A. Statement of Need

1) **Demographic Trends are Likely to Affect the Demand for LTSS:** New Hampshire (NH) covers 8,968 sq. miles, 90% defined as rural. In 2020, NH had approximately 1,377,530 residents, with 509,527 (or 37%) living in rural areas. In 2019, NH's median age was 43, and 19% of the population (~248K people) were 65 or older, making it the 3rd oldest state in the nation, after a 43% growth in older adults between 2008 and 2018.[1,2] In 2016, NH's Office of Energy and Planning estimated that by 2040, 33% of residents will be 65 or older.

Demographers at the University of New Hampshire (UNH) believe this population shift is primarily driven by large cohorts of "Baby Boomers" (~389,000 residents) who reached their 50s and 60s by 2015.[3] However, this shift in the population age structure is not occurring evenly; the more rural counties of northern and central NH have a more significant proportion of residents aged 65 or older than other regions. Residents of NH's rural communities are more likely to be uninsured, of low-income, older, or disabled, than non-rural residents.

As NH ages, it grows more racially and ethnically diverse, heralding the need for programs and services to become more culturally and linguistically appropriate. In a 2015 report, the NH Center for Public Policy Studies estimated that among the state's 1.3 million residents, approximately 75,000 were foreign-born. In 2018, while 90.5% of the state's population was non-Hispanic white, nearly 10% came from communities of color. The current State Plan on Aging (SPOA) noted that 12% of people of color are 60 years of age and older; these residents

[1] US Census Bureau
[2] The 2019 Profile of Older Americans, Administration for Community Living.
[3] *New Hampshire Demographic Trends in an Era of Economic Turbulence*, Kenneth M. Johnson, Carsey School of Public Policy, University of New Hampshire, Fall 2019. Accessed online at https://carsey.unh.edu/publication/nh-demographic-trends

have incomes below the poverty level. Furthermore, the overall population is living longer, including individuals that identify as LGBTQ.[4] The Williams Institute at UCLA estimates that 4.7% of adults in NH are LGBTQ, suggesting that between 4 and 5% of NH's older adults are also LGBTQ. Moreover, the rates of Alzheimer's disease and other dementias and the rates of disability among older adults are increasing. In NH, the percentage of adults impacted by Alzheimer's disease is expected to rise by 33% between 2018 and 2025 to 32,000 people.

2) Evaluation of Access to HCBS Across the State: In NH, State and county governments have complementary responsibilities for the provision of long-term care. NH law mandates that the NH Department of Health and Human Services (DHHS) "develop a broad range of social and related services aimed at protecting adults and enabling aged and infirm adults to live in their own homes or residential care facilities rather than in institutions."[5] State law also requires counties to reimburse the State for care provided to financially and medically eligible county residents within a nursing home or in another setting under a Medicaid home and community-based care waiver for the "elderly and chronically ill."[6]

Long Term Services and Supports (LTSS) are paid for by a mix of public and private funding sources, with Medicaid as the major publicly funded coverage program for these services. The federal government pays for one-half of Medicaid expenses at county nursing

[4] In this proposal, LGBT refers to sexual and gender minority adults which include, but are not limited to, individuals who identify as lesbian, gay, bisexual, asexual, queer, transgender, Two-Spirit, nonbinary, gender nonconforming, and intersex. Our partners in LGBT aging have made this recommendation, because for the current generation of older adults, "LGBT" is the most culturally resonant term.
[5] Title XII, Public Safety and Welfare, Chapter 161, Human Service. http://www.gencourt.state.nh.us/rsa/html/xii/161/161-mrg.htm
[6] Title XII, Public Safety and Welfare, Chapter 167, Public Assistance to Blind, Aged, or Disabled Persons, and to Dependent Children. Section 167:18-a County Reimbursement of Funds; Limitations on Payments. http://www.gencourt.state.nh.us/rsa/html/XII/167/167-mrg.htm

homes and in specific home and community-based settings; the remaining half is split by the State and county. Counties pay most of the non-federal share, covering over 85% since 2012.[7] Within DHHS, the Bureau of Elderly and Adult Services (BEAS) provides leadership and works with State and community partners to develop and fund LTSS. BEAS ensures that NH's aging services and support system have the capacity and flexibility to meet the needs of individuals ages 60 and over and adults with disabilities ages 18-59.

While NH has one of the fastest growing populations of older adults in the nation, the State is far behind others in offering a balanced system of care. NH's spending on home and community-based services (HCBS) as a percent of LTSS spending for older people and adults with disabilities is 14%, far below the national average of 45%, putting NH 50th in the country.[8]

Service providers contracted by BEAS are required to provide culturally and linguistically appropriate services to older people and persons with disabilities. BEAS collaborates with the DHHS Office of Health Equity (OHE), which advances equitable access to effective, quality programs and services, with a particular focus on racial, ethnic, language, and gender/sexual minorities, and individuals with disabilities.

