answering Service that an individual is threatening to commit suicide, or indicating that an attempt of self-injury or bodily harm is being considered.
2. Check for an existing protocol in On-Call Binder for the individual in step 1 above:
 - a. If yes, follow as directed.
 - b. If no, call 911 indicating what town the individual resides in, be prepared to provide police with all available information; police will take further action required.
3. Gather additional information as appropriate. Note: the degree of risk should be assessed by either the police or Genesis Behavioral Health; therefore caution should be used when gathering additional information.
4. Inform the Director of Resource Coordination of the situation; who will notify the Executive Director.

Lakes Region Community Services

NAME OF PROCEDURE: RESOURCE COORDINATOR ON-CALL POLICY

DATE WRITTEN: 11/20/1986

DATE REVISED: 12/4/2003, 3/2011, 5/2015

DATE APPROVED BY MANAGEMENT TEAM: 6/14/2004, 4/2011; 6/1/2015

DATE APPROVED BY BOARD: 10/13/2004 (Board approval not required for revisions)

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5. Inform guardian if applicable.

RESOURCE COORDINATION ADMINISTRATIVE ASSISTANT (RCAA):

Update and distribute the RC On-Call Schedule to appropriate personnel as needed.

Note: Any changes to this schedule is the responsibility of the RC, requesting the change, to find coverage and communicate such changes via email to the Director of Resource Coordination and RCAA. The RCAA shall notify the Answering Service and Director of Operations of any changes to this schedule.

Maintain the On-Call Binders to include the following:

- a. Updated On-Call List
- b. Updated Telephone List
- c. Individual Protocols

COMMUNITY BRIDGES ON-CALL PROCESS

Overview

The Individual and Family Support Case Manager On-Call service is available to the individual/family/guardian and/or provider agency for 24-hour access. The designated On-Call Case Manager responds to emergency events involving or pertaining to an individual receiving supports and services during non-business hours. On-Call Case Managers will not address non-emergent issues.

Authority

Refer to the following authority for details:

- HeM 503 – Eligibility and the Process of Providing Services
-

Responsible Party

The On-Call rotating schedule determines who is on call for a particular week. The On-Call Team determines the schedule via consensus. The On-Call Case Manager is responsible for fulfilling the duties outlined in the procedure.

HIPAA Employee Conduct

Community Bridges has established and will maintain effective Corporate Compliance and Individual Confidentiality Protection Programs. All employees will engage at all times in ethical conduct as regards filing and storing records, as well as planning, providing, documenting, coordinating, monitoring, auditing, and billing of services.

HIPAA Release of Information

All individuals/families/guardians receiving supports through Community Bridges must receive a one time “Notice of Privacy Practices” regarding the release of information for treatment, payment, or operations per HIPAA requirements. Additionally, the individuals/families/ guardians must complete a “Release of Information” form authorizing the release of information to a third party per State HeM regulations, as appropriate. Assure the release of any information is only the minimum necessary to accomplish the purpose.

Timeframe

The On-Call Case Manager is available between the hours of 5pm and 8:30am to respond to all emergency calls and situations. The On-Call schedule is a weekly rotation from Wednesday to Wednesday.

Note: The responsibility of the On-Call Case Manager does not officially end until the cell phone and on-call materials have been

File Name: cm086

8-6-1

Initial Draft –

Final Draft – 04/02/02

Revised – 04/11/04, 03/06/06, 3/7/07, 7/9/08, 01/28/2010, 08/17/2011, 09/11/2012, 03/29/2019

COMMUNITY BRIDGES ON-CALL PROCESS

physically handed over to the next Case Manager On-Call.

