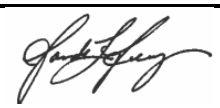
NH Department of Health and Human Services (DHHS) **105 Pleasant St.**
Division of Long Term Supports and Services **Concord, NH 03301**
Bureau of Developmental Services

STATE OF NEW HAMPSHIRE BDS GENERAL MEMORANDUM (GM)	
DATE:	February 27, 2023
TO:	Area Agencies, Case Management Agencies, Service Providers
FROM:	Sandy Feroz, Bureau of Developmental Services, Bureau Chief
SIGNATURE:	
SUBJECT:	Cost of Care Contribution Allocation
GM NUMBER:	
EFFECTIVE DATE:	July 1, 2023
REGULATORY GUIDANCE:	This memo is a communication tool circulated for informational purposes only. The goal is to provide information and guidance to the individuals to whom it is addressed. The contents of this memo and the information conveyed are subject to change. This communication is not intended to take the place of or alter written law, regulations or rule.

MEMORANDUM SUMMARY

The purpose of this memorandum is to:

- Communicate changes to how Cost of Care is allocated to Developmental Disabilities Waiver participants.
- Establish how Cost of Care amounts will be accounted for in service provider billing under Direct Billing standards for Developmental Disabilities and Acquired Brain Disorder Waiver participants.

In accordance with requirements set forth by the Centers for Medicare and Medicaid Services (CMS), New Hampshire waiver-funded services must comply with direct bill regulations. At present, the Department of Health and Human Services (DHHS) designates ten (10) Area Agencies who operate as both Medicaid-enrolled providers as well as the state's Organized Health Care Delivery System (OHCDS). These Area Agencies are responsible for partnering with the Bureau of Developmental Services (BDS) to render services through their own service delivery operations or through a network of private service providers (vendors) that contract with the Area Agencies.

In current operation, the ten Area Agency entities submit all Medicaid billing for services rendered under the Developmental Disabilities (DD), Acquired Brain Disorder (ABD), and In Home Supports (IHS) Waivers for services rendered by their agency and services rendered by the vendors in their catchment area. This current

operating structure is in conflict with CMS' direct billing regulations, 42 CFR §447.10, which identifies that all Medicaid service providers must have the ability to bill Medicaid directly for services rendered.

To come into compliance with CMS regulatory requirements for direct billing, BDS has worked to enroll service providers as Medicaid provider organizations to allow each direct service provider the opportunity to bill Medicaid directly.

As private vendors begin to bill for rendered services directly, changes to some of the operational functions in the current billing system are required. Currently, Cost of Care contributions – the amount some participants are required to contribute to the cost of their total service care, as established under He-M 517 – are deducted from the authorized service amounts for applicable service recipients in the state's Medicaid Management Information System (MMIS). The Area Agencies, as the only current Medicaid-enrolled billing providers, collect the cost of care liability for all services. Further, under current MMIS operations, whichever Medicaid service for a participant is billed first has the remittance amount reduced by the full Cost of Care amount.

DHHS has reviewed both the Cost of Care operational process for the DD and ABD Waivers as well as reevaluated which individuals receiving services on the DD Waiver will be required to contribute a cost of care contribution. This policy outlines which waiver participants will be required to contribute to the cost of care as well as how cost of care will be allocated to the rendering service provider after July 1, 2023 as direct billing goes into effect.

Cost of Care Contribution Groups:
Effective July 1, 2023, a monthly cost of care contribution calculation will only be completed for individuals accessing DD Waiver Residential Habilitation services. No other DD Waiver service participants will have a cost of care contribution calculated. Within the calculation, individuals who reside in an independent living setting, including their family's home, will have the maximum Standard of Need (SON) allowance applied, which is 300% of the SSI Federal Benefit Rate (FBR), or $2,742 as of 1/1/2023. There will be no change to the SON allowance for individuals who reside in a 24/7 staffed residence or enhanced family care (EFC) home. These service settings were selected to incentivize enhanced community-based, independent living settings by allowing participants to have increased access to income to support their independence and due to their overall service cost. No additional changes to the frequency or calculation for cost of care contributions are being changed as part of this policy. No changes to the ABD SON or cost of care calculation are being made.

Active DD Waiver service participants who access Residential Habilitation services will be subject to the new SON allowance and cost of care calculation methodology beginning July 1, 2023. Active service participants who currently contribute to the cost of care but do not participate in residential services will no longer be obligated to pay the cost of care amount after July 1, 2023. Any cost of care payments owed to the service provider or the Area Agency for services delivered prior to July 1, 2023 are still the obligation of the individual as this policy does not clear any outstanding liabilities.

Cost of Care Contribution Operational Process:
Starting July 1, 2023 cost of care contributions will be automatically allocated in the MMIS for participants accessing DD Waiver Residential Habilitation services who have a cost of care calculated. The cost of care amount will be assigned to the Residential Habilitation authorization in MMIS only. Providers supporting an individual with a cost of care responsibility but not providing the Residential Habilitation service will not be liable for the cost of care contribution amount. The cost of care contribution amount will be automatically deducted from the payment remitted to the Residential Habilitation provider. Any credits to cost of care amounts due to recalculations of cost of care will only be credited to the Residential Habilitation provider. Collection of the cost of care funds will be the responsibility of the Residential Habilitation provider, and will not be managed, negotiated or supported by BDS.

The following process outlines the steps that DHHS information technology systems will take to allocate cost of care amounts to Residential Habilitation service authorizations.

1. New Heights will be modified so that the following are considered independent living arrangements with the SON allowance set at 300% of the SSI FBR, currently $2,742, in the monthly cost of care calculation:
    - Own or shared aparment
    - Own or shared home
    - Family home

2. Residential locations will be identified in New Heights using the Living Arrangement screen with verification by the BDS Liaison and/or Prior Authorization Team.

3. New Heights will transmit the applicable cost of care to MMIS.

4. MMIS will automatically allocate cost of care contribution to the Residential Habilitation prior service authorizations for obligated individuals.

5. The MMIS system will automatically deduct the cost of care contribution amount from the payment to be remitted to the Residential Habilitation provider.
    a. In the event of a recalculation to the cost of care contribution that results in a credit, only the current provider of Residential Habilitation will be credited.

6. Individuals participating in Residential Habilitation services who are determined to not have a cost of care obligation, as calculated by the Bureau of Family Assistance (BFA), will not be obligated a cost of care contribution under this policy.