Racial, ethnic, and language diversity is greatest in the more urban and southern cities and towns in NH. In the southern District Offices of DHHS, professional interpreters are available to assist individuals with limited English proficiency in accessing services and applying for public assistance such as Supplemental Nutritional Assistance Program (SNAP) or Medicaid. While NH has no federally recognized Native American tribes, NH has a strong community of

[7] County Medicaid Funding Obligations for Long-Term Care, NH Fiscal Policy Institute, August 2019. https://nhfpi.org/resource/county-medicaid-funding-obligations-for-long-term-care/#_edn4
[8] New Hampshire: 2020 Long-Term Services and Supports State Scorecard Data, AARP

Indigenous people, most notably the Abenaki people. NH's Intertribal Native American Council helps to improve access to services for older Native American individuals.

Among NH's diverse populations that have historically been marginalized are LGBT older adults – many of whom do not experience competent, inclusive health care.[9] LGBT older adults are less likely to rely on family members for caregiving (due to estrangement) and often experience unwelcoming or ill-prepared health care providers.[10] Given the stigma often faced by older LGBT people in residential long-term care (LTC) from staff and residents, HCBS to assist someone to age in place are preferred by many LGBT people. In 2020, BEAS collaborated with the Endowment for Health, Zen Executive LLC, and UMass Boston on an LGBT Aging Readiness Scan of LTSS for vulnerable older adults, inclusive of Adult Protective Services, the Office of the Long-Term Care Ombudsman, and nutrition programs in NH's two most populous counties.[11] This scan provided an assessment of current strengths and challenges and outlined opportunities and recommendations for these and other agencies to ensure appropriate and welcoming access to LTSS for LGBT older adults.

3) **Federal Funding Opportunities Leveraged to Advance LTSS System Reform:** Over the past two decades, DHHS has leveraged multiple federal funding opportunities to advance LTSS system reform, including earlier rounds of Money Follows the Person (MFP) funding. Previously, NH's participation in MFP focused on moving people with disabilities from institutional to home and community settings. In 2007, the Community Passport Program (CPP)

[9] Understanding Issues Facing LGBT Older Adults. 2017. Movement Advancement Project and SAGE. Accessed online https://www.lgbtmap.org/file/understanding-issues-facing-lgbt-older-adults.pdf
[10] LGBT Older Adults and Inhospitable Health Care Environments. September 2010. Movement Advancement Project, SAGE, and Center for American Progress. Accessed online: https://cdn.americanprogress.org/wp-content/uploads/issues/2010/09/pdf/lgbt_environments.pdf
[11] LGBT Aging Readiness Scan: New Hampshire. Porter, K. E., Rataj, A., Mertens, P., Dugan, E. 2020. Zen Executive LLC.

was established with MFP funding. CPP supported the transition of almost 300 individuals with complex social and medical conditions out of nursing homes between 2007-2015. During the program, NH worked diligently to reach the program's transitional goals; however, despite outreach and marketing efforts by CPP administrators, program referrals decreased, and the number of transitions plateaued as the health care landscape evolved.

By March 2016, DHHS created programs to deliver transitional services like CPP; and from April 2016-March 2017, sustained non-transitional program functions and incorporated CPP transitional functions into other programs, waiver services, and initiatives. The Choices for Independence (CFI) waiver program, which helps older adults/adults with chronic illnesses to live in the community, continues the CPP mission of transitioning individuals from institutional settings to HCBS. DHHS added services to CFI to support transition efforts, including case management and community services. Resources include funding one-time expenses to support individuals as they transition from living in a provider-operated setting to a private residence where they are responsible for their own living expenses.

From 2017 until the MFP program closed in 2019, DHHS worked with the Centers for Medicare & Medicaid (CMS) to allocate the remaining MFP administrative funds for NH's sustainability plan and LTSS System improvements. For example, MFP administrative funding was used to implement the Electronic Visit Verification requirements[12], build the capacity of community-based mental health supports that defer institutional placements, and meet updated CMS requirements (HCBS Final Rule) for home and community-based settings. DHHS continues to work with Nursing Facilities (NFs) and CFI Waiver Case Management agencies to

[12] https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/evv-advisory-council-slides-031020.pdf

identify individuals who wish to return to community living and ensure those individuals are given the support they need to do so. Tools and training were developed and are currently used to support individuals and providers who explore transitions back to community settings.

