CFI WAIVER LISTENING SESSION NOTES
November and December 2016

Choices for Independence Waiver Renewal --- Listening Session
December 6, 2016
10:00am-12:00pm
Institute on Disability
MCAC

Appendix A: Waiver Administration and Operations

- Are all the entities current in Appendices A & G?
- Need to look at quality/efficiency of DHHS in addition to providers. As an example, eligibility determination; this should be included in quality evaluation.
- Need timelines for eligibility and how long people can expect for it to take; then quality measure to be is DHHS meeting timeline?
- Indicator: how well DHHS is complying with federal guidelines
- Administrative Operations of BEAS, Client Services needs to be clarified with work flow aligning to rules, regulations and authority
- Process: application now done primarily through NH Easy; need to include broader range of individuals performing this role
- Quality section references data is reviewed and published monthly; do they exist? Where are they published?

Appendix B: Participant Access and Eligibility

- Barrier: we say that there is a choice of waiver; the reality is that it is difficult to move to another waiver-not meaningful choice
- Spend down of resources for community based residents need to be clarified
- RSA151-E11 50%, HC, 50% Res Care
    - 50% aggregate; why is that in the waiver? How is it tracked? Needs to be addressed
    - SB553 session
    - In the RSA, not in the waiver
- Needs to be consistency with RSAs; purpose and intent and workflow
- Consistency between waivers needed
- Need to look at Medicaid eligibility; 65+ older who want to work. People are being told that they need to stop working at 65
    - Need to add in supported employment
- No protection for minimum # of Medicaid beds that a facility needs to have open
- Eligibility timeframes have delays; why are there lapses occurring in services?
- Requirement for face-to-face; how does this impact process? Does this lead to delays?
    - Contract requires complete in 7 days.
    - Multiple organizations can perform this function
    - Delays before and after nurse referral
    - Communication is an issue for redeterminations; need clarifying of roles
- What is cause of delays? For both initial and redeterminations?
    - Assignments not occurring in timely manner

    - End result people move or die before eligibility determination is made
- Look at different mechanisms for initial and redetermination
- Delay with financial determination; look at workflows and structure
- Roles now blended in DHHS
- Need to ensure consistency between waivers
- Spend down issue; leads to delay
    - Can people apply in advance of spend down?
- Look at presumptive eligibility
- Target group; disability is another category; not clear understanding of TBI waiver; needs clarifying
- Delay; too many populations in the category
    - Should there be more than one waiver?
    - MI denials
        - There is no BH, MH component in waiver
- 801 definition of ADLs disconnected with what is used at eligibility; needs clarifying
- Crosswalk waiver and rules language
- Person-centered language needs to be included
- Need to update who does the evaluations
- Consider including person directed services with no cap
- Include vehicle modifications
- Include self-direction
- Include retroactive payment. CMS requires care plan be done prior to payment. People can be close to eviction for non-payment because process is so slow
- Goal get eligibility determination as soon as possible. CMS 5 day requirement
- Get rid of retroactive issue. Allow people to submit application prior to spend down.
- ACA requires waiver to do spousal impoverishment rules, waiver currently states not doing this.
- Cap too low for modifications; increase cap or have no cap

Appendix C: Participant Services

- Non-medical transport is included but needs to be revised because it is too cumbersome for providers to get reimbursed
- Populations. 18-64, no supported employment, should also just be 18 +
- Need to be cross walked with rules
- HDM rules; no basis for appeal because there is no standard in the rules around HDM
- SB553: weaving things together to ensure consistency
- Include consumer directed services as part of the menu in addition to being a separate appendix
- What is consolidated services?
- Additional OT, PT for certain diagnosis needs to be an option. Needs to be person centered. Need to clarify what distinguishes waiver services from state services?
- Consolidated services not well defined. Would be a helpful concept for different situations.

    - Could consider consolidated services of personal care with non-medical transport. Consumer directed budget under consolidated services can meet some unique needs in addition to services listed or create prepackaged services (ie Personal Care and transport. Need to balance so don't box yourself in)
    - All services listed except consolidated services are listed as options. How many consolidated services have been provided over course of waiver? Answer: never implemented. Written to allow movement but taken away before implemented.
- DME List needs to be updated for updated technology
- DME needs its own table for discussion
- Would be helpful to have each item in Appendix C listed with who the designated providers are
- Adult Family Care; is it happening? Not a lot using. 3 sites currently doing this
    - Need to determine why not being provided. Is it because reimbursement rate is so low rather than not that people don't need? Could replicate the DD system.
- Why were in home services taken out and is there a need? RATE ISSUE.
- Ad IN home services providers switch to PCSC due to reimbursement
- Need to be examined, consistent with what people need. Both adult family care and adult in-home supports
- Clear service description with clear rates
- Respite rate currently is below minimum wage. Can't find a provider who will do this so it doesn't exist. Fewer providers willing to do respite.
    - Related with adult in home, some people could be provided respite with ramped up in home services
- Respite beds in facility how do we make system as flexible as possible?
- Safeguard: people have access to respite
- Waiver: check staff to resident ratios, items in waiver need to be examined for correctness
- Electronic Med machines have a separate authorization code under waiver. Where is it in the list of services?
    - Lacks clarity. Needs definition.
- Confusion because same service is offered on state plan and waiver – should be separated out. Can you access same services under other sources? Object that you cannot use services if they are eligible elsewhere. Services not provided because they're denied from both sources because there is eligibility from the other source. Not enough difference between what is provided under state plan and waiver.