Process

The Case Manager On-Call Process is located below:

| STEP | ACTION |
|------|--|
| | ON-CALL TEAM |
| 1 | Create, update and review the <u>On-Call Schedule</u> for completeness and accuracy. |
| 2 | On-Call Team provides a copy of the On-Call Schedule to the Answering Service and the Business Office. |
| 3 | Fax the <u>On-Call Schedule</u> to the answering service each time a change is made. Note: Answering Service of New Hampshire can be reached at 668-9073 and faxed at 668-9687. |
| | CASE MANAGERS Ongoing |
| 4 | Case Managers should keep on-call team up-to-date on any emerging issues, including <ul style="list-style-type: none"> • Medical/Psychological • Behavior Plans • legal • social • program changes • other special needs |
| | CASE MANAGER ON-CALL WEEKLY |
| 6 | Communicates with previous on-call team member for updates on immediate and ongoing issues. |
| 7 | Check for maintenance of the following items: <ul style="list-style-type: none"> • cell phone is charged and you have the charging cord. |
| | CASE MANAGER ON-CALL-DAILY |
| 8 | Answer all incoming calls on On-Call smartphone immediately. |
| 9 | Evaluate the answering service information to determine emergency or non-emergency to include but not limited to: <ul style="list-style-type: none"> • individual/family/guardian name(s) and phone #(s) , and brief description of the incident. |

COMMUNITY BRIDGES ON-CALL PROCESS

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| STEP | ACTION |
|------|--|
| 10 | <p>Call the number provided by On-Call service to gather more specific information to assess and respond appropriately.</p> <p>Note: People whom you may need to contact include families, individuals, guardians, program managers, hospitals or police, legal and social services entities.</p> |
| 11 | <p>If it is determined that there is a high profile emergency event, the Director of Case Management should be notified via phone call. High profile events may include medical or psychiatric hospitalizations, police or legal involvement, and/or death.</p> <p>Note: The Director will place a phone call to their superior for any police or legal involvement of a serious nature, death or any other Sentinel Event.</p> |
| 12 | <p>If the event is a death, the on-call case manager gathers mortality notification information and detail.</p> |
| 13 | <p>Document emergencies and follow-up responses and outcomes via email to the assigned Case Manager, their Supervisor and the On-Call email group, detail to include but not be limited to:</p> <ul style="list-style-type: none"> • Individual's Name • Case Manager • Time of call • Date of call • Nature of call • Party (s) involved with call • Party (s) notified of call • Is the individual connected with one of the following: Bx Plan, Crisis Plan or Project START • Follow-up action taken and/or needed • Comment |
| | <p>Is the individual at Concord Hospital Emergency Department for a mental status exam/psychiatric assessment? If yes, follow steps below. If no, go to step 16.</p> |
| 14 | <p>When an individual arrives at the Concord Hospital Emergency Department and requires a mental status examination/psychiatric assessment, the Emergency</p> |

File Name: cm086

8-6-3

Initial Draft –

Final Draft – 04/02/02

Revised – 04/11/04, 03/06/06, 3/7/07, 7/9/08, 01/28/2010, 08/17/2011, 09/11/2012, 03/29/2019

COMMUNITY BRIDGES ON-CALL PROCESS

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| | Services staff will call START on-call for clinical recommendations and support. This is part of a predetermined Linkage Agreement between START, Concord Hospital, and Riverbend Community Mental Health Center. <u>The individual does not need to be</u> a) connected with START, nor b) a Community Bridges or Area Agency client. They only need to appear to have a developmental disability. |
| 15 | If such a call is received by the Case Management On-Call staff person, they should take down the pertinent information and then call the answering service and ask that the START On-Call staff be called and given the information from Concord Hospital regarding contact person, phone number and situation. Note: These calls should get paged out to START On-Call staff, so these instructions Step 14 and 15, are in the event that that process breaks down. |
| | ASSIGNED CASE MANAGER |
| 16 | Follow-up on On-Call notifications and document in a <u>Contact Note</u> . |
| | PROGRAM ASSISTANT |
| 17 | Receives Fax of On-Call messages from receptionist and files. |
| | CASE MANAGER ON-CALL-END OF SHIFT |
| 18 | Hand over the on-call information and equipment to the next Case Manager On-Call to include the following: <ul style="list-style-type: none"> • cell phone w/charger |



MDS ON CALL INFORMATION

Generally the on call service will call the ASC's cell phone. If you miss the call due to location or other issue. ASC must **RESPOND TO ON CALL SERVICE WITHIN 10 MINUTES** of getting the message. If the on call service isn't able to reach the ASC on call, they will then call the ASC back up on call person- Typically the ASC Supervisor.