In addition to MFP, DHHS has partnered with the Administration for Community Living (ACL), CMS, and the Veterans Health Administration to create an efficient person-centered service delivery system in the community for all populations. As a result, the ServiceLink Aging and Disability Resource Center (SL-ADRC) Network has been recognized as a sustainable, high functioning statewide model for a decade. NH created a No Wrong Door (NWD) system of partner organizations, developed a web portal to access LTSS, implemented a statewide outreach campaign, hired eligibility coordinators, created an LTSS screening process and tools, and streamlined application and eligibility determination processes. This NWD System of Access for LTSS is branded as NHCarePath. It epitomizes the growth and improvements that partners across NH's LTSS system can achieve when flexible within changing environments and opportunities. In 2020, the national *Long-Term Services and Supports (LTSS) State Scorecard* ranked NH second in the nation for ADRC/NWD functions. Working together, NH's SL-ADRCs, Long Term Care Navigators, and the NHCarePath Initiative ensure there is a system in place to identify and assist individuals who seek HCBS as an alternative to facility-based care.

Improving access to LTSS is one part of system transformation. DHHS has received other funding to develop a prevention-focused and person-centered LTSS approach focused on better health, better care, and reduced costs while reducing waitlists for LTSS. In 2013, NH received a CMS State Innovation Model (SIM) Design grant to better connect health care transformation efforts, identify challenges and opportunities, and unite leaders to meet critical health care needs. From that process, DHHS produced the State Health Care Innovation Plan

focused on supporting individuals in need of, or at risk for, needing LTSS -- primarily people likely to have multiple payors for their care who accounted for 64% of the State's $1 billion Medicaid budget. The plan addressed a need for better coordination between the State's medical, behavioral, and LTSS delivery systems. Simultaneously, NH participated in the federal Balancing Incentives Program (BIP) to streamline access to LTSS and improve the balance of care delivery settings by supporting more people in community settings.

Recently, from April 2021 and March 2022, the American Rescue Plan Act of 2021 (ARPA) temporarily increased the federal medical assistance percentage (FMAP) by 10% for certain Medicaid HCBS expenditures. The increased FMAP enabled community or home-based person-centered care to support people with everyday activities. Aimed at enhancing, expanding, or strengthening HCBS, NH invested 67% of resources into the workforce, 18% to increase /improve access to services, and 15% to pilot new services.[13] NH is in year two of a three-year HCBS Spending Plan and is using resources to expand workforce capacity by recruiting, retaining, and advancing HCBS workers through sign-on/retention bonuses, ladder advancement stipends, and education/training support. In year one NH $42.3 to the direct care workforce through NH's four 1915 (c) waivers.

4) **Trends in Long-Term Care Facilities May Impact Rebalancing Strategies:** In 2016, Governor Christopher T. Sununu signed legislation instructing DHHS to develop an implementation plan for Medicaid Managed LTSS (MLTSS), inclusive of NFs and HCBS provided under the CFI waiver. DHHS retained Navigant Consulting (now known as Guidehouse) to identify LTSS service delivery models that addressed legislative requirements.

[13] Fourth Quarter Update to Spending Plan for Implementation of the American Rescue Plan Act of 2021, Sect. 9817, April 2022, NH Medicaid update as submitted to Centers of Medicare and Medicaid Services (CMS).

Guidehouse's report assessed LTSS service delivery models, including capitated managed care organizations (MCOs), administrative services organizations, accountable care organizations, the Program of All-Inclusive Care for the Elderly, and primary care case management models.

In 2018, NH's Legislature ended the MLTSS discussion by passing HB 1816.[14] The effort to transform the LTSS system continued; in the next phase, Guidehouse assessed NH's current LTSS delivery network, including HCBS and NF care for older adults and individuals with physical disabilities, to advise the State accordingly. While data do not reflect the impact of the COVID-19 public health emergency, they provide relevant historical context.[15] Prior to the pandemic, the aggregate NF occupancy rate was high (89%) compared to the national average (81%). Guidehouse suggested this might be due to consumers' unawareness of care options, a lack of available HCBS services, or unnecessary residential care referrals in discharge planning.

From 2015-to 2021, demand for services for older residents increased while the LTSS workforce decreased, losing more than 2,000 workers from home health care, continuing care/assisted living, and skilled nursing facilities.[16] In health care, demand is highest for nursing assistants, Registered Nurses, Licensed Practical and Vocational Nurses, medical/ health services managers, personal care aides, and home health aides.

The direct care workforce providing HCBS and NF care to older adults and people with disabilities was already experiencing challenges nationwide pre-pandemic. In 2019, the starting

[14] Bill Text - HB1816 (2018): Relative to Medicaid managed care. https://bills.nhliberty.org/bills/2018/HB1816/revision/3841

[15] New Hampshire Long Term Supports and Services (LTSS) for Seniors & Individuals with Physical Disabilities, Findings and Recommendations, Presented to NH Department of Health and Human Services, March 12, 2021, Guidehouse Inc.