Appendix D: Participant-Centered Planning and Service Delivery

- Risk of people should be considered but not used as an exclusion of their qualifying for waiver. People are being excluded because of risk they are willing to accept. (ie. Willing to stay at home overnight alone even though they're a fall risk) Needs to be addressed.
- Does the waiver support person centered decision-making?
- What is risk protocol? Michelle will send it to the group
- Timeframe for pre-eligibility and CM timeframe should be clear.

  - Not getting referred for 50 days so person dies, etc.
  - EX. Person in assisted living facility, provider does not accept Medicaid, she is eligible can she still get CFI Case Management?
- WHO is the Authority? Such confusion.
- CM agencies don't have state plan provider numbers
- CM why is it not identified under CFI service?
- CM should be service of waiver and state plan and perhaps defined differently.
- Add CM to list of services

Participant directed services

- Nothing currently in this section. Not authorized by NH or CMS
- Need to build on this and define in detail
- Go to consolidated services. Look at model in other waivers.
- Consolidated services morphed under DD to participant directed services

Appendix F: Participant Rights

- Information should go out to person about eligibility timelines. For example, call if not done in X number of days, or if you receive denial; currently notification only goes to CM
- Need to educate participant so that they can respond when expectations not met
- Rights are clearly defined in other waivers look at language and see if applicable to this population
- Uniformity across waivers is important here
- Need to provide resources where people can call if denied etc., DRC, NHLA
- Established cases when authorization for services are denied and consumer is not getting any notice. Nursing ex. CM enters authorization, BEAS nurse denies, goes back to CM with note stating skilled nursing weekly is not covered. Appendix F & B. BEAS will provide with notice and dispute resolution process. No time frame on DHHS to respond for determination. Need to include timeframes so appeals can occur. Letter C states requesting reconsideration does not take away right to dispute, but have to ask for denial so appeal can be initiated.
- In assisted living people subject to discharge are allowed to appeal to appeals unit. The CFI option for appeal is superior or probate court. Not realistic choice. Rewrite needed for RSA. Modify in renewal or start from scratch and make across all waivers.
- People are denied service while waiting for denial.

Appendix G: Participant Safeguards

- Assumption that licensing monitors use of restraint and is this true? Is monitoring happening?
  - Needs to include pharmaceutical restraint
- Description of medication management needs to be updated
- CM monitor medication management in residential care, does this happen? (answer was no it is not) Needs updating.
- If CM should be doing this need to be in 805

CFI WAIVER LISTENING SESSION NOTES
November and December 2016

- What's not in there:
  - LTS ombudsman needs to be available for CFI
  - Look at other states
  - Michelle to send out information on safeguards to MCAC, pull from A through F to include in G, figure how you measure and report so there can be accountability
- Are phone calls to participants by BEAS occurring?
- Network adequacy-no services due to lack of staff, puts clients at risk, linked to rates
  - How do you measure? Unmet need. Authorized hours vs unfulfilled hours usually due to inability to find staff (rate issue)
  - Department licenses but nobody looking at big picture of what state needs
  - Include as consumer safeguard
  - Analyze what is needed to have a system of care, the number of providers needed by category
  - Register through annual survey to capture data,
  - ADHC

Appendix H: Systems Improvement

- Quality improvement process needs to be reviewed
- Direct survey system needed for appropriate feedback
- Include focus groups of participants (to include appropriate supports for them to be active and engaged)
- Sentinel event reporting went through series of changes. Providers don't have current information for reporting purposes
- Sentinel event process in the waiver needs to be relooked at upon renewal to determine if that makes sense and how the department operationalizes this. Need to look at uniformity and practice among all waivers.

Appendix I: Financial Accountability

- Need information about how states determine payments
- Include fairness and equity in looking at what it costs
- Quality costs, how do we achieve it?
- Need different rate structure, reimbursement rates; include tiered rate structure. This was a recommendation put forth by the State Innovation Model (SIM)

Appendix J: Cost Neutrality

- Needs to be aggregate against cost of nursing homes
- Review methods used for other waivers: multiply number of people on waiver times average cost of nursing home stay, and as long as average cost is 100 % or less should be used. Not on individual basis. Some will cost more than average.
- Need tiered rate structure
- CFI data, less costly than facility; there should be room to increase rates

- Is the department looking at this on an ongoing basis?
- Where is the data (SB553 asked for this)
- Amend waiver to bring budgeted amount up (done on DD side)

MCAC CFI WAIVER RENEWAL LISTENING SESSION
KEY POINTS FROM MCAC ATTENDEES

General:

- Update and crosswalk all standards to current Federal and State statutory and regulatory requirements.
- Clearly define the actors, the workflow sequence, and process steps in DHHS waiver-related actions throughout the waiver application. This should include eligibility determinations, service authorizations, quality oversight, fair hearing process, and more.

