

**Responses to Comments on the New Hampshire Choices for Independence [CFI]
Home and Community Based Services [HCBS] 1915c Waiver Renewal
Public Input Process January 30, 2017 through March 30, 2017**

Comment 1: One commenter and one stakeholder group asked about the status of incorporating the requirements of New Hampshire HB 461 [2014] regarding the Nursing Facility Special Income Standard into the waiver renewal.

Response 1: The Department has addressed this in the final draft of the waiver renewal application in Appendix B.

Comment 2: A number of commenters expressed concern about the amount of time it takes for initial Medicaid eligibility and annual Medicaid eligibility redetermination processes and asked that the Department find ways to streamline these processes.

Response 2: The Department appreciates the suggestions made to streamline these processes and is working to implement strategies to reduce the amount of time between application and Medicaid State Plan eligibility.

Comment 3: Several commenters asked about presumptive eligibility for CFI Waiver applicants.

Response 3: The Department appreciates the importance of presumptive eligibility as a way in which CFI Waiver service requests can be expedited and is working in consultation with the Centers for Medicare and Medicaid Services to determine how we can align the requirements of RSA 151-E:18 with federal requirements for presumptive eligibility for individuals with disabilities and elders.

Comment 4: Several commenters suggested the Department implement an advanced filing period to allow prospective CFI Waiver applicants to request CFI Waiver services before their financial resources are fully spent down and their State Plan Medicaid eligibility determined.

Response 4: The Department appreciates this suggestion and will continue to work on ways in which requests for CFI Waiver participation can be streamlined as soon as an individual's State Plan Medicaid eligibility has been determined.

Comment 5: Several stakeholder groups applauded the state's efforts to use the MDS or OASIS in place of the state's MEA assessment, when available, for initial and annual CFI Waiver eligibility and level of care determinations. Several other commenters indicated this is a positive change.

Response 5: The Department appreciates this feedback.

Comment 6: Stakeholders recommended several additional services be included in the CFI Waiver menu of services, including a Companion Service to provide non-medical support for socialization and orientation, an Enhanced Case Management Service for individuals with

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mental health challenges or complex medical conditions and Heavy Chore Services to allow for periodic heavy cleaning of a person's home. Additionally, it was suggested that the Department review its administrative rules regarding the provision Adult Family Care and Adult Family Care provided by family members and increase the rate paid for this service.

Response 6: The Department appreciates these suggestions, but due to fiscal constraints, is only considering adding the new services requested (Supported Employment, Participant Directed and Managed Services and Financial Management Services) in the waiver renewal application at this time. The Department welcomes increased use of the Adult Family Care service, is willing to explore areas where the administrative rules governing this service could be amended to enhance the use of this service and encourages providers to explore this service option with waiver enrollees. Rate adjustments to the Adult Family Care service will be considered as part of the rate setting process.

Comment 7: One stakeholder group requested that the Department, in its rate setting methodology, consider an annual rate review instead of the proposed biennial review. A number of commenters indicated that the rates for CFI Waiver services need to be increased. Another asked if all rates for all services would be considered during rate setting.

Response 7: The Department's approach of reviewing rates on a biennial basis is intended to provide a higher level of predictability during the biennial budget process. Rate increases are considered during the rate setting and budgeting processes. Rate setting will address all rates for all services.

Comment 8: Several stakeholder groups were pleased to see non-medical transportation as an adjunct service to personal care. The groups wanted clarification around billing for the service; specifically whether it would require a separate service authorization and whether or not non-medical transportation could be provided at the same time as personal care services. There were also questions about the adequacy of the rate.

Response 8: The Department appreciates the importance of aligning non-medical transportation and personal care services. A separate service authorization is needed for each service; however, both services can be provided to an individual in accordance with the person centered plan without formally stopping one service to begin the other. The mileage rate is intended to provide access to the non-medical services in the person centered plan in the individual's home community.

Comment 9: One stakeholder group suggested including information in the waiver renewal about the State's proposed movement of CFI Waiver services into its managed care program and suggested further that the state address how it plans to transition individuals from nursing facilities into the community and the number of individuals who will be transitioned.

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Additionally, they felt it was important to include how many positive responses are given to Section Q [of the MDS] and forwarded to Service Links on an annual basis.

Response 9: The waiver renewal does not include information about the Department's proposed movement of CFI Waiver services into its managed care program because this is to be addressed in a future waiver amendment. The waiver renewal does include information about how a nursing facility resident can access CFI Waiver services as an alternative to nursing facility services by indicating this preference in Section Q of the MDS.

Comment 10: Several commenters expressed concern about the lack of providers and direct support staff and suggested the Department evaluate provider and direct support staff adequacy statewide.

Response 10: The Department appreciates this recommendation and will continue its work to promote provider and workforce capacity through follow through on initiatives such as the 2016 Governor's Commission on Health Care and Community Support Workforce.

Comment 11: Several commenters expressed concern about delays in determining initial CFI Waiver eligibility because of the delay it causes in starting CFI Waiver services, citing safety concerns for those who are waiting for services. In addition, concerns were raised about delays in CFI Waiver eligibility annual re-determinations, noting that these delays have a negative effect on service providers' ability to bill for services that are being provided ongoing.

Response 11: The Department appreciates these concerns as well as the suggestions made to streamline initial CFI Waiver initial eligibility and CFI Waiver annual redeterminations and has incorporated a number of suggestions made by stakeholders to address this. Examples include the addition of Skilled Professional Medical Personnel as assessors/evaluators of CFI Waiver initial and on-going eligibility and the use of additional level of care assessments/instruments in addition to the state approved MEA such as the MDS and the OASIS when available.

Comment 12: One commenter suggested that the waiver renewal was lacking performance measures for timely eligibility determination, service authorizations and notice of service coverage denial.

Response 12: The Department appreciates this input and notes that assurances regarding participant access, eligibility and participant rights of appeal are found in the narrative sections of the waiver renewal application. A performance measure has been added to assess the length of time between a request for CFI Waiver services for a Medicaid eligible individual and the Department's response to this request.

Comment 13: One stakeholder group recommended changing the language referencing "medication administration" and suggested it should include medication oversight and not be

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provided only when an individual needs physical assistance with taking a medication. Likewise, the group suggested the acceptable list of qualifying “ADLs” should reflect the definition of ADLs contained in He-E 802, the supporting state regulations for RSA 151-E.

Response 13: The Department uses the term “medication administration” as referenced in NH State Statute RSA 151-E; likewise, the activities of daily living included in the Waiver Renewal are included as referenced in the state statute.

Comment 14: One stakeholder group was concerned that language in the waiver draft appears to be different from the language in the waiver renewal regarding cost limits, suggesting that a new cost limit is being introduced. Several commenters suggested that the Department eliminate the requirement that limit costs to 80% of nursing facility costs and others requested that all of the language in RSA 151-E:11 specific to cost limits be articulated in the Waiver renewal.

Response 14: The CFI Waiver currently operates in accordance with the cost limits articulated in NH State Statute RSA 151-E:11. The waiver renewal application has been updated to clearly articulate the elements of RSA 151-E:11 specific to cost limits.

Comment 15: One commenter suggested that Title XIX participants that have been declared to be Medically Frail and are covered under the CFI Waiver be exempt from mandatory Managed Care enrollment and be allowed to enroll under a Qualified Health Plan [QHP]; the same commenter suggested that the healthcare needs of CFI Waiver participants is “more than any single payer insurance program can provide.”

Response 15: The Department appreciates this observation; however, the medically frailty designation is specific to eligibility in the NH Health protection program (NHHPP). Moreover, anyone in the NHHPP who identifies as medically frail is excluded from QHP coverage under the Section 1115(a) demonstration waiver that governs the Premium Assistance component of the NHHPP. Adopting this suggestion would be inconsistent with how medical frailty is currently treated within New Hampshire’s Medicaid program. .

Comment 16: One stakeholder group stated, it is unclear why both “spousal impoverishment rules *are* used” and “spousal impoverishment rules *are not* used” are checked off.

Response 16: In this section of the Waiver Renewal application, there are two different time periods under which requirements for spousal impoverishment apply, accounting for why both areas are checked.

Comment 17: One stakeholder group was concerned that the review standards are lower than the current waiver. For example the “operating agency performance monitoring” is currently a

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100% review. The waiver renewal is “less than 100%”. Additionally, the “data aggregation and analysis” is currently done quarterly, but will only be done annually under the waiver renewal.

Response 17: The Department has revised the performance measures in the Waiver and has elected to use a sampling approach with annual data aggregation and analysis as opposed to 100% review and monthly/quarterly data aggregation and analysis.

Comment 18: One stakeholder group recommended the use of independent case managers by nursing home residents when Service Link is not available.

Response 18: The Department appreciates this recommendation and is open to exploring ways in which Transitional Case Management services, in addition to the resources available from Service Link, can be of value to nursing home residents who are interested in transitioning from institutional to home and community based services.

Comment 19: One stakeholder group recommended that legally responsible persons, relatives and/or legal guardians be permitted to provide Adult Day Health citing that under the current waiver, relatives are permitted to provide the service and, in fact, do so in many culturally-diverse homes in NH. For example, in the Nepali culture, it is very common for a relative to care for another family member in this way. It is also recommended that this service be available as a “participant directed” service.

Response 19: The Department recognizes and supports the provision of culturally appropriate services and services provided by relatives. The Renewal application has been amended to allow for this and for this service to be provided under the Participant Directed and Managed Services category when appropriate.