[16] November 2021 presentation by Richard Lavers, Deputy Commissioner of NH Employment Security and Brian Gottlob, Director of NH Economic and Labor Market Information Bureau to the NH State Commission on Aging.

wage for direct support professionals was $12/hour, yet entry-level food service and retail jobs were $15/hour. Medicaid reimbursement rates (which as of 2019 had not increased for 13 years) were blamed for restricting LTSS worker wages.[17] While a rate increase of 3.1% was enacted in 2019, wages were still low compared to other industries; such wage disparities are problematic given the growing costs of basic needs, particularly housing in NH. Additionally, given the rurality of NH and the high percentage of older residents in NH's rural communities, there is a lack of adequate workers in areas most in need of direct care workers.

Today, demand for workers across all industries is at a record high, while labor force participation is decreasing. The number of posted job openings nearly doubled from 10,000 a month in January 2019 to 19,000 in April 2022.[18] During this period, job postings in home health care, skilled nursing facilities, and continuing care and retirement facilities have increased from 170 in January 2019 to 440 in April 2022. Industries serving older adults have slightly more workers at or near retirement age than other industries. Workers ages 55-64 comprise 20% of all workers yet account for 22% of workers in continuing care, home health, and skilled NFs.

The COVID-19 pandemic illuminated challenges within LTSS and prompted overdue changes to the LTC system. Early on, front-line workers faced shortages of Personal Protective Equipment (PPE) and later, hit barriers to timely vaccines. LTSS options were limited by the pandemic, as access to LTC facilities was restricted by quarantine rules that reduced the number of available beds, and several NFs were required to refuse admissions from the community as a matter of infection control policy.

[17] https://www.nhbr.com/nhs-eroding-direct-care-workforce/
[18] Updated Economic and Labor Market Information, provided to DHHS Associate Commissioner, Christine L. Santaniello, on May 12, 2022, by Richard Lavers, Deputy Commissioner NH Employment Security.

In April 2020, in response to the pandemic, an LTC Stabilization Fund was implemented by Governor Sununu's Executive Order that temporarily augmented income for direct care workers providing Medicaid-funded LTSS. This policy acknowledged the personal risks taken by workers in residential, home, and community settings and sought to incentivize workers to remain in or rejoin a critical workforce serving the State's most vulnerable residents.

As of May 11, 2022, NH had recorded 316,127 cases of COVID-19; 5% (14,341 cases) were among people associated with LTC facilities, inclusive of residents and staff.[19] Of the 2,499 COVID-19 deaths recorded (as of May 9, 2022), 46% or 1,152 deaths were associated with LTC facilities. NFs have continued to experience challenges in high case and death rates during periods of a surge, likely due to the highly transmissible nature of variants and the nature of congregate care settings. The prolonged pandemic has created burnout among front-line health care workers, which has exacerbated the workforce shortage.

5) **Quality Improvement and Measurement Incorporated into LTSS System**

Reporting: For Medicaid-funded LTSS, DHHS employs staff specifically designated to oversee the performance of operational and administrative functions. Designated staff work in partnership with the DHHS Division of Program Quality and Integrity to assess the qualifications and performance of non-State entities. Methods used to assess performance include oversight and monitoring of Medicaid Provider agreements, annual contract review, licensing and certification reviews, and quality assurance activities such as record and performance reviews of provider agencies based on the performance measures in contracts and as part of the CFI waiver.

[19] New Hampshire COVID-19 Response Dashboard, NH Department of Health and Human Services, Division of Public Health Services: https://www.covid19.nh.gov/dashboard/case-summary

BEAS utilizes performance measures to demonstrate progress with the design and implementation of an effective LTSS system of care. These include 1) a process and tools to evaluate an applicant's or participant's level of care is consistent with care provided in a hospital or NF at least annually or as specified; 2) an adequate system to ensure waiver services meet required licensure and/or certification standards prior to furnishing waiver services, including verifying that provider training is conducted in accordance with State requirements and the approved waiver; 3) an effective system for creating and reviewing service plans that meet participant-centered planning and service delivery, address assessed needs (including health and safety risk factors) and personal goals, and are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan; 4) an effective system for assuring participant health and welfare that identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death, maintains an incident management system to effectively resolves those incidents, prevents further similar incidents to the extent possible, and ensures policies and procedures for the use of prohibition of restrictive interventions (including restraints and seclusion) are followed; and 5) an adequate system for ensuring financial accountability of the waiver program by providing evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered, and that rates remain consistent with the approved rate methodology throughout the waiver cycle.

This framework includes such performance measures as the % of person-centered plans developed with participant involvement, % of plans that addressed individualized goals of a participant, % of waiver participants who experienced abuse, neglect, and exploitation that were assessed and addressed annually, and % of restrictive interventions in which policies and

procedures were followed. DHHS requires all funded providers to comply with its Sentinel Event (unanticipated deaths, permanent loss of function, suicide deaths, sexual assaults, and other serious incidents) reporting process and NH Adult Protective Services reporting requirements.