When to respond in person (typically):

- Psychiatric emergency
- Life threatening emergency
- Medical emergency or serious illness w/person in ER
- Person arrested or police at the scene
- Outreach-not all outreach have 24 hr support w/ vendors, we need to cover this

Typical calls:

- Person needs authorization for a cab
- Notification of person going to ER for "typical" medical attention, ie. person with seizure disorder whose protocol is to have blood levels checked w/ every seizure; person may have sprained their ankle; person fell and needs a few stitches

What ASC needs to do:

This is basically the same job as an emergency that occurs during business hours.

If the person needs to be admitted, make sure that process moves smoothly.

If there are tests that could be done and are not being done, advocate for them. Assisting in the explanation to the individual of what is happening.

If an emergency respite situation needs to be found, assist with the phone calls or stay with the individual while the program manager makes calls.

At times you may need to advocate that the person be seen by a specialist, i.e. psychiatrist, cardiologist, etc.

If the person has been to the ER/doctor repeatedly with same symptoms, you may need to push for answers.

General moral support for the team.

When to call back up On Call:



~In the event of a death

Who died? How did they die? Was the death expected? Cause and time of death?

Was 911 called? Was there a DNR in place? Has the family & guardian been notified?

Who was with the person when s/he died?

~When there is any kind of police involvement

~When someone is hospitalized

~When there has been a significant behavioral incident involving injury to an individual, family or staff person

Administrative:

~On Call runs from evenings/nights Monday 4:30pm-Friday 8am, then throughout the weekend and all paid holidays

ON-CALL BOOK MANAGEMENT/OVERSIGHT

Purpose and Scope

The On-Call Book is reviewed/updated every three months to ensure up to date contacts from our Vendor Agencies, Service Coordination, and internal Gateways contacts. Current policies and procedures are also kept in the book in the event the On-Call SC has a sentinel event or issue that requires additional support.

Focus Area: Service Coordination, Family Support

Protocols

- Any new protocols are reviewed by the SC Director before adding to the book.
- Senior SC will check the protocols that are in the book every three months to be sure they are current and ensure any necessary updates are made.

Admin Support Assistant

- Quarterly updates made to the On-Call book
 - Print out a current client list and be sure that it is dated
 - Print a copy of all staff phone extension numbers
 - Check the following lists to be sure numbers are current and update if necessary:
 - List of cell phone numbers
 - Contact numbers for other departments

Senior Service Coordinator

- Provide general oversight of the book
 - All contacts and information are checked and updated quarterly
 - Vendor after hours contacts, Vendor On-Call numbers, internal department contacts and current extensions
 - Check all Protocols for any updates
 - Check the log sheets, organizing if necessary, and check to see if entries are being made correctly/completely/legibly
 - Provide training if needed
 - Add blank pages to the back when necessary
 - Check to see if the binder is in good shape

Emergency On-Call Guide

Purpose

Service Coordinators rotate on call for one week, Wednesday to Wednesday. If a Service Coordinator is unable to be on call during their time, he/she is responsible to find coverage and inform the Administrative Support Assistant.

Focus Area: Adult Services, Family Support

Service Coordinators are expected to keep the on-call phone with them and respond at all times while Gateways is closed (4:30pm-8:30am Monday-Friday), weekends and holidays.

- The on-call service, which is accessed by calling our main number, will call the on-call cell phone first.
 - If there is no answer, the service will wait and call again.
 - If no one answers a second time, the on-call service will call the secondary number listed on the schedule for the assigned SC.
 - If no one answers the secondary number, the on-call service will call the next person on the on-call rotation.
- When a Service Coordinator is on call and information is given:
 - Respond to the person accessing on call
 - Enter the information into the log.
 - Share the information with the appropriate Service Coordinator by the following morning.
 - The information can be shared in person, phone message, or email if on call SC will be out of the office.
- Some clients have specific protocols relating to after hours and on-call.
 - Before responding to any situation, check the Client Protocol section of the On-Call book for guidelines relating to client situations.
- High level issues may arise while on call. Follow the policy/procedure in the book for the following issues. High level issues may include:
 - Suicide attempt
 - Client death
 - Missing person
 - Sentinel Event

CASE MANAGEMENT ON-CALL PROTOCOL AND EXPECTATIONS

I. Contact Information

On-call hours: 4:30pm – 8:00am Monday – Friday & 4:30pm Friday – 8:00am Monday & Holidays

- If emergency occurs during business hours call CM directly. If no answer, dial 0 and ask for assistance in contacting CM or Office Coverage CM.