Comment 20: One stakeholder group felt the increased cap of \$15,000 every five years [vs. a lifetime cap of \$15,000] for environmental accessibility services was too low. Additionally, they requested this service be available under the participant directed model. The group also identified that providers of environmental accessibility services should not have to be a Medicaid provider as outlined in the waiver.

Response 20: The Department appreciates the observation regarding the modest increase in the amount of Environmental Accessibility Adaptations that can be accessed under the Waiver and believes that the increased funding available to CFI Waiver participants will be beneficial.

The Department also appreciates the recommendation that this service be added to the menu of services available to individuals who elect to use Participant Directed and Managed Services and has made this change in the Renewal application.

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Under the current Waiver, providers of this service are required to be enrolled Medicaid providers. This is an important requirement which assists the Department to ensure the integrity of the providers being approved to utilize Medicaid Waiver funding.

Comment 21: One stakeholder group asked that the reference to “Specialized Medical Services” be explained/defined.

Response 21: The Department appreciates this request for clarification. This term has been corrected to reflect “Specialized Medical *Equipment* Services”.

Comment 22: One stakeholder group questioned why non-medical transportation was not included in the list of participant directed services.

Response 22: The Department appreciates the recommendation that this service be added to the menu of services available to individuals who elect to use Participant Directed and Managed Services and has made this change in the Renewal application.

Comment 23: One commenter recommended a review of CFI Waiver administrative rules to remove regulatory barriers to service provision.

Response 23: The Department recently undertook a review of the CFI Waiver administrative rules and is interested in hearing from stakeholders regarding specific areas that can be improved.

Comment 24: One stakeholder group suggested the Department add specific language to the waiver specifying that an individual can retain services pending appeal as specified in the He-E 801.07 so long as the appeal is filed within 15 calendar days of the date of the notice.

Response 24: Participants’ option to continue to receive services pending appeal has been clarified in the Waiver renewal application.

Comment 25: One commenter questioned why the performance measures had been modified from the current waiver and cited concern that measures in the renewal do not assure a waiver participant’s health and welfare. The same commenter suggested measuring the length of time from the CFI Waiver clinical assessment to the services being authorized and billed.

Response 25: The Department has included a number of new performance measures in the waiver renewal application as well as information in Appendix G specific to participant safeguards. Examples of performance measures addressing health and safety include those related to risk assessment, review of sentinel events and the provision of information to all participants regarding how to recognize and report abuse, neglect and exploitation. The

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Department has also added a performance measure to evaluate the timeliness of CFI Waiver service authorization requests.

Comment 26: One attendee at a public hearing requested detailed information about the Statewide Transition Plan.

Response 26: NH's Statewide Transition Plan can be found at:
<https://www.dhhs.nh.gov/ombp/medicaid/draft-transition-framework.htm>

Comment 27: One attendee at a public hearing asked for the definition of Skilled Professional Medical Personnel. Another commenter requested that the definition, in addition to the federal regulatory reference, be added to the waiver renewal.

Response 27: Per 42 C.F.R. section 432.50(d)(1)(ii): Skilled professional medical personnel have professional education and training in the field of medical care or appropriate medical practice. "Professional education and training" means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care. The skilled professional medical personnel are in positions that have duties and responsibilities that require those professional medical knowledge and skills. The definition has been added to the waiver renewal.

Comment 28: Attendees at a public hearing asked if a current service provider or provider agency could apply to be an enrolled Medicaid provider of Financial Management Services.

Response 28: Yes.

Comment 29: An attendee at a public hearing questioned whether or not Participant Directed and Managed Services provided by Licensed Nursing Assistants, Licensed Practical Nurses and Registered Nurses were in violation of the NH Nurse Practice Act. The same attendee stressed the importance of ensuring that licensees receive the level of supervision appropriate to their licensure.

Response 29: The Department appreciates the importance of ensuring that services provided to CFI Waiver participants, regardless of whether or not they are provided under the Participant Directed and Managed Services model or under traditional service models, be provided in accordance with the NH Nurse Practice Act. To this end, Appendix C includes specific

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references in the Provider Specifications section, where appropriate, regarding providers licensed under RSA 326:B, the NH Nurse Practice Act.

Comment 30: One commenter indicated that it was unclear if the rate setting methodology outlined in the waiver renewal applies to all waiver services or to a subset of services.

Response 30: The rate setting methodology outlined in the waiver renewal applies to all services, not just to a subset of services. This has been clarified in the waiver renewal application.

Comment 31: One attendee at a public hearing asked if the Department considered moving Targeted Case Management from the State Plan to the CFI Waiver during the renewal process.

Response 31: The Department has no plans to change how Case Management is provided at this time.

Comment 32: One attendee at a public hearing asked why the initial waiver renewal draft did not include Adult In-Home Care, a long-standing but infrequently utilized CFI Waiver service.

Response 32: The Department considered eliminating this service in the waiver renewal because less than 10 participants currently access Adult In-Home Care services and because the service is similar to another waiver service. The Department followed up with inquiries into whether or not another waiver service would meet the needs of those currently receiving this service and found that eliminating the service and introducing a new service would cause a disruption in services. Based on this feedback the service has been added back into the waiver renewal application.

Comment 33: Several commenters expressed concern that references to the Bureau of Elderly and Adult Services in the current approved waiver have been replaced in the waiver renewal application with references to the Office Medicaid Services.

Response 33: Although the waiver renewal document does not specifically reference the Bureau of Elderly and Adult Services, the NH DHHS Office of Medicaid maintains its commitment to ensuring that the needs of adults with individuals and elders are met.

Comment 34: Several commenters suggested that individuals with co-occurring mental illnesses should be eligible to receive CFI Waiver services.

Response 34: The CFI Waiver currently serves, and will continue to serve, individuals who meet the eligibility criteria outlined in RSA 151-E:3, including those who may have a co-occurring mental illness.

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Comment 35: One commenter stressed the importance of ensuring on-going supports in the workplace for participants accessing the newly proposed Supported Employment service.

Response 35: The Department concurs with this observation and believes this is captured in the service definition which references ongoing supports to “obtain and maintain an individual job” in competitive employment in an integrated work setting.

Comment 36: One commenter noted that in Appendix F-1 of the waiver renewal there is language that could be interpreted as suggesting that an adverse decision could be made by the Department without being issued in writing. The same commenter indicated that a specific reference to service continuation pending appeal should be specifically included in the waiver renewal. Another commenter indicated that information about timely notice of service coverage denial needs to be articulated in this section.

Response 36: The Department appreciates these observations and has amended the waiver renewal application to specify the notice requirements in the administrative rule governing CFI Waiver services He-E 801, which includes assurances regarding continuation of services pending appeal.

Comment 37: One commenter noted that references to eligibility criteria should align with state statute and not include additional descriptors or qualifiers.

Response 37: The Department appreciates and agrees with this observation and has made amendments to the waiver renewal where appropriate.

Response 38: One commenter suggested that the Department should consider amending the State Plan and the CFI Waiver renewal application to include individuals age 65 and older who buy into Medicaid.

Response 38: The Department appreciates this suggestion and will explore this recommendation further as it considers additional ways, beyond the state’s current MEAD [Medicaid for Employed Adults with Disabilities] program, to support waiver participants who wish to work.

Response 39: One commenter suggested refining the definition of personal care services to eliminate references such as skill acquisition that may be inappropriate for elders and others receiving services under the CFI Waiver.

Comment 39: The Department appreciates this recommendation and has made corresponding changes in the definition of personal care.

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Comment 40: One commenter recommended changes to Appendix G-3c, specifically to include references to medication administration by unlicensed assistive personnel.

Response 40: The Department appreciates these recommendations and has incorporated them into Appendix G.

Comment 41: While the majority of those who provided comments strongly support the addition of Participant Directed and Managed Services [PDMS], one stakeholder group expressed concern that this service could put waiver participants at risk.

Response 41: The Department appreciates the positive feedback regarding the addition of PDMS and also acknowledges the concerns of the stakeholder group. In response the Department has added a performance measure to the waiver renewal that measures the extent to which PDMS service records demonstrate that provider qualifications reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services.

Reagan, Lorene

From: Amy Moore <AMoore@ascentria.org>
Sent: Tuesday, February 28, 2017 7:52 PM
To: DHHS: NHCFI Waiver Renewal Input
Subject: CFI Waiver Renewal Application- Questions/Comments

CFI Waiver Renewal Application Comments/Questions

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Services
Service Name: Non- Medical Transportation

This section describes the provider qualifications, but there is no information on authorizations or billing.

- How will non-medical transportation be authorized? Will it be included in the service authorization or will there be a separate authorization for transportation?
- How will we bill for non-medical transportation?
- The current system makes it very difficult for providers to track and bill for. Non-medical transportation is a necessity for our consumers. Personal Care Service Providers must be able to perform essential errands with their consumers, such as grocery shopping, post office, banking, etc.

Thank you,
Amy

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Reagan, Lorene

From: Jeff Dickinson <jdickinson@gsil.org>
Sent: Tuesday, February 28, 2017 6:59 PM
To: DHHS: NHCPI Waiver Renewal Input
Cc: Dickinson, Jeff
Subject: comments on the 2017 draft CFI waiver amendment

Hello. Please accept these comments on the 2017 draft CFI waiver amendment.