The Office of the Long-Term Care Ombudsman (OLTCO) conducts data collection through *OmbudsManager*, a web-based case management software system that follows the National Ombudsman Reporting System and ACL requirements. The system generates data reports and tracks consultations, facility visits, and education and training activities. Under the current SPOA, OLTCO is working with the Local Area Network for Excellence (LANE) to focus on national quality benchmarks related to performance and medical goals that can be obtained through individualized, person-centered, and person-directed approaches.

6) **Assessment of Partnerships:** Supporting the health and wellbeing of older adults requires mobilizing resources and building partnerships across DHHS. The Division for Behavioral Health oversees community mental health centers and psychiatric emergency and crisis services. The Division of Economic and Housing Stability oversees the Old Age Assistance Program, State Supplemental Program, and SNAP. The Division of Public Health oversees the Bureau of Emergency Preparedness, Response, and Recovery and the Bureau of Population Health and Community Services (inclusive of chronic disease prevention and the Commodity Supplemental Food Program for Adults 60+). An Interagency Integration Team (IIT) facilitates monthly collaborative meetings with representatives from the BEAS and other bureaus to review cases of individuals needing assistance from multiple service delivery systems. These meetings allow the bureaus to review complex situations on a case-by-case basis, identify barriers, and create pathways to meet an individual's holistic needs. The IIT also identifies large-scale policy changes to ensure quality oversight for people with multiple needs.

A fundamental part of NH's LTSS system is the ServiceLink network of 13 primary and additional satellite community-based ADRCs. ServiceLink administers programs and services that include: Information and Referral Assistance, Options Counseling, NH Family Caregiver Program, State Health Insurance Assistance Program (SHIP), and Senior Medicare Patrol (SMP). ServiceLink specializes in providing guidance, support, and referrals for older or disabled adults who seek assistance locating and/or applying for LTSS.

NHCarePath, the ADRC/NWD System of Access, builds upon the ServiceLink network's assets. Residents of any age, income level, or ability can access information on services and supports, assistance with daily living needs, and care options at home or in the community through NHCarePath. Effective cross-agency partnerships ensure "no wrong door" in accessing caregiver supports, resources for developmental disabilities, elderly, and adult supports, financial assistance, housing and community-living options, Medicaid, mental health supports, personal and legal rights, treatment for substance use disorders, transportation, and military or veterans services. Given the complexity of systems and supports, NHCarePath employs options counselors to assist people in exploring the range of choices available. *NH Easy* is another interagency collaboration to ensure access to resources across DHHS. Through one portal, individuals and families can screen for eligibility, identify options, and apply for cash, medical, nutrition, childcare assistance, Medicare beneficiary, and LTC assistance.

In 2019, DHHS finalized its SPOA (2020-2023), which was approved by NH leaders and ACL. The planning process integrated input from 3,500 community voices and 40 organizations, including DHHS representatives from the Bureau of Developmental Services, the Division of Economic and Housing Stability, the Division of Public Health Services, the Division of LTSS, OLTCO, and the ServiceLink ADRCs.

BEAS operates under the Division of LTSS and collaborates with the Division of Economic and Housing Stability, which works with individuals and families across the lifespan to address social determinants of health, including housing support to maintain stability and independence. This collaboration is particularly critical given that NH is experiencing an unprecedented affordable housing shortage.[20] BEAS works with organizations like Southern NH Services (SNHS), one of NH's leading housing providers for low-income older adults. With funding from the US Department of Housing and Urban Development (HUD) 's Section 202 Supportive Housing Program, SNHS has built and manages quality, affordable housing in 25 different Senior Housing sites throughout the state.[21] Older adults pay 30% of their adjusted gross income to rent one of 817 apartments; the balance is subsidized by HUD's Section 8 Rental Assistance Program. With funding from the NH Housing Finance Authority and local housing authorities like Nashua Housing and Redevelopment Authority, providers offer Low Income Housing Tax Credit (LIHTC) sites for older adults, including 93 units in Nashua.[22]

7) **Strategies to Increase the Share of LTSS Provided in Community-based Settings:** For 20 years, NH has been working to reduce reliance on institutional care and increase home or community-based LTSS. As of 2019, 47% of total Medicaid spending for LTSS clients was used on HCBS, a 1% improvement from the prior year but still below the national average

[20] https://www.nhbr.com/worsening-shortage-in-new-hampshire-reduces-access-to-affordable-homes/
[21] Southern NH Services, Housing & Homelessness Prevention: Supportive Housing for the Elderly. Accessed online: https://www.snhs.org/system/files/2021-04/uploads/file/HOUSING_SUPPORTIVE%20HOUSING%20FOR%20SENIORS.pdf
[22] Southern NH Services, Housing & Homelessness Prevention: LIHTC Senior Housing Program. Accessed online https://www.snhs.org/system/files/2021-04/uploads/file/HOUSING_LIHTC%20SENIOR%20HOUSING.pdf

of 59%.[23] NH is showing signs of a reduced reliance on institutional care. On February 28, 2022, DHHS conducted a one-day census of the state's nursing homes; at that time, 73.1% of the 7,226 skilled nursing facility/interim care facility licensed beds were occupied, leaving 1,941 unoccupied beds. Among the 71 facilities participating in the census, the average occupancy was 75.6%. This census indicates a change of -15% from the 89% occupancy of NH's nursing home beds reported in AARP's *2018 Profile of Long-Term Services and Supports in NH*.[24]