Administration and Operations:

- Develop waiver application in tandem with related administrative rule development/amendment.

Eligibility:

- Detail the full process for determining and imposing RSA 151-E:11 cost controls in the application.
- Establish required time frames and actors for each step in DHHS eligibility determination process.
    - Consider that service coverage currently is not retroactive and cannot occur before the clinical eligibility determination.
    - Consider pursuing CMS authorization for 3-month retroactive service coverage.
- Develop and implement a timely and pre-staged eligibility determination process for people in residential care nearing the completion of resource spenddown so as to ensure timely service coverage and no loss of service coverage/provider payment.
- Relative to eligibility groups under waiver:
    - Add eligibility group for those age 65 and older who continue to work.
    - Distinguish when an applicant with a mental illness comorbidity is eligible or not for the waiver program.
- Activate the presumptive eligibility process.

Services:

- Review and assess current service needs and ensure waiver services meet those needs. Consider, at a minimum:
    - Needs of applicants/participants;
    - Needs met by each service;
    - Substitute services when provider availability bars access to the service actually needed; and

    - Reimbursement rate and any limiting effect of the rate.
- Add to covered services:
    - Employment support;
    - Vehicle modification; and
    - PT, OT, and Speech Therapy in excess of State Plan limits.
- Develop and implement consolidated services (also known as, participant-directed services).
- Work with community to develop a transportation service that is workable, cost efficient, and effective.
- Ensure a clear eligibility standard for each service and clearly distinguish services that are comparable to State Plan services (e.g., home health services, DME, PT, OT, Speech Therapy, personal care).
- Ensure a meaningful process for choice of waivers.

Participant-Centered Planning and Service Delivery;

- Work with the community to reassess and amend the risk protocol.

Participant Rights:

- Clearly define and commit to educating participants on all participant rights.
- Ensure notice of denial to the participant in accordance with the law.
- Ensure continued coverage of service in the interim to a fair hearing decision.

Participant Safeguards:

- Review, correct, and update monitoring assurances to identify the monitoring that actually occurs—whether relative to restraint, seclusion, medication management, or other safeguards.
- Define network adequacy. Consider unmet need in this assessment and in quality measures.
- Include LTSS ombudsman for waiver populations.

Systems Improvement:

- Carefully review and update quality improvement process to ensure meaningful process.

Financial Accountability:

- Develop and include reimbursement rate information for all services.
- Implement tiered rate structure.

Quality:

- Assessing quality of DHHS actions is equally as important as assessing the quality of provider actions. (For example, timeliness of eligibility determinations.)
- Commitment to timely reporting and publication of quality measure results is key to a successful quality program.

CFI WAIVER LISTENING SESSION NOTES
November and December 2016

Choices for Independence Waiver Renewal --- Listening Session
December 7, 2016
10:00am-12:00pm
Institute on Disability
NH Home Care Association

Q: is the waiver renewal is separate from Step 2 of Medicaid Managed Care?

Response- to our knowledge yes

Q: what is the timeline for implementation of new waiver?

Suggested to make sure this is answered as part of the public notice/hearing process

Appendix A:

Read the CMS definition to group

- There have been organizational changes at DHHS that makes it confusing to understand who is overseeing CFI. This should be clarified. Especially Policy and Rates leadership.

Appendix B:

Q: How is the level of care is decided?

- Uncertainty of how level of care is decided.
- While level of care may support waiver eligibility, staff find that participants are unsafe to live in the community. This is due to memory issues, physical environmental factors, other individuals who may be residing in the home, and other factors not identified using current assessments.
- There is no home safety assessment
- What other things they have access too is a missing piece?
- Home health agencies would benefit from having safety information at the start of the care planning process. They try to get the info from CFI case managers. Does not seem to be collected and if is, not shared.
- Safety assessments should not determine eligibility, but should rather be a part of the initial care planning process. From an operations perspective, assessment could be derived from or completed in tandem with the MEA.

Q: How is the "number of individuals to be served" included in Appendix B determined? Is this determined by funding? By estimates of population?

- NH statue dictates a cap of spending, for home health agency services at 50% or 60% of nursing facility costs.