Contact numbers: Area Agency # will go directly to answering service who contacts on-call CM during non-business hours: 206-2700. Or call Case Manager direct line and dial 0. This will transfer line to main number/answering service who contacts on-call CM during non-business hours.

II. Notification:

Contact on-call CM* if any of the following occur during non-business hours:

- Individual is seen for emergency room visit or hospitalization
- Individual moves – pulled suddenly or unanticipated move
- Accusation of Abuse, Neglect or Exploitation or client rights issue
- Individual is missing or AWOS exceeding specified unsupervised time
- Individual is involved in a vehicle accident resulting in any medical attention
- Any potential for negative media coverage related to individual
- Any high risk behavior such as unwanted sexual contact with another person, premeditated aggression, fire-setting or threats of suicide or homicide unless otherwise identified in a plan - call 911 and any other actions required for immediate safety –
- 911/Police involvement associated with individual**
- Death of an individual

*On-call CM will notify assigned CM on the next business day regarding all information relayed in the on-call situation. On-call CM will also notify appropriate Supervisors, Directors, Senior Leaders and State Personnel of any serious incident requiring such notification.

Give the following information:

- Individual(s)/staff/provider(s) involved, date, time, location, incident/reason for call.
- Any current intervention/plan.
- Other parties that have/will be notified.
- Your contact information.

III. Vendor Follow-up:

- Confirm notification of appropriate parties – services are responsible for notifying, if applicable: guardians, nursing, PCP, and/or any other team members.
- Update CM as new/related information unfolds.
- Complete Incident Report within 24 hours (in most cases all items listed above will require and incident report including hospital visits) and submit to appropriate staff.

**If individual is involved with a high risk criminal matter such as fire-setting 911 must be contacted (unless otherwise specified in individual's plan) and on-call CM will provide further instruction.

If you are calling to make a Client Rights complaint, please make sure the following numbers have been called:

BDS: 1-855-450-3593 (for all allegations)

BEAS: 1-800-949-0470 (for allegations involving abuse, neglect and/or exploitation)

ON-CALL & EMERGENCY EVENT PROCESS

Department: Service Coordination

Contact: Director of Service Coordination & Director of Quality Improvement

Effective & Revision Date: 3.29.19, 9.27.19, 11.26.19

PROCEDURE STATEMENT: Outside of office hours (8:30am-4:30pm), from Wednesday afternoon to the following Wednesday morning, there will be a Service Coordinator available to receive calls to the agency at his/her work-issued cell-phone number. The Service Coordinator that is on-call will bring his/her work computer home to access phone numbers and records as necessary.

PURPOSE STATEMENT: This process goes over the expectations for Service Coordinators on-call and the appropriate response to calls received.

PROCEDURE & CONDUCT:

1. A change is made to the On-Call Schedule;
 - a. At least 24 hours prior to the shift start inform the SC Scheduler & Facilitator and the Director of Service Coordination.
2. A Service Coordinator is informed of an incident listed as an Emergency Event
 - a. Immediately notify your Director or Team Manager
 - b. If he/she is unavailable, notify the CEO.
3. A call is received that is NOT an Emergency Event;
 - a. Be professional. Answer questions. If necessary, assure that follow up will occur. Thank the caller.
 - b. Write a detailed contact note in HRST, be clear and specific
 - c. Email the individual's service coordinator to inform them of the call.
4. A call is received that is an Emergency Event
 - a. Be professional. Answer questions and provide information, as necessary. Assure that follow up from senior leadership will occur. Thank the caller.
 - b. Immediately call to inform the CEO; Chris Muns at 603-493-5775 (texts 603-498-6229) and the Director of Service Coordination; Keryn Bernard-Kriegl at 603-828-9602. If you are unable to get in contact with either;
 - i. Send a text stating "On-Call Emergency Event, Call Back."
 - ii. Call Director, Lenore Sciuto, at 603-498-0796
 - iii. Keep up outreach until you have spoken to a Director on the phone.
 - c. Email the individual's service coordinator, the team manager, the Director of Service Coordination, and the CEO to describe the call and situation.
 - d. Write a detailed contact note in HRST, be clear and specific
5. Any call from a member of the media
 - a. Do not speak with any member of the media.
 - b. Direct them to outreach the Director of Outreach and Development, Billie Tooley and/or the CEO, Chris Muns.