Advancing Equity for Diverse Populations: To advance equity, BEAS will partner with OHE to identify and implement culturally and linguistically appropriate practices for underserved and marginalized communities for outreach, assessment, care planning, and service delivery. OHE provides policy, strategic guidance, training, coaching, and technical assistance across all DHHS for ongoing organizational improvement related to diversity, inclusion, and equity as well as organizational cultural effectiveness, supporting all program areas' capacity to provide quality care and services. OHE offers expertise and relationships, having created and promoted a framework and toolkit for Culturally Effective Organizations in health care and for organizations addressing the broader social determinants of health.[25]

Momentum and resources to promote improvements in LTSS related to diversity, equity, and inclusion (DEI) are growing in NH. The NH Alliance for Healthy Aging (NH AHA), a statewide collaborative of government, non-profit, and private organizations, has established a DEI Committee to ensure that older adults who have historically been marginalized or underrepresented are no longer overlooked, and equity remains at the center of all activities and

[23] Medicaid Long Term Services and Supports Annual Expenditures Report, Federal Fiscal Year 2019. Centers for Medicare and Medicaid Services, December 9, 2021. Prepared by Mathematica. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf
[24] https://www.aarp.org/content/dam/aarp/ppi/2018/08/new-hampshire-LTSS-profile.pdf
[25] https://www.amoskeaghealth.org/center-of-excellence-for-culturally-effective-care/

strategies. This committee advanced a partnership between NH AHA and the Carsey School of Public Policy to host leaders in LTSS and other aging services for a cohort of the Leadership Learning Exchange for Equity. Individuals from BEAS, the SLRCs, HCBS providers, and other aging services organizations engaged in an intensive series of facilitated dialogues focused on systemic and structural racism, implicit bias, and privilege associated with social identities.

In May 2022, BEAS participated in LGBTQ Inclusive Aging Training for Organizational Leaders, which was co-sponsored by NH AHA and the LGBTIA+ Aging Project of The Fenway Institute. This training was designed to help aging service organizations build awareness and take steps to become LGBTQ-inclusive aging service organizations. The training was designed for leaders able to influence decision-makers and/or affect change within their organization.

To assess racial and/or ethnic trends in aging and identify potential differences in access to HCBS based on demographic characteristics, agencies must improve the collection of race, ethnicity, and language data. During the SPOA planning process, BEAS worked with the SPOA Committee to field a survey completed by 3,000 individuals across the state. In addition to English, the survey was available in Arabic, English, French, Greek, Kinyarwanda, Nepali, Portuguese, Spanish, Swahili, and Vietnamese. The survey solicited input on participant demographic characteristics such as race, ethnicity, language, income, and sexual and gender identity. BEAS can advance better data collection by expanding these efforts and investing in training and tools to ensure HCBS providers meet these standards.

B. Proposed Target Population and Geographic Target Area

Previously, funding for MFP focused on transitioning people with disabilities from institutional settings to community-based settings. NH will use lessons learned from prior MFP efforts and build on the momentum created towards HCBS during the pandemic. With funding to

plan and implement a new MFP demonstration, BEAS proposes a target population of older adults and adults with chronic health conditions eligible for the CFI Waiver Program. CFI serves adults ages 65+ and/or adults ages 18-64 with a disability. In addition to being medically eligible for nursing home placement, they must meet Medicaid income and asset guidelines. BEAS will also provide transitions to HCBS for targeted residents of NH's Glencliff Home. DHHS's geographic target for the MFP Demonstration is statewide.

Table 1: NH Residents in Choices for Independence and Nursing Facilities by County Calendar Year 2021[26]

County	Choices for Independence (CFI)	% of total in CFI	Nursing Facility (NF)	% of total in NF	County Total
Belknap	315	54%	269	46%	584
Carroll	151	35%	281	65%	432
Cheshire	274	39%	427	61%	701
Coos	196	38%	317	62%	513
Grafton	290	45%	354	55%	644
Hillsborough	1,596	49%	1,684	51%	3,280
Merrimack	587	48%	635	52%	1,222

[26] Source: Medicaid Management Information System. Includes all Medicaid eligible adults for Choices for Independence and Nursing Facilities served in calendar year 2021. Does not include private pay.