CFI WAIVER LISTENING SESSION NOTES
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- MEA assessments are not completed in a timely manner, and once completed, are not processed in a timely manner. Eligibility sometimes takes months, which is challenging, especially for clients who are in the hospital and need a quick decision.
- Organizations often start to provide services but unsure if payment will be made. This requires organizations to submit for reimbursement for services already provided.
- There are gaps in reimbursements for services. Gaps could be from a keying error- and takes months to fix. Random in length of time of gaps and reasons they occur. Agencies contact case managers, who are typically unable to assist with a resolution. Agency staff go directly to DHHS.
- Medicaid eligibility directly effects CFI eligibility.
    - Medical eligibility is not always completed within the same timeline as financial eligibility. A client could be approved for medical eligibility, and be receiving services with the assumption of reimbursement, but will not meet financial eligibility.
    - Case managers are typically responsible for resolving this issue, but if a client loses Medicaid, the case manager will sometimes withdraw from the case.
- Service authorizations and eligibility do not always matchup: Services will be delivered, but due to an administrative or processing error, the dates submitted for reimbursement do not match with the dates the client was receiving Medicaid. This can take months to resolve / clear up. Frequently, the issue cannot be resolved and the home health agency does not receive reimbursement.
- Process of how information shared effects eligibility, especially between DHHS, case managers, and home health agencies.
- **Performance measures in this section are really measures used to determine if the department is following their identified waiver process. The performance measures do not measure the performance of the services delivered by the waiver, or the outcomes experienced by individuals. -**
    - **Over the years there has been a decline in the number of RN and personal care service approvals-could be justified but Department is not able to answer.**

Appendix C

- Home Health Agencies provide home health aide, homemaker, personal care, and skilled nursing services.
- Adult medical day services- - reimbursement rate is $14/hour
- **Q: What is included in non-medical transportation?**
- Non-Medical Transportation- $8/unit, with a unit being a ride to or from a single location- Can be to grocery store, post office, etc. Difficult to bill and get reimbursement- therefore difficult to offer.
- Challenging from a reimbursement perspective-
    - PCSP Providers are able to provide non-medical transportation. PCSPs are still paid (by the agency) their normal salary, but are reimbursed at $8 / unit. The process for

submitting reimbursement for both PCSP services and non-medical transportation is cumbersome and time consuming.

  - From a policy perceptive- there are times when clients want to go out and go places. Since the service is difficult to bill for, and the reimbursement rate is so low, the service is not utilized. In this way, the spirit of the waiver is not being met. They are not really "living in the community". AKA community access! Reducing isolation and depression.
  - **Currently, PCSPs can complete errands for clients while the client remains at home. The messaging has been that if a PCSP can complete the errand or task on behalf of the client, then the client does not need to utilize the non-medical transportation benefit, and so units are not approved. However, this is not person centered, and clients are unable to secure things like haircuts, choose their own food items, or access the community.**

- Best to have the same person who is doing personal care also do transportation-
- Rate of pay for PCSP v homemaker- homemaker rate is higher the PCSP for same services. People washing the dishes are getting paid more than those bathing the client.
  - Different classification lines in the budget – one line might have gotten a bump and not the offer. Should be fixed
  - Operating your business is hard. Staffing issue created. Make more money at McDonald's then as a PCSP.
  - Now seeing more PCSP authorizations-which is a lower rate than homemaker services. PCSP can do both PCSP and homemaker role- PCSP is the lower rate.
- **The home health aide is often not put in the care plan when they are going in and out of Medicare. Have to stop a home health aide when Medicare is involved where they do not have to stop a PCSP. Could be a broader issue with Medicaid Managed Care.**
- Alarming the LNA is stopped and PCSP continues to provide services.
- Case Managers could get a flex fund to help keep people at home. Like an air-conditioner.
- Have home health companies work more with Case Managers instead of dictated too about services. More of a team approach from the start, including DHHS.
- Need more information from Case management when referred to home health for services- like physician orders, MEA- set standards.
- There is not description of why skilled nursing is needed. A better understanding of why skilled nursing is needed would allow home health agencies to better serve the client and would streamline service delivery.
- The organizations are putting more guidelines in before accepting a referral. Could there be a standard? Feels like they don't want to share much because they want you to take a high need or acute client.
  - Need clearer guidelines for information sharing
  - Even if the referral is for non-medical services- still need the medical information so PCSP can alert to issues
  - **Having access to MEA should be a requirement. Client and family have already answered the questions.**
- Lab services- is it expected of nursing visits? They do them but not really addressed. A physician will ask for a lab draw but a nursing visit is not authorized (or already done this week). So client needs is not met.

- It was suggested that regular Medicaid (go through MCO) could be billed- But not all those who are CFI providers are Medicaid providers.
- There are not limits in the rules that limit to nursing visits in policy
- Seems like checking I & R draws a few times a week in a facility is just a way of business, these clients are facility level of care- so why are lab services so limited?
- Nursing home level care=Nursing as needed!!!
- Lab services also include medication management.
- Coumadin is on the top of the list for ER visits.
- Allow some PRN visits. They used too until about a year or year and half ago.

Q: What is consolidated service?

- Not aware that congregate services where part of waiver.