DEFINITIONS:

On-Call: The phone system option for any person calling the Front Desk outside of business hours. Selecting this option forwards the call to the service coordinator selected to be covering on-call hours that week.

Emergency Events: Events that require **immediate** notification to the CEO or Director, including;

- Death or Serious Injury of Individual (or provider, if response is necessary)
- Suicide attempt requiring medical intervention
- Hospitalization or Emergency Room Visit
- Restraint-related Injury
- Police Involvement
- Elopement or Homelessness
- Sexual Assault/Rape
- Emotional Abuse or Psychological Injury
- Other sensitive situations with possible media coverage
- Other incidents deemed emergencies at the service coordinator's discretion

REFERENCE

Time and Compensation:

- Per the Department of Labor, when a service coordinator answers the phone for on call he/she will be automatically compensated a minimum of two hours pay.
 - Note: this does not mean that compensation for every call equals two hours pay. Service Coordinators will not be additionally compensated until they have worked additional hours exceeding two within a given calendar day.
- Per Agency Overtime Policies: Preapproval for overtime is not necessary when on-call.
 - If you are not the assigned on-call person, but you respond to an issue or assist the on-call person with addressing an issue, you must inform your supervisor immediately of the time spent. In response, your supervisor may ask you to reduce your regularly scheduled work hours to prevent crossing in to overtime.

BDS Complaint Investigation Toll Free Number – 1-855-450-3593

Vendor Contact Policy: All service providers are required to contact One Sky On-Call outside business hours (8:30am-4:30pm) to report any significant incidents; these include, but are not limited to;

- Death
- Hospitalization (medical/psychiatric)
- Elopement
- Police Involvement
- Serious Injury
- Emergency placement/respite

SECTION: Agency Operations

POLICY: Agency On Call Emergency Response System

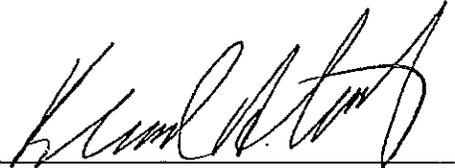
It is the policy of Community Crossroads, Inc. to assure that designated staff are available at all times to respond to emergency needs which arise outside of the agency's regularly scheduled business hours. The on call system is designed and implemented to respond to emergency situations in a timely, efficient and professional manner. It is further intended as a support mechanism primarily for individuals receiving services and their families and for provider agencies and staff after internal support has been accessed. The on call system is supportive to individuals and families in that it affords an emergency back up system which can become operational during times of concern and/or crisis. The on call system also provides an immediate response and/or information to providers and staff during these same situations. Appropriate use of the on call system is expected. Routine communications should be conducted during business hours or through voice mail/e-mail messages after hours.

An emergency is defined as any situation requiring immediate action beyond the control, authority or knowledge of the involved providers and staff and/or informing the service coordinator of an emergency situation according to the following definition: death or significant injury of an individual receiving services; missing individual; a family's need for immediate assistance; need for authorization for medical treatment, funding, etc.; emergency maintenance and repairs to agency property which must be addressed immediately; situations involving the police or fire departments or other high profile incident; any situation which is deemed hazardous to the health and well being of individuals receiving services such as alleged abuse, neglect, exploitation or violation of rights, serious injury or illness.

Community Crossroads, Inc. service coordinators assume responsibility for on call response as scheduled on a rotating basis to respond to emergency needs of individuals receiving services and their families, and involved providers. The on call service coordinator is responsible for notification of all appropriate individuals of significant emergency incidents or issues and for maintaining documentation of all calls and actions taken in response to them.

Community Crossroads, Inc. maintenance personnel will be on call to respond to emergency maintenance and repair needs at agency owned properties.