For many years now a number of CFI provider agencies including GSIL, Ascentria, and Crotched Mountain have been meeting with representatives of DHHS to attempt to address the transportation needs of the consumers they serve. All along, these providers have requested the ability to bill as a CFI service non-medical transportation provided by personal care workers to CFI consumers to meet goals related to accessing the community in their care plans. Initially the response of DHHS was that non-medical transportation categorically cannot be billed as a CFI service, a position that we disagreed with based on our reading of written guidance from CMS that we felt indicated that this in fact is possible if NH requested it as part of the CFI waiver.

As a compromise DHHS offered to CFI providers a way for personal care workers to bill for non-medical transportation as a separate non-CFI service at a rate of \$8 per trip. A couple of agencies did small pilots of this arrangement and provided feedback to DHHS that it was not workable for a number of reasons: the system of billing was unclear, it took a very long time for workers to be paid for rides they provided, and the time-keeping and bookkeeping requirements of accounting for these two types of services was unmanageably complicated. After this, most CFI providers felt compelled to discontinue offering non-medical transportation to consumers as an available service leaving some consumers unable to access the community. It was communicated to DHHS that what would really help CFI providers assist their consumers is to have the ability to include non-medical transportation as a CFI personal care service to be billed just like all other CFI services rather than as a separate service.

In recent feedback sessions as well as one-on-one meetings with representatives from DHHS, we have made the above request, and our understanding was that non-medical transportation would be in the new CFI waiver amendment. It is heartening to see that the language specifically barring transportation as a personal care service in Appendix C has been removed and that transportation is listed as a service under personal care services. We are hopeful this means that CFI providers will finally be able to bill for transportation as a CFI personal care service. However, the section on non-medical transportation in Appendix J still shows the current rate of \$8 per trip for this service set in the unworkable compromise arrangement described above.

We respectfully request that DHHS clarify its intent and we renew our request that the waiver amendment be written in such a way that non-medical transportation can be billed as a CFI personal care service when it is included in the consumer care plan so that consumers can have more access to the community.

Thank you to DHHS for your willingness to collaborate with us over the years to resolve this issue.

Jeff Dickinson
Advocacy Director

E-mail is the best way to reach me: jdickinson@gsil.org

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February 28, 2017

Lorene Reagan
NH Department of Health and Human Services
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RE: CFI Waiver Renewal

Ms. Reagan,

I am writing on behalf of the Granite State Home Health Association (GSHHA) to offer comments on the State of New Hampshire's draft Choices for Independence (CFI) Waiver Renewal. GSHHA is a non-profit membership organization that advocates for home care agencies and the people they serve.

GSHHA's member agencies are essential providers of home-based care for over 2500 vulnerable citizens who rely on CFI long-term services and supports to remain independent. Home care agencies provide skilled nursing care, home health aide services, personal care services and homemaker services. GSHHA's members range from large, non-profit providers to small, community-based organizations and private businesses. In SFY 15, the last year for which GSHHA has access to public CFI data, New Hampshire's home care agencies provided:

- More than 37,000 nursing visits
- Over 46,000 home health visits that lasted less than 2 hours
- Nearly 110,000 hours of home health aide services for longer visits
- 1,400,000 hours of personal care services

The Granite State Home Health Association appreciates NH DHHS's efforts to seek input from CFI stakeholders. The Listening Sessions provided a unique opportunity for collective dialogue regarding ways to improve the Choices for Independence Program. Below are GSHHA's comments on information shared in the draft waiver document and at the Public Hearings in February.

CFI Draft Waiver Document - APPENDIX B

The Granite State Home Health Association supports NH DHHS's proposal in Section B-6 (Evaluation/Reevaluation of Level of Care) to allow determination and redetermination of level of care to be based on the Medical Eligibility Evaluation (MEA) or information in the current MDS or OASIS. Timely processing of determinations and redeterminations has been a challenge for New Hampshire's CFI program. Allowing DHHS's qualified medical professionals to evaluate applicants based on information in clinical assessments that may already have been completed will eliminate redundancy and should improve timeliness of determination and redeterminations.

CFI Draft Waiver Document – APPENDICES E and C

The Granite State Home Health Association opposes the addition of Participant Direction of Services to New Hampshire's Choices for Independence Program. As home care providers, our member agencies fully support consumer engagement in their care. In fact, New Hampshire's Home Care Clients' Bill of Rights (RSA 151:21-b) affirmatively states that clients have *a right* to (c) "participate in the development and periodic revision of the plan of care and (f) "suggest changes in service or staff."

There are both practical and technical reasons why we oppose participant direction of services in the CFI program. From a practical perspective:

- We believe that oversight from licensed home health agencies is critical to safeguard New Hampshire's vulnerable CFI population, including assuring that participants are free from harm and appropriate services are being provided. CFI participants are eligible for 24-hour nursing care, and for the most part are elderly and in declining health. While this does not preclude their ability to direct their services, it is important to recognize that CFI participants are medically fragile and vulnerable. Some clients may initially be able to direct services, but declines in health or cognition may unknowingly hinder the continuation of their management capability.
- NH DHHS's draft waiver does not have sufficient safeguards for participants who choose to self-direct their care. A recent report from the United States Government Accountability Office entitled *CMS Could Do More to Harmonize Requirements across Programs* focused on the risks inherent in provision of in-home personal care services. While Section E-1 of the Waiver Document states that "The Case Manager will work in partnership with the participant to ensure that all aspects of the person-centered plan are implemented," this does not meet CMS's requirements for states to safe-guard beneficiaries, as outlined in the GAO Report. It neither constitutes a quality assurance system that continuously monitors health and wellbeing, nor does it measure individual outcomes. It does not assure that the participant is free from abuse, neglect or exploitation, or that critical incidents will be reported. By virtue of their state license, home care agencies – whether licensed under New Hampshire's He-P 809 rules or He-P 822 rules – are required to do these things, while individuals who would provide participant-directed services are not.
- New Hampshire's Governor, Legislature, and Department of Health and Human Services have indicated their intent to transition CFI waiver services to managed care organizations soon, possibly as early as January 2018. This will be a major change in the provision of CFI services for both providers and beneficiaries. Introducing participant-directed services now will add confusion for beneficiaries, providers, and managed care organizations that will soon be adjusting to a new delivery system.

From a technical perspective:

- State law precludes registered nurses, licensed practice nurses and home health aides from providing services – as individuals – to clients. NH RSA 151:2, I(a) requires licensure of home health providers, as defined in RSA 151:2-b in order to provide nursing, home health aide, physical rehabilitation services, personal care and homemakers services. Agencies that provide medical services are licensed in accordance with NH He-P 809 rules. Agencies that provide personal care or homemaker services are licensed under NH He-P 822 rules. Both sets of rules include standards for agency administration, employee qualifications, scope of services, supervision, training, quality assurance, and complaint processes. Licensed agencies must follow the Home Care Clients' Bill of Rights and comply with RSA 151:26-a, which includes important consumer protections for the discharge of home care clients. The CFI Draft Waiver Document that allows for participant-directed employment of individual nurses and home health aides is contrary to New Hampshire's laws and rules.

- **New Hampshire’s Nurse Practice Act (RSA 326-B) and its corresponding rules include important scope of practice requirements that create supervisory roles for licensed professionals and do not allow for direct participant supervision.** For instance, licensed nursing assistants (home health aides) must be supervised by a RN or LPN, a LPN must be supervised by a RN, and a RN may only work under a plan of care developed by a physician. This creates a complex hierarchy of employment that participants would need to follow if they were to direct their own medical care. We are uncertain how DHHS would assure individual participants and their employed providers would follow all facets of the Nurse Practice Act.
- **GSHHA is extremely concerned that NH Medicaid would enroll home-based providers who lack training, oversight and offer no consumer protections.** NH RSA 151:2-b,V allows for “individual home care service providers” to solicit and provide personal care or homemaker services. These providers must be “registered” under He-P 820 rules and complete a criminal background check and state registry check. While these types of providers may qualify for participant-directed employment, they have no requirements for training, minimum qualifications, oversight, or quality assurance processes. They are not required to comply with the Home Care Clients’ Bill of Rights and discharge requirements which afford important consumer protections.

GSHHA believes that the practical and technical reasons cited above demonstrate that participant direction of services is unfeasible for New Hampshire’s Choices for Independence Program. Most importantly, we believe that CFI beneficiaries should have the consumer protections and safeguards that the current agency system provides. We believe that consumer involvement in their own care is already a right and a requirement afforded under New Hampshire law. **We urge DHHS to delete the participant direction of service option from the draft waiver, along with any coordinating services – such as Financial Management Services – that are otherwise unnecessary.**

CFI Draft Waiver Document – APPENDIX I

GSHHA supports NH DHHS’s addition of a Rate Setting Methodology that is based on the CMS Home Health Prospective Payment System Market Basket Update. Current CFI rates do not cover the cost of providing home care and other services. In the past, the Department has failed to follow NH RSA 126-A:18-a which requires establishment of a rate-setting methodology for home health services, and annual rate-setting that reflects the average cost to deliver services. As a result, inadequate reimbursement rates have led to a deterioration of the CFI home health provider network and negative impacts on access to care, especially in rural parts of the state. Including a rate-setting methodology in the 5-year waiver proposal gives some assurance to providers that NH DHHS recognizes and is willing to respond to the financial challenges facing CFI providers.