Appendix D:

- Blended plans would be great- Case Management has plans, providers make plans- need to work together.
- Would be good to have more in-person meetings between all those serving the individual.
- Quality measures- if client needs a new service- home health org askes the Case Manager for change in plan of care/services. When redetermination is done is there a quality process to assure that the client's needs are being met from the services already in place? Not sure that is part of the process.

Appendix E:

- Current the waiver does not provide participant directed services. The current CFI model is more agency directed.
- Consumer directed options- Acentric Care Alliance in - all of their services are consumer directed. They have found that more recent clients have needed more assistance with self-direction. Amy shared what the benefits are- hiring someone from their church. Making a schedule that works for them.
- Challenges are around individuals with memory issues. Or consumers with mental health challenges may been more assistance. Becomes more agency directed but keep them involved as much as possible. Often have a representative involved.
- Several agencies' around the table include some level of participate directed.
- This group is support of adding participant direction language.
- Given the staffing shortages everyone is under- most around the table have included some hiring of friends/families to provide care.
- Moore Center has a model of creating a budget for consumers- consumer controls the budget- hiring and hours- etc.
    - Under this model a caregiver could take time off- the funds would just be used for the coverage. But if agency is controlling the budget- they can't hire someone else for a week while a caregiver goes on vacation
    - Might not sync with licensing of home health organizations. This would have to be addressed.

CFI WAIVER LISTENING SESSION NOTES
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Appendix F:

- Client are expected to go to DHHS for denials- since they are nursing facility level of care- this is difficult to go to DHHS for a hearing.
- The number for complaints of CFI providers go to "home health hotline". Health Facilities unit is that hotline. The waiver currently states that complaints go to BEAS. How is the home health hotline that is part of the home care bill of rights (all patients are given) getting to BEAS per the waiver?

Appendix G:

- No comments

Appendix H:

- Talked a bit earlier about authorization and eligibility process is clunky.
- There is an ad hoc way for providers to ask for different services based on their assessments. Would be good to have it clear and more team approach.
- Communication is a huge issue.
- Not really even sure how is the lead- under BEAS? BDS? Who is BEAS quality person described in waiver

Appendix I:

- There is a federal statute that says rates need to be economic, efficient, high quality, and support access to care. How is the State meeting this or being held to this.
- 5% increase a year ago…first in 10 years but still no finical accountability from the state that it meets the demands of the services.
- Is there is underserved or unserved because demand is outpacing staffing.
- When DHHS looks at this- they just cant look at what other states are paying- they need to look at the market.
- The rate setting methodology included in current waiver has expired. And been suspended by legislator- will have rewrite that whole appendix. They are state level rules – why isn't the current waiver amended?

Appendix J:

- No comment

General comment at end

- Move to other then fee-for-service payment- Move to population management.
- Needs to be a streamlined process for licensing CFI providers- less waiting. No need to go through full process for a name change.
- Fear of Managed Care-
    - Almost have to think of this waiver as it will not happen since step 2 is coming-
    - Role of Case Manager

  - How to get authorizations
  - Right now Case Managers don't have authority – give them more authority.
- Ability to have two people in the home and both get paid- with extreme obesity and need 2 assist.

Choices for Independence Waiver Renewal --- Listening Session
December 8, 2016
5:00-7:00pm
Brown Building Auditorium
General Public

Appendix A:

- No comments

Appendix B:

- PCSP v Home Health Aide:
  - Over the past few years- since PCSP services have been introduced, things that were traditional home health aide services are not PCSP. Is that the model moving forward?
  - PCSP vs home health aide services are really dependent on the individual's needs- both services should be available.
  - What are the reasons for an individual receiving one v other in their service package?
  - PCSP staffing is easier than LNA training.
  - Rates can be a challenge to staff both positions but more issue on PCSP side.

Appendix C:

- The services include are very beneficial to the individual.
- PCSP services are our most utilized.
- Companion services have dropped off for her organization.
- Coordination of services- Case Managers reach out to the organization to find services. Seems to work well.

Appendix D:

- Verbally receive information on the service plan in terms of what has been approved. Eventually get a paper copy from Xerox.
- Not sure how the service plan is developed. It is not her role.
- What is the difference between a care plan and a service plan? Do people use that inter-changeably and should they?
- Question was asked between participants in the learning session: Collaboration with other Case Managers to know what other services are in place; does this occur?

- Response: Sometimes it takes a two agencies to cover one service plan. In those cases, the Case Managers do facilitate that information is shared.

Appendix E:

- Not sure if organization has provided participate directed services.
- There have been scenarios where a client wants to bring a worker from another agency to still work with them even though they are now being serviced by another. They become the agency employee.

Appendix F:

- Asked the participant if it was her or her loved one in the waiver- what protections would you want in place? Response- to be able to talk to whomever I felt most comfortable with.