Approved: 07/26/01
Revised: 02/12/09
Revised: 08/09/12


Edward Adamsky, President

Area Agency Service Coordinator Requirements

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|----------|---|
| Region 1 | <p>Bachelor's degree and at least one year of relevant experience in case management and direct support for individuals with developmental disabilities and/or mental illness (However, we do have several that don't have BA degrees)</p> <ul style="list-style-type: none"> • Bachelor's degree preferred with 2 to 3 years of case management experience required; extensive case management experience may substitute for degree • 2 years of human services experience required; experience with developmental disabilities preferred • Excellent verbal, interpersonal and written communication skills required • Ability to multi-task and prioritize a must • Proficient ability with MSOffice and general technology skills a must • Budgeting experience preferred |
| Region 2 | <p>For our PDMS Case Managers we also require prior supervisory experience.</p> |
| Region 3 | <p>LRCS requires bachelor's degree and might consider experience along with an associate's degree if the experience is extensive and relevant.</p> |
| Region 4 | <p>Our Service Coordinators (Case Managers) are required to have a Bachelor's degree. We do not accept years of education in lieu of the degree.</p> |
| Region 5 | <p>Bachelor's degree from an accredited college or university in a human services or related profession. Minimum of three years experience providing services to individuals with developmental disabilities. Must possess excellent communication skills.</p> <p>We do have one employee who does not have a degree but worked her way up from a DSP, Home Provider, and Program Manager.</p> |
| Region 6 | <p><u>Qualifications, Education and Experience</u></p> <ul style="list-style-type: none"> • Bachelor's degree preferred in related field; or equivalent combination of education and/or experience. • Prior casework or related experience with people who have developmental disabilities and their families. • Strong belief in provision of community services for people with developmental disabilities. • Ability to function as a member of a team and be a team builder. • Technical competence (Proficient in MS Office applications; word processing and spread sheet (Word/Excel) - Relational data base knowledge a plus |

| | |
|-----------|---|
| | <ul style="list-style-type: none"> • Ability to work effectively with individuals with developmental disabilities and ability to advocate and help them advocate on their behalf • Effective interpersonal and communication skills. • Good organizational/time management skills. • Knowledge of Gateways Community Services, Greater Nashua community and available resources • Possess reliable transportation, valid drivers' license and applicable vehicle insurance for business travel. |
| Region 7 | <p>Case Manager/Level One Case Manager – Bachelor degree preferred, consideration may be given to those with an Associate degree and a minimum of two years of work experience in human services</p> <p>Lead Case Manager - Bachelor's degree in Human Services or related field. Minimum of 4 years of experience working in Human Services with working knowledge of area agency services, vended services and evaluation of individuals' needs and budget requirements to meet those needs</p> <p>We have a Resource Coordinator position in Family Support:</p> <p>Resource Coordinator - Bachelor's degree in Human Services or related field. Minimum of 2 years' experience working with developmentally disabled persons</p> |
| Region 8 | <p>We require the same thing for all positions-- a minimum of an Associate's degree, Bachelors preferred in a related field, and 2 years of experience working with individuals with intellectual disabilities. We will make an exception on the 2 years of experience (you have to start somewhere) but not with the degree.</p> |
| Region 9 | <ul style="list-style-type: none"> • Associate degree or equivalent required, Bachelor's Degree preferred • Two to three years of relevant field experience preferred • Valid driver's license, proof of adequate automobile liability insurance and reliable transportation required |
| Region 10 | <p>Job Specifications:</p> <ol style="list-style-type: none"> 1. An understanding and respect for the needs of individuals with developmental disabilities and families with a member with a developmental disability, an understanding of advocacy, family systems and dynamics, self-advocacy, state developmental disabilities regulations, entitlements, adult services and concepts of self-determination and individualized budgets. 2. Strong skills in the areas of communication, problem solving, conflict resolution, facilitation, advocacy, group process and mediation coordination and monitoring of services. 3. Ability to empower individuals/families through modeling, encouragement, providing accurate information and offering non-judgmental supports. <p>Qualifications:</p> <ol style="list-style-type: none"> 1. B.S. in Human Services, psychology, social work or related field. Two year's case management/rehabilitation or family support experience. |

Requirements:

1. Flexible schedule to include evenings/weekends as necessary.
Valid driver's license, auto insurance of \$100,000.00/300,000.00 and a vehicle for use to perform job.