Rockingham	670	48%	729	52%	1,399
Strafford	533	54%	446	46%	979
Sullivan	233	50%	236	50%	469
Total	**4,845**	**47%**	**5,378**	**53%**	**10,223**

In 2021, the population of Medicaid-eligible adults participating in CFI and living in nursing facilities (NF) totaled 10,223 (see Table 1). At 53% of the total, the Medicaid eligible NF population was slightly larger than the CFI population. However, there were regional differences in the split of NF vs. CFI. In the more rural counties of Carroll, Cheshire, and Coos, NF residents exceeded 60% of the total. These differences indicate that the MFP approach must address the unique challenges that make CFI a less viable option for residents of certain rural counties and invest in building capacity for solutions.

The data above (Table 1) does not include private pay NF residents. A one-day census in February 2022 found the total number of all individuals, both Medicaid eligible and non-Medicaid residents, living in NFs (skilled nursing facilities and interim care facilities) was 7,226.

As noted earlier, NH is among the country's top three states with the oldest population. In 30 of NH's 237 towns, mostly in rural areas, 30% or more of residents were aged 65 or older. Demographers believe this is a function of preferences for aging-in-place among current residents of these regions, coupled with the migration of young adults to more urban places. While the proportion of older adults is more significant in the north, most of the state's older adults reside in southern and central NH.

As more of NH's older adults live longer, many people will experience complex health conditions, increasing the demand for LTSS. According to the *2019 New Hampshire Healthy*

Aging Data Report,[27] 12% of older adults (65+) in the state were living with Alzheimer's disease or related dementia. More than half of NH's older people (54%) were diagnosed with four or more chronic conditions, 22% had chronic kidney disease, and 70% had hypertension. Depression was experienced by 29% of older adults, and 5% suffered from schizophrenia or other psychotic disorders.

The State operates Glencliff Home, a 118-bed NF for individuals with severe mental illness and intellectual disabilities. DHHS has been working to transition residents into various integrated community-based settings, including enhanced family care, independent apartments, and supported housing. The MFP Demonstration will include a specific pilot focused on transitioning a cohort of Glencliff residents.

C. Proposed Demonstration Design and Planning Phase Project Plan

Upon project launch, BEAS will hire a full-time MFP Project Director and full-time MFP Data and Quality Analyst. The Project Director is responsible for the overall operation of the MFP project, including overseeing the implementation of project activities, coordinating with other departments within DHHS and external to the state agency, and conducting meetings. The Project Director will oversee the planning phase, including convening the MFP Consultative Group, collecting and analyzing data, engaging stakeholders, and designing the operations protocol. The Project Director will have the authority to ensure necessary reports/documentation are submitted to CMS and supervise the MFP Data and Quality Analyst. The Data and Quality Analyst will design, collect, and analyze the required data needed for the system assessment, gap analysis, and reporting to CMS.

[27] Dugan, E., Porell, F., Silverstein, N., & Lee, C.M. (2019). Highlights of the 2019 New Hampshire Healthy Aging Data Report. https://healthyagingdatareports.org/wp-content/uploads/2019/03/2019_NH_Healthy_Aging_Data_Report.pdf

The Project Director will convene an MFP Consultative Group comprised of key stakeholders from within DHHS and those external to the State agency. Consultative Group members will leverage resources at the state and community level, provide advice to the Project Director, offer input to assist with a decision-making process, serve as an essential link to the community, and report progress to relevant organizations. BEAS will create an MFP Consultative Group charter that provides clarification of member roles and responsibilities, decision-making processes, expectations regarding meetings (frequency, duration, location), and process for announcing meetings and distributing materials in advance. Meetings will be facilitated by the Project Director or designee from BEAS. A BEAS representative will take minutes to document all activities, which will be circulated after each meeting. While the MFP Consultative Group will provide input during the planning phase and on the proposed demonstration design, BEAS envisions this group will continue to meet for the duration of the grant period. In addition to BEAS, MFP Consultative Group members will include representatives from the following agencies and organizations: **DHHS, Division of Public Health Bureau of Population Health and Community Services,** oversees chronic disease prevention and screening, injury prevention, women's health, nutrition services, and tobacco prevention and cessation section; **DHHS, Division of Economic and Housing Stability,** includes the Bureau of Family Assistance and the Bureau of Housing Supports; **DHHS, Medicaid Care Management,** delivers health benefits and services through contracts with MCOs or Medicaid Health Plans (AmeriHealth Caritas NH, NH Healthy Families, and WellSense Health Plan); **ServiceLink**, NH's designated Aging and Disability Resource Centers that serve as the single point of entry into the long-term supports and services system for older adults; **NH Hospital Association** with 31 members (13 critical access hospitals, 12 large