Appendix G:

- Nothing really specific comes to mind
- Her organizations is more pulled into helping keeping individuals safe

Appendix H:

- No comments

Appendix I:

- Questions or topic has been when will this population move into managed care, if at all? Are there additional dates? Updates from DHHS?
- Concern about how the whole transition happen to managed care, how will authorizations happen, will it increase the timeline since it is not an acute authorizations- please move to shorter durations.
- Does an organization have enough time to transition- get the right people in place?

Appendix J:

- Projections need to be in this section but have to balance that with the budget allowed by the department

Choices for Independence Waiver Renewal --- Listening Session
December 15, 2016
10:00am-12:00pm
Brown Building Auditorium
ARCH/General Public

Appendix A: Waiver Administration and Operations

- Who are the entities involved? Where in the department with the systems operations occur?

CFI WAIVER LISTENING SESSION NOTES
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Appendix B: Participant Access and Eligibility

- Concerns around timelines for eligibility
  - Initial evaluations are not being done within 45 days
  - Redeterminations are not timely so there is a gap in payment
- How is the number of individuals to be served determined?
  - For the provider that # is lower than it was 10 years ago
- Case Management is the lowest paid service within the waiver (this is historic)
- Recommendation: Eligibility be completed by other people than RNs
  - CFI is a medical program. The feds say that a medical social worker can do the eligibility process

Appendix C: Participant Services

- There should be the ability to bundle services
  - It used to be that someone living at an Assisted Living Facility (ALF) could attend Adult Medical Day Services; now CFI won't pay
- He-P 804 regulation group has begun discussion around nursing
  - Cost is an issue for some ALFs
- Adult Medical Day Services is disappearing
  - It's an amazing program
    - In the Lake Sunapee area it is no longer offered
    - In the Upper Valley, things are rocky
  - The infrastructure is problematic
- Recommendation: partner services and allow those living in Adult Family Care or Kinship Care to access Adult Medical Day Services (AMDS) like DD/ABD waivers do
- Rate needs to increase for AMDCs
- Case management is not under the CFI waiver; it is a state plan service
- Case management role in a residential setting is ill-defined; need specific expectations
  - Example: setting works with 5 CM agencies; two on top of eligibility, others don't know anything
  - ALFs don't know status of eligibility; would be helpful to know status
  - CM role should include eligibility
  - Recommendation: offer an expanded CM rate for expanded CM role (critical care situations). Mirror ABD waiver
- Recommendation: develop rate based on acuity
  - Broad rate looked at for level of care
  - Dual diagnosis people are more challenging
- Adult Family Care

    - model could work better with increased rate
    - has worked in the past with good oversight
- Infrastructure is problematic
    - Workforce issues create inability to implement care plans
- Disparity in who gets the higher number of hours
    - Needs to be an understanding of how hours are determined
    - Same tool should indicate the same number of hours and it does not
    - Recommendation: someone help the participant to advocate for more hours when the assessment is being done
        - Recipient can't express or doesn't know what they need
- Environmental Accessibility Services
    - Only four providers around the state for modifications and you need multiple quotes
        - Recommendation: only one quote needed if mod is less than $5,000
    - Cap it too low
    - Rumor has it that vehicle modifications would be included
- Recommendation: Personal Care Support be able to do transportation and be paid for the time
- Recommendation: Skilled Nursing fill automated pill dispensers
- Recommendation: increase respite beds from 20 to 30 days
- Recommendation: caregivers be paid for respite
- Recommendation: allow facilities to offer respite (expand networking)
    - Additional beds in facilities to be able to offer respite
    - Those doing respite have minimum stay requirements (7-10 days); this eats up bed days; often only need a few days
    - Regs say there is 21 days of respite
- Non-medical transportation mileage process needs streamlining; it's too cumbersome
- Consolidated services need to be improved
- Consumer directed services need to be implemented; make it an option in the waiver, currently it is not
- Additional services be added such as:
    - Support for employment
    - Heavy chore services
    - Companionship
- Meals-on-wheels:
    - People not getting meals that are needed
    - Some areas have 14 meals a week delivered

    - Sometimes the PCS staff are making meals, that is not accounted for in MOW numbers
- Workforce issue
    - No providers for residential services/home Care Providers
    - Need more providers in the Southwestern part of the state
    - Home Care Provider are dropping people once their Medicare funds run out
- Consumer Directed Services, Adult In-Home Supports, and Adult Family Care services are underutilized
- Workforce issues make it so you don't get services you need
- Communication needed regarding what respite beds are available; system for all to know of open beds