The Home Health PPS Market Basket Update is a reasonable indicator of the increasing cost of doing business for home care agencies. The Draft Waiver Document proposes that the rates be updated on a biennial basis. We assume this is because the NH Legislature adopts a biennial budget. However, it’s essential that rates be updated annually in compliance with state statutory requirements and to ensure that rates reflect the increasing cost of labor, benefits, insurance, and administrative requirements. **We urge DHHS to amend the waiver to set rates *annually*, utilizing the CMS Home Health PPS Market Basket Update in the first year of the biennium, and an average rate based on a 3-year rolling trend of the CMS Home Health PPS Market Basket Update in the second year of the biennium.**

CONCLUSION

New Hampshire's Choices for Independence Draft Waiver Document forms the basis for a critical program to help some of the Granite State's most vulnerable citizens remain independent at home and engaged in their communities. A strong CFI program can also help the State avoid the expense of higher cost institutional settings. The Granite State Home Health Association believes that the CFI program will be strengthened by the new assessment tools for determination and redetermination, and an annual provider rate increase based on the CMS HHPPS Market Basket Update. We are concerned that the CFI program will be weakened by addition of Participant Direction of Services, because the proposal lacks important safeguards to protect individuals from harm and exploitation, reduces consumer rights, and contradicts existing New Hampshire laws that are designed to protect the public.

The Granite State Home Health Association members appreciate the opportunity to provide input on New Hampshire's Draft CFI Waiver Document. We welcome continued dialogue regarding the Choices for Independence Program.

Respectfully,

A handwritten signature in black ink, appearing to read "Gina Balkus", with a long horizontal flourish extending to the right.

Gina Balkus
Chief Executive Officer

Reagan, Lorene

From: Earle Kolb <earlectric@rocketmail.com>
Sent: Tuesday, February 28, 2017 1:49 PM
To: DHHS: NHCFI Waiver Renewal Input
Subject: CFI Waiver Amendment
Attachments: HCBC-CFI Waiver Amendment Request.docx

To Whom It May Concern:

Please find the attached document available for your perusal and I hope to follow-up with you should you have any questions about my amendment request. Also, I shall forward a PDF copy of the attachment as soon as I am able to do so.

Regards,

Earle W. Kolb

HCBC-CFI Waiver Amendment Request

Title XIX consumers that have been declared to be Medically Frail and are covered under the HCBC-CFI Waiver shall be exempt from mandatory Managed Care enrollment and be allowed to enroll under a Qualified Health Plan (QHP) of their choice under the exchange. Re-enrollment under any sort of fee for service system shall be considered antiquated for those of whom that are covered under the HCBC-CFI Waiver as their healthcare needs simply require more than any single-payer insurance program can provide.



NEW HAMPSHIRE LEGAL ASSISTANCE

Working for Equal Justice Since 1971

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February 28, 2017

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TTY: 1-800-735-2964

Lorene Reagan
NH Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord, NH 03301
Via E-Mail: nhcfiwaiverrenewalinput@dhhs.nh.gov

Re: Comments to the New Hampshire Department of Health and Human Services' Proposed Choices for Independence Waiver Renewal Application

Dear Ms. Reagan:

Please consider this letter the written comments of New Hampshire Legal Assistance (NHLA) regarding the New Hampshire Department of Health and Human Services' (Department) proposed 1915(c) waiver application for the Choices for Independence (CFI) program. NHLA submits these comments on behalf of our disabled and elderly clients who are eligible for services through the Choices for Independence Program.¹

NHLA applauds the Department for including participant-directed services in its renewal application. However the proposed application fails to include some important provisions to ensure timely access to services under the CFI program.

NHLA fully supports the comments submitted by the Disability Rights Center-NH and Michelle Winchester and offers the following additional comments:

The CFI Waiver Renewal Executive Summary distributed by the Department in January 2017 acknowledges that one of the themes from the five listening sessions it held included: "Recommendation for streamlining the eligibility and redetermination processes, consideration of a 3 month retroactive service coverage to address timeliness of initial eligibility and redeterminations and implementation of presumptive eligibility." Despite this acknowledgment of the need to streamline the eligibility and determination processes, there is nothing in the proposed renewal application that addresses this issue.

¹ NHLA submits these comments without prejudice to the right of our law firm and/or our clients to make additional claims or take different legal positions should this matter proceed to litigation. The absence of comments relative to any provision not specifically discussed does not necessarily reflect support of the provision, nor agreement that the provision is lawful.

For many years now, CFI applicants and recipients have experienced significant delays in getting approved or recertified to participate in the CFI program. The delays are found both in making the financial eligibility determination and level of care determination. Since there is no retroactive coverage for the CFI program, these delays mean that frail elderly and disabled adults are waiting months to receive critical services, which can have serious consequences, including death. And because they have to spend down their resources before they can apply for the CFI program, they do not have the funds available to private pay for those services. This also results in assisted living residents who are awaiting approval of their CFI application being issued discharge notices when they cannot afford to pay for their residence fee.

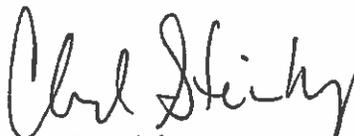
This problem persists despite the fact that there is a state law, RSA 151-E:18, that allows for "presumptive eligibility" of CFI applicants who are likely to be eligible for services. This law went into effect nearly ten years ago—in 2008. However, since that time very few, if any, presumptive eligibility applications have been processed by the Department.

While implementation of the presumptive eligibility process would be a significant step forward, even this process does not move as quickly as it can and should. The presumptive eligibility process gives the Department up to 25 days to make a decision. This means that applicants may be going without services for nearly a month. We would ask the Department, as it has done with past contractors, to require that all level of care determinations be made within 5 business days from when an application is received. This will help minimize the gap in coverage for CFI applicants.

We would also ask the Department to implement, as previously promised, an advanced filing period for CFI applications. Under this advanced filing period, applicants would be able to submit an application before their resources are fully spent down. This would allow for a seamless transition from private pay to Medicaid coverage for CFI services. Attached is a letter NHLA sent to the Department in August 2014 memorializing a meeting that took place where the Department agreed to implement an advanced filing period. To our knowledge, no such procedure has gone into effect since that meeting.

Thank you for the opportunity to comment on this proposed renewal application and please feel free to contact me if you have any questions. I may be reached at (603) 206-2210 or csteinberg@nhla.org.

Very truly yours,



Cheryl S. Steinberg
Director, Senior Law Project
Concord Office

Enclosure



www.nhla.org

NEW HAMPSHIRE LEGAL ASSISTANCE

Working for Equal Justice Since 1971

August 14, 2014

Mickie Rae Grimes, Regional Manager
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Re: Presumptive Eligibility

Dear Ms. Grimes:

Thanks again to you and Kim Dionne for taking the time to meet with us to discuss ways in which the Department can expedite the Choices for Independence (CFI) application process. I am pleased that you have agreed to develop an advanced filing period to help eliminate or minimize any potential gap in services for CFI applicants. In addition to implementing this new advanced filing period, we are also asking that the Department implement the presumptive eligibility application process as required under RSA 151-E:18.

Additional Method for Expediting CFI Applications: State Mandated Presumptive Eligibility Process

As we discussed during our meeting, the Department is already mandated under RSA 151-E:18 to expedite the processing of CFI applications by making presumptive eligibility determinations. The presumptive eligibility process was established to "prevent the unnecessary and costly institutionalization of individuals who are Medicaid eligible for nursing facility services and choose to receive services in a less restrictive environment." RSA 151-E:18, I. Pursuant to RSA 151-E:18, II, "Pending verification of application information, the department shall authorize medical assistance in the interval between application and the final Medicaid eligibility determination if the department determines the applicant is likely to be eligible." The law further provides that presumptive eligibility shall be made available at district offices, ServiceLinks and other qualified providers.

Based on anecdotal evidence, since 2008, when the presumptive eligibility law went into effect, it appears that very few, if any, CFI applicants have been screened or approved for this expedited application process. In addition, since there is no written information that alerts applicants about the presumptive eligibility process they are not aware of their ability to ask to be screened for this special process.

Critical Need to Screen Applicants for Presumptive Eligibility

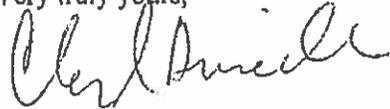
In light of the serious consequences that may result from delays in approving an applicant for CFI services, it is critical that the Department ensure that the presumptive eligibility process is fully operational. For example, it is not uncommon for CFI applicants to die while waiting to be approved for services. Since CFI services are only, according to the Department, available prospectively, residents in assisted living facilities are almost guaranteed to experience a gap in coverage from the time they apply for services until their application is approved. The longer it takes to process the application, the longer the gap in coverage. This can result in facilities seeking to discharge residents based on their inability to pay the monthly residence fees.

Given that the Department prepared a comprehensive interview reference guide in 2008, implementing the presumptive eligibility application process should be relatively easy. (copy attached). The guide provides detailed instructions to Department staff and qualified providers on how to screen applicants for presumptive eligibility and assist with the application process.

As you are already contemplating providing training to Department staff, qualified providers and assisted living administrators about the new advanced filing period you are developing, you could also include a refresher course on the presumptive eligibility process. This will ensure that applicants will be able to qualify for services as soon as possible and not suffer any harm from a gap in coverage.

I would appreciate hearing back from you by September 12, 2014, to learn about your plans to ensure that the presumptive eligibility application process is being utilized as required under RSA 151-E:18. I may be reached at (603) 206-2210.