Appendix D: Participant-Centered Planning and Service Delivery

- Case manager goes out after referral often without the MEA
    - Need to be able to have access to MEA by CM and ALFs
    - Need to use technology so access is easy and available
- Participants compromise or go without due to workforce issues
- Level of service must be appropriate
- CM advocate for additional services; don't want the ability to do that to change
- Assessment/Level of Care/Outcomes all are important and should be connected
- Sometimes Medicaid is being cancelled and ALFs don't know; sometimes BEAS call ALF and let them know
    - CM may not know that it's being cancelled
    - With New Heights system they CM should get an email on the 15th saying that someone's Medicaid is going to expire the following month
- CM can't print out the MEA that they put information into
- Recommendation: participants sign off on their POC
    - Then there will be a printed copy and it can be given to all team members
- Recommendation: could Xerox portal include the redetermination date?
- Xerox: different person every time you call. When they don't call you back, you have to begin the process with a new person. Used to have regional people; that system was good
    - Timely payments occur with Xerox
    - Want MCOs to continue with timely payments

Appendix E: Participant Direction of Services

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- BEAS did Consumer Directed Services years ago. The system worked because the person decides what services they want, and they get the budget. Process would work on a larger scale.
    - Process needs constant education (intensive) as well as supports to fill in the gaps
- For younger participants this type of service might work. For older participants, the CM may be the only person in their life.
- Clients at any level will direct as best they can. Providers encourage them to do so and make sure they have the assistance needed.
- Diagnosis (Alzheimer's/MI) may prevent individual from knowing what support/need level is. Others can see all their needs; support services are critical

Appendix F: Participant Rights

- CMS now requires development of CFI Ombudsman within the next five years. How will the state do that?
    - Recommendation: expand the current office, not start another one. Someone answering the phones in Concord is not sufficient
- Case Manager is more important than the Ombudsman's office
- Recommendation: review rights and responsibilities with person

Appendix G: Participant Safeguards

- Concerns about abuse, neglect and exploitation, as well as self-neglect
    - DHHS response to these situations is limited
- Recommendation: need money to pay for guardianship (replicate the DD/ABD waiver)
- Annual licensing is a safeguard

Appendix H: Systems Improvement

- Recommendation: Using NH Easy and opening it up to all of the providers involved with the participant would be an improvement
- Issue with knowing what the income of the resident is when it comes time to do a contract with the resident. The residential provider only knows if the resident tells them. Resort to getting information from a friendly tech.
    - Providers used to get a worksheet from the state; this stopped four or five years ago

Appendix I: Financial Accountability

- Concerns around variable rates for different providers.
- Xerox: timely payments which is good. Old technology is not helpful
- The MCO portals are very helpful
    - Smaller providers may not be able to access portals

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Appendix J: Cost Neutrality

- Cost must be a certain percentage below institutional cost
  - Anything above 80% must be approved by the commissioner
    - Recommendation made to abolish the requirement
      - Person should be able to choose care as long as it's not 100% of institutional cost
    - The 50-80% requirement is in statute (RSA151E:11)so it is in the CFI waiver; this cannot be changed by the waiver submission

Additional Comments:

- Recommendation: Element of conflict free case management remain and be implemented
- Waiver be published before hearings
  - Yes and an email will be sent

Gateways Community Services

Choices for Independence Wavier Renewal Recommendations

December 15, 2016

Gateways Community Services submits to the Department of Health and Human Services (DHHS) the following recommendations for changes to the Choices for Independence Program (CFI) Medicaid Waiver as DHHS goes through the CFI Waiver renewal process. We are submitting this as part of the Listening Sessions. We believe these additions to and expansion of the CFI Waiver will strengthen the services to better meet the needs of the participants. This will would allow more of NH most vulnerable residents to realize the CFI Program purpose of being able to age in place, stay in their own homes and avoid costlier placements.

<u>New Services Recommendations</u>

New Service-Companion Service

Participants sometimes need socialization and companionship to combat the effects of the isolation that comes with being home bound. They would benefit from having a non-medical direct support professional with them for socialization and orientation. We recommend the CFI Waiver be amending to include a Companionship Service.

New Service-Consumer Directed Services

Consumer Directed Services is a model that has higher consumer satisfaction levels and less average cost then agency provided services. The BEAS Care Giver Grant is a consumer directed model and has worked well for years. We recommend that the CFI Waiver be amended to allow a robust Consumer Directed Services Program with a consolidated rate. This would require marking yes to the

check box in the Appendix J of the CFI Waiver which references that the NH CFI Waiver would have Consumer Directed Services.

It should be noted that even if the CFI Waiver is renewed with Consumer Directed Services include, infrastructure work and provider training will be needed for Consumer Directed Services to be delivered. This would be a n exciting new opportunity, especially for younger CFI participants or caregivers. For example, people could use a portal to manage their expenditures electronically.

New Service-Employment Support

Many of the CFI participants are younger and could have employment if they had the right personal care support. Encouraging employment for all NH residents is a DHHS priority. The CFI waiver should be amended to allow the CFI Supports to be available to eligible people who are employed or desire employment.

New Service-Enhanced Case Management

Independent Case Managers are excellent at supporting participants in the CFI Program. This support includes the personal centered planning and oversight the CFI services. Independent Case Managers also provide advocacy and community connections for participants. They are often the first person that the participant calls when they have problems.

Because of this role, they are being uniquely positioned to provide additional support to high need participants. Independent Case Managers could be providing intensive and targeted support to people who have mental health conditions or complicated health care needs or are high utilizers of medical services. This is not possible under the current rate system or the CFI Program rules. A higher Medicaid Case Management Rate would allow Independent Case Managers to do this with a smaller caseload. The goal would better health care outcomes and reduced utilization. We recommend that the CFI Waiver should be amended to include an Enhanced Case Management Service and rates.

Any changes to the Case Management Service should include continue to include conflict free in the definition.

New Service - Heavy Chore Services

We recommend that a new category of services, Heavy Chore, be added to the CFI Waiver. Heavy Chore would allow periodic heavy cleaning of a person's home. Some new participants to the CFI Program live in units that have not been cleaned in a very long time. The CFI Program allows light housekeeping but these participants need heavy cleaning to get their housing unit to a place where the light housekeeping can maintain it. There are also a few people who might need the heavy chore once a year to maintain a healthy living environment.

New Services-Provider Adequacy

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The CFI Waiver should be amended to allow BEAS comprehensive monitoring of provider adequacy throughout the state and new tools to address areas where there are not enough providers to meet the needs of the CFI participants living in the area.

Expansion of Current CFI Services recommendations

Expand Transportation Service

Transportation is repeatedly cited as one of largest barriers to living independently in NH. The CFI Waiver should be broadened to allow payment for more transportation options.

Transportation Services should be expanded to allow Personal Care Support Professionals (PCSP) to transport the participant on errands, to go work or go to medical appointments.

The definition of PCSP Services should be expanded to include reimbursement for the time the PCSP worker is providing the transportation.

Expanded Skilled Nursing Service

We recommend amending the CFI Waiver definition of Skilled Nursing Services to allow nurses to fill automated medication dispensing units. They are allowed to fill pill boxes but not the automated medication dispensing units.

Expanded Respite Services

We recommend that the CFI Waiver be amended to include the following Respite Program changes:

Increase the number of days per year allowed per person from 20 days to 30 days.

Allow reimbursement to caregivers for caregiver arranged respite, similar to how it is reimbursed in the BEAS Care Giver Grant. This would be respite which is not provided by a nursing home, residential care facility or home care provider.

Explore changes to the CFI Program that will make it easier for a nursing home or residential care facility to offer respite. There is a limited number of approved facilities which will accept CFI respite reimbursement under the current rules.

Expanded Eligibility and Medical Eligibility Assessment (MEA) Assessors

Registered nurses are the only staff allowed to complete the MEA. Shortages in RN availability has resulted in delays in completion of the MEA. This results in delays for people starting Prior Authorizations. Medical eligibility could be completed by a trained staff other than a RN. The recommend that the CFI Waiver should be amended to allow RN and or other non-RN staff to complete the eligibility tool.

Expanded Prior Authorization Timeliness

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Many CFI Service Authorizations renewals show in MMIS after CFI services begin resulting in claims denials. This takes much administrative time to search denied claims, wait for renewed Service Authorizations to show in MMIS, and finally resubmit these denied claims. This also impacts cash flow in organizations. Service Authorizations can be entered in Options and uploaded in MMIS system only after the State reviews and approves the medical redetermination of clients. Individuals continue to receive services before receiving Service Authorizations. Service Authorizations approval should be completed before providing services.

BEAS should explore any changes to the CFI Waiver which would improve the timeliness of the Prior Authorization process.

Expanded Adult Family Care and Kinship Care

The Adult Family Care and Kinship Care services have been underutilized in large part because of the rates. However, the Adult Family Care and Kinship Care services have been underutilized because there is no infrastructure in place to promote and support it. We recommend a review of the Adult Family Care and Kinship Care rules to identify any ways to enhance the infrastructure so that more AFC homes would be opened up and more families would be reimbursed to take in family members on the CFI Waiver and in need of residential support through Kinship Care.

Expanded Environmental Accessibility Services

We recommend that the CFI Waiver definition of Environmental Accessibility Services be expanded to include vehicle modification.

Rates Adequacy

The rates for all services are not adequate, especially Home Care, Independent Case Management, Adult Medical Day Care, Supportive Housing, Residential Care Programs and Respite. This has negative impact. The overall NH provider network is not adequate because it is not financially feasible to provide services in all parts of the state. There are not enough Supportive Housing or Residential Care Housing because program developers will not do new units with the current rates. Adult Medical Day Care Programs continue to close because of reimbursement rates. All level of workers cannot be recruited because the wages are low because the reimbursement rate is low. Few approved respite facilities do Respite because of the rates.

We recommend increases in all CFI contracted provider rates.

Gateways is grateful for the opportunity to provide this feedback. We would also welcome the opportunity to answer questions or discuss and of these ideas. If there are any questions, please contact LaVonne Colon.

Submitted by

LaVonne Colon

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