Very truly yours,



Cheryl S. Driscoll
Director, Senior Law Project
Concord Office

Enclosure
cc: Robert Berry, Esq.
Susan Lombard



nh healthy families

2 Executive Park Drive

Bedford, NH 03110

February 27, 2017

NH Department of Health and Human Services
ATTN: Deborah Fournier, State Medicaid Director
129 Pleasant Street
Concord, NH 03301

RE: Choices For Independence Waiver Renewal Draft

Dear Ms. Fournier:

Thank you for the opportunity to provide feedback relative to the Choices For Independence (CFI) Waiver Renewal draft. DHHS' proposal has successfully incorporated much of the stakeholder feedback shared at listening sessions held in November and December of 2016.

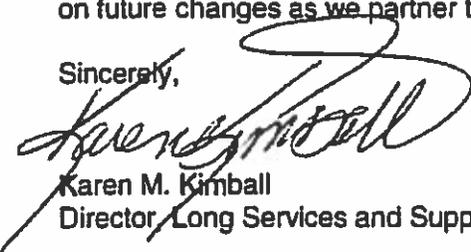
NH Healthy Families (NHHF) supports the addition of Participant Directed and Managed Services, Financial Management Services, Supported Employment, Vehicle Modifications, as well as modifications to Environmental Accessibility Services lifetime cap, Non-Medical Transportation, and Respite Services. Additionally, including other assessment tools, specifically, the Minimum Data Set (MDS) and Outcome and Assessment Information Set (OASIS), as well as broadening the definition of staff qualified to conduct assessments, may serve to streamline the CFI Waiver eligibility process.

In conjunction with this waiver's renewal, DHHS could explore opportunities, including reducing administrative and regulatory barrier(s), to expand the utilization of Adult Family Care and Kinship Care. These models have been successfully employed under NH's Developmental Disabilities and Acquired Brain Disorder Waivers. If comparable rates are available for these and other CFI Waiver services, it may assist the Department in its efforts to broaden the available workforce.

Given the closure of certain CFI providers in recent years, including Adult Day Health, Home Health Agencies, and Residential Care settings, DHHS is encouraged to continue its efforts to achieve adequate waiver reimbursement rates to facilitate access to services which may prevent the use of higher cost institutional services, including hospitals and nursing homes.

NHHF appreciates DHHS' significant effort in crafting this proposal. If adopted, these changes will assist the CFI waiver to better meet the needs of participants and help prevent unnecessary institutionalization for those choosing community based services. We look forward to weighing in on future changes as we partner to bring CFI services into Managed Care.

Sincerely,



Karen M. Kimball
Director Long Services and Supports

c: Lorene Reagan, DHHS
Jennifer Weigand, NHHF

1-866-769-8085

TDD/TTY 1-855-742-0123

February 28, 2017

Lorene Reagan
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301
Via E-Mail: nhcfiwaiverrenewalinput@dhhs.nh.gov

IN RE: Choices for Independence Waiver Renewal, Proposed Application

Dear Ms. Reagan:

Thank you for this opportunity to comment on the proposed 1915(c) waiver application for the Choices for Independence (CFI) program.

While only comments and recommendations on changes to the proposal are listed below, I would like to take this opportunity to express appreciation for the inclusion of the long-awaited participant-directed service.

Respectfully,
Michelle M. Winchester, JD

General Comments:

- The following key measures are missing from waiver application performance measures and should be included:
 - Timely eligibility determinations;
 - Timely service authorizations; and
 - Timely notice of service coverage denial.
- There are various legal citations throughout the proposed waiver application that are inaccurate or less than helpful, should CMS, for example, seek to reference them. For the most part, these are not referenced below. The recommendation here is a review and correction.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Groups

b. Additional criteria.

Individuals must ~~require assistance due to a chronic medical diagnosis and/or frailty associated with aging, and meet clinical eligibility requirements established in RSA 151-E:3 I. Individuals who would otherwise require the services of an IMD, and are of the age of 21 through 64 (per 1905(a) 2829(B) of the Act), or who would otherwise require the services of a psychiatric residential treatment facility as defined in 42 CFR 483.352, are not eligible. However, an individual with a co-occurring mental illness, who otherwise requires a nursing facility level of care, as specified here, is eligible to receive services comparable to those provided in a nursing facility.~~

Comments and Recommendations:

- The clinical criteria in RSA 151-E:3 do not include the phrase “require assistance due to a chronic medical diagnosis and/or frailty associated with aging.” See recommended edit (first sentence, in red) to correct.
- As written, the waiver clause above may be and has been used to deny entrance to the waiver to the individual who actually requires a nursing facility level of care, but also has a co-occurring mental illness. This same individual would be covered under Medicaid if in a nursing home. See recommended edit above (last sentence, in red).

B-2: Individual Cost Limit

a. Individual Cost Limit.

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

According to NH State Statute RSA 151-E: 11:

"No person whose costs would be in excess of 80 percent of the average annual cost for the provision of services to a person in a nursing facility shall be approved for home-based or mid-level services without the prior approval of the commissioner of health and human services. The prior approval shall include a comparison of the mid-level or home-based care costs of the person with the costs of a facility qualified to provide any specialized services necessary for the proper care and treatment of the individual".

Comments and Recommendations:

- It is not clear why “Cost Limit Lower than Institutional Costs” is checked in the waiver application and only a reference to the process step for Commissioner approval is listed. Commissioner approval is merely an additional step to approval, not an affirmative bar to institutional cost. It does not limit costs to below institutional costs. This should be clarified.
- In turn, missing from the above are the actual limits that do result in care plan costs below institutional cost limits. These should be included in the waiver application—
 - “ . . . the average annual cost for the provision of services to persons in the mid-level of care shall not exceed 60 percent of the average annual cost for the provision of services

in a nursing facility. The average annual cost for the provision of services in home-based care shall not exceed 50 percent of the average annual cost for the provision of services to persons in a nursing facility." NH RSA 151-E:11, II.

B-2: Individual Cost Limit

b. Method of Implementation of Individual Cost Limit.

Comment and Recommendation: In the waiver application section identified above, the implementation of all of the limitations of NH RSA 151-E:11 should be included, and are not. The process for implementation of the 50% and 60% average annual costs should be described. If and when the CFI program is administered by managed care entities, this will need to be very, very clear and should be addressed here.

B-2: Individual Cost Limit

f. Selection of Entrants to the Waiver.

Pursuant to 42 CFR 441.301(b)(1)(iii) and (b)(6), eligibility shall be restricted to individuals who meet the target population criteria approved by CMS for this program and who, without the services provided by the program, would otherwise require institutional placement in a long term care nursing facility as described in He-E 802, and not services provided in a hospital, an institution for mental diseases (IMD) as defined in 42 CFR 435.1010, or an intermediate care facility for the mentally retarded (ICF/MR) as defined in 42 CFR 440.150.

Comment and Recommendation: In the waiver application text above, the implementation of all of the limitations of NH RSA 151-E:11 should be, and is not, included. The process for implementation of the 50% and 60% average annual costs should be described. If and when the CFI program is administered by managed care entities, this will need to be very, very clear.

B-4: Eligibility Groups Served in the Waiver

Comments and Recommendations:

- HB 461 (2014) (text below) is not and should be included in this waiver application.

"Subject to written approval by the Center for Medicare and Medicaid Services, financial eligibility rules in paragraph II shall include eligibility if the person's countable income is at or below the nursing facility special income standard, as defined in 42 C.F.R. 435.236, for the Medicaid program or the person incurs allowable medical expenses each month, including the anticipated cost of waiver services, which when deducted from the individual's income would reduce the individual's income to an amount that is no higher than the nursing facility special income standard. The department shall submit a request for such approval within 30 days of the effective date of this paragraph." [See HB 461 (2014).]
- The State should amend the Medicaid State Plan and this waiver application to include "Working Individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in § 1902(a)(to)(A)(ii)(XIII)) of the Act." People with disabilities, age 65 and older, are working or trying to work. This is happening for a host of reasons, including the increased age requirements (over age 65) for collecting a full Social Security benefit, requirements that are being felt now.

B-6: Evaluation/Reevaluation of Level of Care

d. Level of Care Criteria.

Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized. [Highlight added.]

~~Individuals must require assistance due to a chronic medical diagnosis and/or frailty and meet clinical eligibility. Individuals must require assistance due to a chronic medical diagnosis and/or frailty and meet clinical eligibility requirements established in RSA 151-E:3 I, which are: To be clinically eligible for Medicaid coverage of long term care, a person must require 24-hour care for one or more of the following purposes: medical monitoring and nursing care; restorative nursing or rehabilitative care; medication administration requiring medical or nursing intervention; or assistance with two or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence.~~

Comment and Recommendation: Only the level of care standard under New Hampshire law should apply here. (See relevant portion of RSA 151-E:3 below.) State law does not include "individuals must require assistance due to a chronic medical diagnosis and/or frailty." The recommendation here is that the text should be struck, as shown in the recommended edits (in red) above.

NH RSA 151-E:3 Eligibility. –

I. A person is medicaid eligible for nursing facility services or Medicaid home and community-based care waiver services if the person is:

(a) Clinically eligible for nursing facility care because the person requires 24-hour care for one or more of the following purposes:

- (1) Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;
- (2) Restorative nursing or rehabilitative care with patient-specific goals;
- (3) Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or
- (4) Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence;

B-6: Evaluation/Reevaluation of Level of Care

f. Process for Level of Care Evaluation/Reevaluation & i. Procedures to Ensure Timely Reevaluations.

f. . . . Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

i. . . . Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (specify):

NH DHHS maintains qualified medical personnel directly employed by or under contract with the department to complete reevaluations of level of care.

NH DHHS contracts with an outside entity to assist with reevaluations.

Comment and Recommendation: Timeliness is not, and should be, addressed here. I remind the DHHS of the impact of untimely level of care determinations. Retroactive coverage of services is not available, except retroactive to the date of the level of care determination. This is particularly challenging for the applicant who requires services in the short term and then experiences a long wait to a final eligibility determination. The level of care determination should be done within a few days of application – some states requiring it done within 5 days of application.

B-7: Freedom of Choice

a. Procedures.

Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Eligible individuals are informed of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services in the following ways:

Through information provided by NH's Aging and Disability Resource Center [ADRC], ServiceLink/NH Carepath whose counselors receive comprehensive training and supervision by DHHS concerning the importance of each applicant being accurately informed about his/her ability to choose either institutional or community based care.

Service Link Resource Center Counselors conduct standardized education of each applicant concerning:

- 1. Availability of CFI Waiver services as an alternative to institutional care.*
- 2. The range of available long term care services.*
- 3. The appeal process if the application is denied.*

In addition, case managers ensure this information is made clear to enrollees and documentation is maintained in each applicant's record of his/her choice of community based services instead of institutional services. This documentation is updated annually.

Comments and Recommendations:

- A discussion of feasible alternatives should include the wait time to and actual availability of services.
- A process for nursing facility residents (acute or long-term) also should be listed here, when ServiceLink does not participate, and should include independent case management participation in the process.

Appendix C: Participant Services

Comment and Recommendation, general:

- I look forward to working with the DHHS to develop clear service coverage standards in rule for each service listed in this waiver application. In the MCAC listening session, the attending DHHS representative acknowledged and agreed with the need to concurrently amend the CFI administrative rules. I hope DHHS has not lost sight of this important step and I look forward to that effort.

C-1: Summary of Services Covered

Adult Day Health

Comment and Recommendation: The service delivery method for adult day health is listed as provider managed only. In discussions in the community, concerns have been raised about this. Apparently, there is an adult day provider in the New Hampshire Nepali community (Maintaining Independence Adult Day), which serves members of that community in perhaps one of the more culturally sensitive settings. However, given the nature of the organization, in some instances it may be viewed as service by legally liable relatives. The recommendation here is to consider such a situation and expand the service delivery method appropriately.

C-1: Summary of Services Covered

Home Health Aide Service

Service Definition (Scope):

Services defined in 42 CFR 440.70 that are provided in addition to home health aide services furnished under the approved State Plan. Home Health aide services under the waiver differ in nature, scope, supervision arrangements or provider type from home health aide services in the State Plan. The difference from the State Plan is that the employing agency is licensed by the state to direct or provide therapeutic services in accordance with state licensing requirements found at He-P 809.

...

When Participant Directed and Managed, the individual or his/her representative shall define the provider qualifications that reflect sufficient training, expertise, experience and/or education to ensure delivery of safe and effective services, unless otherwise required by state or federal licensing or certification requirements.

Comments and Recommendations:

- It would appear from the above text that the difference between home health aide services under the CFI waiver and State Plan home health aide services is that, under the waiver, the employing agency must be licensed under He-P 809. However, the State Plan service also has that requirement. (See He-W 553.02 & 553.04 provisions below.) This should be corrected or it should be clarified if not the intended message.

He-W 553.02 Definitions.

(e) "Home health care provider" means any organization or business entity engaged in arranging for or providing home health services as described in RSA 151:2-b(1) and 42 CFR 440.70(d) and which is a NH enrolled medicaid provider in accordance with He-W 553.04.

He-W 553.04 Provider Participation.

(a) All home health care providers shall:

- (1) Hold a current New Hampshire state license as a home health care provider, in accordance with RSA 151:2-b, I, and He-P 809;
- (2) Be certified to participate in the medicare program; and
- (3) Be a New Hampshire enrolled medicaid provider.

- Given the current Nurse Practice Act requirements for nursing assistants, which require supervision by a nurse, I look forward to working with the DHHS to bring as much flexibility to this service as possible and as appropriate under a participant-directed model. As with so many standards in CFI, this standard should be made very clear prior to MLTSS implementation.

C-1: Summary of Services Covered

Personal Care Services

Service Definition (Scope):

Personal Care Services includes a range of individually tailored supports to assist with the ~~acquisition, retention, or improvement of community living skills including: assistance with activities of daily living such as meal preparation, eating, bathing, dressing, personal hygiene, medication management, community inclusion, transportation, and social and leisure skills, and adaptive skill development~~ to assist the individual to reside in the setting most appropriate to his/her needs. Supports may include hands-on assistance, cueing, personal care, protective oversight, and supervision as necessary for the health and welfare of the individual. Services and supports may be furnished in the home or outside the home.

Comments and Recommendations:

- See suggested edits above (in red). The concern behind these edits is that there not be an implication that this population typically has, for example, a condition that requires education in “community living skills.” For the two-thirds of the population that are over age 65, this is not likely necessary. Nor is it likely necessary for the one-third of the population that is made up of working-age adults, many of whom actually work.

In turn, the “protective oversight” and “supervision” in the second sentence may be necessary for recipients with a dementia, for example, while otherwise being inappropriate for these populations generally.

- The transportation issue mentioned by so many is not resolved here. As presented on February 8th, the provider would still have to bill as a transportation provider—clock in as a personal care provider, clock out as a personal care provider, clock in as a transportation provider, clock out as a transportation provider, clock in as a personal care provider, etc. Personal care agencies report this very, very challenging and looked for a simpler solution.
- NH RSA 161-I governs the personal care service provider in the CFI waiver program and should be included in this section.

C-1: Summary of Services Covered

Community Transition Services, Specialized Medical Equipment, & Environmental Accessibility Services

Comments and Recommendations:

- The waiver application should make clear that community transition services are one-time costs and not counted toward the annual spending limit. Absent such a standard, some would be barred from transition. Other costs that should be similarly treated are: specialized medical equipment and environmental accessibility services.
- The waiver application should make clear that a community-based nurse or case manager should assess and provide information to the service applicant residing in a nursing facility, rather than a nursing facility nurse/case manager with less community-based service experience.
- It is not clear why community transition services may not be participant-directed and, absent any bar to such an allowance, the DHHS is encouraged to do so.

C-1: Summary of Services Covered

Environmental accessibility services

Service Definition (Scope):

Physical adaptations to the Participant's home or vehicle, required by the comprehensive care plan, which are necessary to ensure the health, welfare and safety of the Participant or which will enable the Participant to function with greater independence and, without which, the Participant would require institutionalization. Services may include the installation of grab-bars, widening of doorways, modification of bathroom facilities, installation of a ramp or other adaptations to allow an individual to be safely transported in a vehicle, or installation of specialized electric equipment or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the health and welfare of the Participant. Adaptations or improvements that are of general utility, add to the square footage of the home, or are not of direct medical or remedial benefit to the Participant, such as carpeting, roof repair, or air conditioning, are not included in this service. Does not include the purchase of a vehicle.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services must be prior authorized by DHHS, and are limited to \$15,000 per Participant per five period.

This limitation is applied to this service independently of specified limits on other services (e.g.:

Specialized Medical Services). [Highlight added.]

Recommendation: The term "Specialized Medical Services" should be explained.

C-2: General Service Specifications

Facility Specifications (p. 91)

Recommendation: Remove the check next to "staff : resident ratios" in the table entitled "Scope of State Facility Standards." New Hampshire does not have staff to resident ratios in residential care facilities.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

j. Information and Assistance in Support of Participant Direction.

In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):

Comment and Recommendation: On page 133, consider whether non-medical transportation should be checked in the "waiver service coverage" table.

E-2: Opportunities for Participant-Direction

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Funding for participant directed services is based on the annual average cost of CFI Waiver services.

Participants whose assessed needs exceed the level of services provided, on average, may request additional funds. Requests for additional service funding are reviewed by DHHS and are approved based on demonstrated clinical or functional need as documented in an approved assessment and on the requirements contained in NH State Statute RSA 151-E: 11:

"No person whose costs would be in excess of 80 percent of the average annual cost for the provision of services to a person in a nursing facility shall be approved for home-based or mid-level services without the prior approval of the commissioner of health and human services. The prior approval shall include a comparison of the mid-level or home-based care costs of the person with the costs of a facility qualified to provide any specialized services necessary for the proper care and treatment of the individual".

Comment and Recommendation: See recommended edit above (in red). Additional LTSS needs may be based on demonstrated functional needs, as well as clinical—given the primarily functional nature of LTSS.

Appendix G: Participant Safeguards

G-3: Medication Management and Administration

c. Medication Administration by Waiver Providers

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication administration is provided by licensed personnel in ~~home care~~ any settings or by licensed nursing assistants or unlicensed personnel in accordance with the Nurse Practice Act (NPA) under RSA 326-B: 14, II-a and RSA 326-B:28 when the licensed nurse delegates the task of medication administration to the LNA who is employed in the home care, hospice, residential care, or adult day care setting.

~~AA~~Additionally, medication administration for CFI Waiver participants living in assisted living/residential care facilities is governed by State Administrative Rules He-P 804 and He-P 805 [http://www.gencourt.state.nh.us/rulesfstate_agencies/hep800.html] and allows for self administration, self-directed medication administration, self administration of medications with supervision, administration of medications by a licensed nurse or medication nursing assistant.

Prior to supervising medication administration in an assisted living facility/residential care setting, personnel who are not licensed practitioners or nurses but who assist a resident with self administration with supervision or self-directed administration are required to complete, at a minimum, a 4-hour medication supervision education program covering both prescription and non-prescription medication taught by a licensed nurse, licensed practitioner or pharmacist, or other person who has undergone such training by a licensed nurse, licensed practitioner or pharmacist, and shall be conducted either in person or through other means such as electronic media.

Comment and Recommendation: See recommended edits (in red) above. It is not clear why other waiver service providers are not included in the second and third paragraph discussion, e.g., adult day providers, home health care providers, adult family care, etc. All have similar licensure standards.

G-3: Medication Management and Administration

c. Medication Administration by Waiver Providers

iii. Medication Error Reporting. Select one of the following:

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to record:

(c) Specify the types of medication errors that providers must report to the State:

Comment and Recommendation: In this section of the proposed CFI waiver application, the response includes information on home health care providers and residential care providers licensed under He-P 804. As in the prior comment/recommendation, the DHHS should also include the other CFI providers—adult day, adult family care, other qualified agencies, supported residential health care (licensed under He-P 805), and participant-directed services.

Appendix I: Financial Accountability

1-2: Rates, Billing and Claims

a. Rate Determination Methods.

In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The following approach is taken by the State Medicaid Agency regarding Rate Setting Methodology for all services listed in Appendix C:

(a) The rate setting methodology shall use baseline rates in effective on June 30, 2017.

(b) All CFI rates shall be adjusted each Biennium to be effective July 1 of the even State Fiscal year (For example, for State Fiscal Year 2018 and 2019 Biennium, rates will be adjusted to be effective on July 1, 2017).

(c) Rates shall be calculated by adjusting the rate in effect the prior July 1 of the even State Fiscal Year of the previous biennium by applying the Centers for Medicare and Medicaid Services (CMS) Federal Register, Actual Regulation Market Basket Update for Home Health Agency Prospective Payment System (PPS) Market Basket Update (For example, the federal fiscal year 2017, or calendar year 2017 on the Home Health Agency PPS table, will be used to calculate the July 1, 2017 rates).

(d) The calculated rates in (c) above shall be multiplied by an estimated utilization by service to reach an aggregate estimated expenditure for all CFI services.

(e) Using the aggregate estimated expenditure, calculated in (c) and (d) above, rates for CFI waiver services may be subject to a budget neutrality provision.

(f) When the New Hampshire Legislature approves CFI rate increases in a state budget, the rate increases rather than the rate adjustments established in (c) above, shall be applied as required by the budget legislation. The Department shall apply the procedures in (d) and (e), for rates not established by the New Hampshire Legislature, above to align the aggregate estimated expenditures with the legislative appropriation.

(g) No updated rates shall be in excess of the usual and customary charge for the service as provided to

the general public as required by RSA 126-A:3111.(b).

Comment and Recommendation: If I correctly understood the DHHS presentation on February 8th, the Federal home health agency market percentage increase (2.5% in CY 2017) will be used across the board annually for all CFI waiver service provider rates (services listed below). Given the highlighted language above, as proposed the text could appear to apply only to home health care provider services. An edit similar to the recommended edit above (in red) would serve to eliminate confusion and allay provider concerns.

Appendix C Services

Adult Medical Day
Home Health Aide
Homemaker
Personal Care
Respite
Supported Employment
Financial Management
Adult Family Care
Community Transition
Environmental Accessibility
Home-Delivered Meals
Nonmedical Transportation
Participant-Directed and Managed
Personal Emergency Response System
Residential Care Facility
Skilled Nursing
Specialized Medical Equipment
Supportive Housing
Case Management



DISABILITY RIGHTS CENTER-NH

64 North Main Street, Suite 2, Concord, NH 03301-4913 • advocacy@drcnh.org • www.drcnh.org
(603) 228-0432 • (800) 834-1721 voice or TTY • FAX: (603) 225-2077

February 27, 2017

N.H. Department of Health and Human Services
129 Pleasant Street
Concord, N.H. 03301

Re: Comments to Choices for Independence (“CFI”) Waiver Renewal

DHHS:

We appreciate and thank you for the opportunity to comment on the proposed 1915(c) CFI Waiver Renewal application.

We are hopeful that the Department’s willingness to consider all comments received from the community will ensure a strong CFI waiver able to address the many issues facing the aging population in New Hampshire.

Sincerely,

Cindy Robertson
Senior Staff Attorney

COMMENTS TO CFI WAIVER RENEWAL

February 28, 2017

General Recommendations:

1. It is unfortunate given the aging of NH residents that the Department does not have a bureau or division dedicated solely to the elderly and adults with physical disabilities as it once did in BEAS. This lack of a bureau or division solely dedicated to this population and appropriately staffed is evidenced by the changes throughout the waiver renewal from “BEAS” to simply “DHHS Office of Medicaid Services” generally. It is critical that such a focus become a priority again for the Department.

Section 2. Brief Waiver Description

The Department should specify in detail its plan to transition individuals from nursing facilities to the community. Additionally, the Department should publicly report the number of individuals actually being transitioned to the community from nursing facilities and how many positive responses to Section Q are being sent to Service Link on an annual basis.

Appendix B: Participant Access and Eligibility

2. B-1: Specification of the Waiver Target Group(s)

- b. Although this section of the waiver specifically references RSA 151-E:3, it is recommended that the requirements under this section to qualify for the CFI waiver be amended in order to address the current issues faced by the growing number of elderly and adults with physical disabilities wishing to live in the community. Specifically, “medication administration” should include medication oversight and not be provided only when an individual needs physical assistance with taking a medication. Likewise, the acceptable list of qualifying “ADLs” should reflect the definition of ADLs contained in the supporting state regulations for RSA 151-E, He-E 801.02 which has a broader inclusion of activities including medication supervision. (See also p. 36, B:6 d).

The waiver should also be specific in stating that an individual with a co-occurring mental illness, who otherwise requires a nursing facility level of care is eligible to received services comparable to those provided in a nursing facility.

3. B-2: Individual Cost Limit (1 of 2)

- a. It is unclear why the Department has chosen to lower the individual cost limit in the draft waiver (see Appendix B:2 a). Currently, if the cost of an individual’s services in the community *is the same as* or lower than the cost of an institution able to meet his/her needs, the individual will be qualified for the CFI waiver. The draft waiver, however, modifies and requires the cost to be *lower* than the institutional cost of care.

This change could result in individuals being denied entry onto the waiver when, in fact, they choose to be served in the community and their cost of care is the same as the cost of the institution. There is no greater cost to the State should the current language be maintained, but there is a higher quality of life when a person is able to remain in the community. We would urge the Department to keep the level of care as currently reflected in the waiver. (It should be noted that this proposed change is not reflected in other parts of the waiver renewal. See for example, p. 24, Section B-3 f).

It is unclear why the “Cost Limit Lower than Institutional Costs” is checked in this section since this review is simply an additional step to approval and not a bar to institutional cost.

Also, it is recommended that the cost cap of 80% requiring a second level of approval for CFI waiver entry be eliminated. So long as the cost of the services provided in the community is the same as or lower than the cost of the institution, the State maintains its goal of quality and cost-effectiveness.

B-2: Individual Cost Limit

- b. It is unclear why all of the limitations contained in RSA 151-E:11 are not contained in this section, but only the portion referencing the 80% cap. Specifically, the limits of 50% average annual cost (for nursing facilities) and 60% average annual cost (for residential care homes) should be included. The process for implementation of the 50% and 60% average annual cost should be described.

4. B-4: Eligibility Groups Served in the Waiver

In May of 2014, HB 461 went into effect. The text of this law should be included in the waiver application:

“Subject to written approval by the Center for Medicare and Medicaid Service, financial eligibility rules in paragraph II shall include eligibility if the person’s countable income is at or below the nursing facility special income standard, as defined in 42 C.F.R. 435.236, for the Medicaid program or the person incurs allowable medical expenses each month, including the anticipated cost of waiver services, which when deducted from the individual’s income would reduce the individual’s income to an amount that is no higher than the nursing facility special income standard. The department shall submit a request for such approval within 30 days of the effective date of this paragraph”.

The State should amend the Medicaid State Plan and this waiver application to include “Working Individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in § 1902(a)(to)(A)(ii)(XIII) of the Act).” People with disabilities, age 65 and older, are working or trying to work and should be able to do without the risk of losing vital health care coverage.

5. **B-5: Post-Eligibility Treatment of Income**

- a. It is unclear why both “spousal impoverishment rules *are* used” AND “spousal impoverishment rules *are not* used” are checked off.

Appendix B: Evaluation/Reevaluation of Level of Care

There are a number of tables included in pages 38-45 in which categories are checked off in the renewal waiver that are lower review standards than what is required in the current waiver. For example, on p. 38, under section a.1.a, the “operating agency performance monitoring” is currently a 100% review. The waiver renewal is “less than 100%”. Additionally, the “data aggregation and analysis” referenced on p. 39 is currently done quarterly, but will only be done annually under the waiver renewal. It is unknown why these changes have been made or why they should be lower going forward than they have been since 2012. With the expectation of LTSS moving into managed care, regular, frequent monitoring will be critical.

6. **B:6: Evaluation/Reevaluation of Level of Care**

- i. There is no indication of how the Department ensures that timely reevaluation are done. This information should be included.

7. **B:7: Freedom of Choice**

The waiver should include information about wait times for services and the actual availability of services as part of the feasible alternatives to nursing home care.

The waiver should include information about the use of independent case managers by nursing home residents when Service Link is not available.

Appendix C:

C-1/C-3 Services Specification:

1. **Adult Day Health.** It is recommended that legally responsible persons, relatives and a legal guardian be permitted to provide this service. Under the current waiver, relatives are permitted to provide the service and, in fact, do so in many culturally-diverse homes in NH. For example, in the Nepali culture, it is very common for a relative to care for another family member in this way.

It is also recommended that this service be available as a “participant directed” service.

2. **Supported Employment.** It is important that an individual requiring supported employment be able to have ongoing supports *in the workplace* which provides intensive services as needed. While this notion is clearly stated in the first paragraph of the

definition, such services do not appear to be included in what is actually provided. To the extent such intensive supports to maintain employment are not already included, they should be.

3. **Environmental Accessibility Services.**

While it is appreciated that the one-time only funding for these services has been changed to “once every five years”, the cap of \$15,000 is too low and should be increased or eliminated to ensure individuals are able to remain in their homes. The focus should be on the individual’s needs based on an individual assessment.

It is unclear why this service is not available for the participant directed model. It is recommended that it should be.

Under the current waiver, the individual providing the services does not have to be a Medicaid enrolled provider. The renewal waiver now makes this a requirement. It is recommended that this requirement be removed as many contractors providing home modifications are not and have no reason to become Medicaid providers.

The term “Specialized Medical Services” needs to be explained and/or defined.

4. **Specialized Medical Equipment Services.** Again, while it is appreciated that one-time only funding for these services has been changed to “once every five years”, the cap of \$15,000 is too low and should be increased or eliminated to ensure individuals have access to the medical equipment they need. The focus should be on the individual’s needs based on an individual assessment.

Appendix E: Participant Direction of Services

E-1: Overview

It is unclear why “non-medical transportation” has not been included in the list of participant-directed” services. (p.133).

E-2: Opportunities for Participant Direction

b. **Participant – Budget Authority**

- ii. Consistent with the comments provided for Section B-2 a above, it is recommended that the mandatory review by the Commissioner when an individual’s cost of services exceeds 80% of the average annual cost of a nursing facility be eliminated. So long as the cost of the services provided in the community is the same as or lower than the cost of the institution, the State maintains its goal of quality and cost-effectiveness. There is no legitimate reason for this level of review.

It is unclear why all of the limitations contained in RSA 151-E:11 are not contained in this section, but only the portion referencing the 80% cap. Specifically, the limits

of 50% average annual cost (for nursing facilities) and 60% average annual cost (for residential care homes) should be included. The process for implementation of the 50% and 60% average annual cost should be described.

Additionally, because LTSS needs may be based on demonstrated “*functional*” need as well as clinical needs, this should be included.

Appendix F: Participant Rights

F-1: Opportunity to Request a Fair Hearing

1. The option of the Department providing any type of notice of an adverse decision other than in writing violates federal law and must be omitted. (See the last sentence of this section on page 139 which reads, “Unless otherwise specifically provided in applicable federal or state law . . . appeal shall be submitted within 30 days after the date: The department’s notice of decision was issued, if applicable, or *of the department’s notice to the appellant of its action if a notice of decision was not issued*”.) Written notices guarantee the timely filing of an appeal without any disagreement on when “notice” was actually given or received.
2. The ability of an individual to have services remain in place pending appeal as specified in the He-E 801.07 so long as the appeal is filed within 15 calendar days of the date of the notice should be included in the waiver.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

It is unknown why the quality improvement performance measures have been modified from the current waiver. For example, currently data is kept on “*the number and percent of critical incidents requiring review/investigation where the State adhered to the specified follow-up methods*”. It does not appear this measure is included in the renewal waiver, although there is reference to simply “the number and percent of Sentinel Event reports received for the CFI waiver”. Further, two of the performance measures in the renewal waiver address only whether the APS brochure was provided to individuals on the waiver. It is unclear how such a measure would demonstrate “*an effective system for assuring waiver participant’s health and welfare*”. It is recommended that performance measures be selected that truly capture those substantive areas where health and safety can be at risk.

For example, given the on-going problem of delayed eligibility determinations resulting in either institutionalization or death of those waiting to be placed on the CFI waiver, the length of time between the date of application for the CFI waiver and the date of assessment, and the time from the assessment to the services being authorized and actually billed should be tracked as quality improvement performance measures. It is

believed that as a result of delayed eligibility determinations, a de facto waitlist for the CFI waiver exists contrary to what is indicated in Appendix B-3: Number of Individuals Served.

Reagan, Lorene

From: Reagan, Lorene
Sent: Wednesday, February 22, 2017 1:42 PM
To: DHHS: NHCFI Waiver Renewal Input
Subject: CFI Waiver Renewal Public Input

From: Beth Raymond [<mailto:braymond@gatewayscs.org>]
Sent: Monday, February 20, 2017 10:42 AM
To: Reagan, Lorene
Cc: St Jacques, Mary; icolon@gatewayscs.org; mbsmaha@gatewayscs.org
Subject: RE: Report on the listening session feedback and Proposed Changes to the CFI Waiver

Lorene

I wanted to let you know that we did the review of the proposed changes CFI Waiver and were pleased that so many of our recommendations to the Listening Session were included. I was happy to see that over half of our recommendations were included.

Thank you. I think these changes will improve the CFI Waiver considerably. Gateways is looking forward to working closely with you and all of the BEAS staff as they move forward with all of the changes but especially the Participant Directed Services and Supported Employment components.

Beth

GATEWAYS COMMUNITY SERVICES
Beth Raymond
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Gateways Community Services

Choices for Independence Wavier Renewal Recommendations

February 22, 2017

Gateways Community Services is in support of the proposed CFI Waiver changes that address the following:

Participant Directed and Managed Services
Supported Employment
Non-medical transportation
Skilled-Nursing Services
Respite Care Services
Medical Eligibility Assessment
Rate Setting Methodology

We remain strong advocates for the following recommendations to be added to the CFI Waiver renewal and resubmit these to the Department of Health and Human Services (DHHS) for changes to the Choices for Independence Program (CFI) Medicaid Waiver as DHHS prepares to submit their proposed changes to the waiver. We resubmit these as part of the Listening Session.

As expressed previously, we believe these additions and service expansions 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.

New Services Recommendations

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 amended to include a Companionship Service.

New Service-Enhanced Case Management

Independent Case Managers are excellent at supporting participants in the CFI Program. This support includes the person 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 be 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 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

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.

Expanded Prior Authorization Timeliness

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.

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

Submitted by

LaVonne Colon
Elders Case Management Supervisor
Gateways Community Services
144 Canal Street
Nashua, NH 03060
603-459-2759
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Reagan, Lorene

From: Reagan, Lorene
Sent: Tuesday, February 07, 2017 3:13 PM
To: DHHS: NHCPI Waiver Renewal Input
Subject: FW: CFI Renewal Question-HB 461 (2014)
Attachments: HB 461.pdf

Lorene Reagan, MS, RN
Medicaid Senior Health Systems Administrator
New Hampshire Department of Health and Human Services
129 Pleasant Street, Brown Bldg
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603-271-9180
Lorene.reagan@dhhs.nh.gov

From: Michelle Winchester [<mailto:M.Winchester@maine.rr.com>]
Sent: Tuesday, January 31, 2017 2:51 PM
To: Reagan, Lorene
Subject: CFI Renewal Question-HB 461 (2014)

Lorene-
HB 461 (2014), see attached, was supposed to be incorporated into this waiver renewal. It was long delayed because of the setting rule— the Dept. knowing that once the waiver was opened, it had to deal with the setting requirements.

Could you just tell me the status of this? I'm not seeing evidence of it in the posted draft — but I could just be missing it.
Michelle

MICHELLE WINCHESTER, JD
HEALTH POLICY ANALYST
M.Winchester@maine.rr.com
603-534-9060

CHAPTER 33
HB 461-FN – FINAL VERSION

22Jan2014... 2337h
5Mar2014... 0426h

2014 SESSION

13-0756
01/10

HOUSE BILL ***461-FN***
AN ACT relative to long-term care services.
SPONSORS: Rep. Donovan, Sull 4
COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill clarifies long-term care eligibility for the purpose of receiving Medicaid-funded nursing home services.

.....

Explanation: Matter added to current law appears in ***bold italics***.
 Matter removed from current law appears [~~in brackets and struckthrough~~]
 Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

CHAPTER 33
HB 461-FN – FINAL VERSION

22Jan2014... 2337h
5Mar2014... 0426h

13-0756
01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Fourteen

AN ACT relative to long-term care services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 33:1 New Paragraph; Long-Term Care; Eligibility. Amend RSA 151-E:3 by inserting after
2 paragraph II the following new paragraph:

3 II-a. Subject to written approval by the Center for Medicare and Medicaid Services, financial
4 eligibility rules in paragraph II shall include eligibility if the person's countable income is at or below
5 the nursing facility special income standard, as defined in 42 C.F.R. 435.236, for the Medicaid
6 program or the person incurs allowable medical expenses each month, including the anticipated cost
7 of waiver services, which when deducted from the individual's income would reduce the individual's
8 income to an amount that is no higher than the nursing facility special income standard. The
9 department shall submit a request for such approval within 30 days of the effective date of this
10 paragraph.

11 33:2 Effective Date. This act shall take effect upon its passage.

12

13 Approved: May 27, 2014

14 Effective Date: May 27, 2014