community hospitals, five specialty hospitals, and an academic medical center; **Cheshire, Strafford, and Hillsborough County Government** LTSS representatives; **NH Association of Residential Care Homes**, NH's professional organization for residential and assisted living facilities that assures the quality of living/ care for residents; **Easter Seals NH** provides senior services, including adult medical day care, homemaker and home health services, memory care, and flexible funding services; **Brain Injury Association of NH** provides support, prevention, education, and advocacy; **Home Care Hospice & Palliative Care Alliance of NH,** a membership organization of more than 40 licensed agencies delivering home health and hospice care; **Granite VNA,** the largest home health and hospice provider in the state; **AARP NH** empowers people to choose how they live as they age; **NH Alliance for Healthy Aging (NH AHA),** a collective impact effort of 170 government, non-profit, and private entities working to create communities where older adults can access a wide range of choices to advance health, independence, and dignity; **Granite State Independent Living** provides home care services, community-based supports, and services to assist people with tools for living life independently; **SNHS,** a Community Action Program and Supportive Housing Provider for seniors; agencies providing Case Management for CFI Waiver; and **NH Health Care Association** represents health care providers who believe that all individuals served are entitled to a supportive environment.

BEAS plans to contract with the University of New Hampshire (UNH), Institute for Health Policy and Practice (IHPP) and will work with the Center on Aging and Community Living (CACL) at UNH to provide project support, building on a successful history of working together on related projects, including evaluating, expanding, and enhancing the ServiceLink ADRC for over 15 years, Project Management entity for BIP, the Business Acumen Initiative to

promote Community Based Organizations to contract with integrated health care entities and alternative payment structures, and Direct Connect, a prior effort funded by the U.S. Department of Labor to address direct care workforce issues. Today, CACL serves as the hub for a regional Project ECHO, focused on Aging, Community, and Equity, and provides backbone support for NH AHA.[28] In 2014, CACL completed an environmental scan that encompassed six areas of healthy aging in NH: Living Arrangements, Family Caregivers, Social and Civic Engagement, Physical and Mental Well-being, Advocacy, and Fundamental Needs. It is well-positioned to support the MFP process, leveraging its effective relationships with a range of stakeholders – from older adults themselves to advocates and providers to the State's elected and appointed officials.[29]

With guidance from the MFP Consultative Group and support from CACL, the Project Director will lead a system assessment and gap analysis that looks at a range of demographic data, including race, ethnicity, age, and gender at the state and county levels. The team will study LTSS utilization trends among older adults and older adults with physical disabilities. BEAS will examine state and county trends and compare urban, suburban, and rural communities. BEAS will also look at the diversity of people served and how they reflect the state's population.

During the planning phase, BEAS will analyze the HCBS system capacity to understand services covered under Medicaid, provider capacity, existing quality improvement and assurance systems, cross-agency collaborations, and affordable/accessible housing capacity (including wait times). BEAS will also conduct an inventory of community-based networks and resources that support community integration. Furthermore, BEAS will identify gaps in HCBS capacity based

[28] https://nhaha.info/
[29] https://nhaha.info/wp-content/uploads/2017/09/collaborating_to_create_elder_friendly_communities_final_report.pdf

on LTSS population needs and geographic needs. Finally, BEAS will assess institutional capacity to determine how NH can restructure for increased investment in HCBS.

While BEAS will benefit from multiple perspectives represented on the MFP Consultative Group, the team will engage additional stakeholders to inform the creation of the project plan. Using a participatory approach, the team will conduct surveys among LTSS providers and those who play a role in transiting individuals between institutional settings and HCBS. The team will also conduct informant interviews with key officials who can provide insight on utilization trends, processes, and systems and offer input on areas of improvement.

Connecting with stakeholders will enable BEAS to better understand how to best recruit transition coordination and other HCBS providers to participate in MFP. Stakeholders representing diverse/underserved populations include DHHS OHE, NH AHA's DEI Committee, and Southern NH Area Health Education Center. Stakeholders representing tribal entities include the NH Intertribal Native American Council. Key statewide agencies include the Alzheimer's Association of NH, the Foundation for Healthy Communities, and the NH Association of Regional Planning Commissions. There are eight regional planning commissions; it will be essential to have each represented. State and local public authorities include the NH Commission on Aging, NH Housing Finance Authority, NH Department of Transportation, Bureau of Developmental Services, Office of the Long-Term Care Ombudsman, Division of Economic and Housing Stability, Division of Public Health Services, Division of Long Term Supports and Services, and Greater Manchester Area Committee on Aging. Community-based organizations involved in transitions include the NH Association of Residential Care Homes, Homecare, Hospice, and Palliative Care Association of NH, NH Health Care Association, NH Hospital Association, ServiceLink ADRC, Easterseals NH, NH's Visiting Nurses Associations, Granite

State Independent Living, county nursing homes, private nursing homes, skilled nursing facilities, rehabilitation facilities, hospitals, and housing providers for older adults. Agencies representing HCBS beneficiaries include EngAGING NH, AARP NH, agencies providing CFI Case Management, and New Futures. By enlisting stakeholder input and contracting with experts in the field, BEAS will understand how to develop contracts and establish billing procedures that align with best practices among HCBS providers. BEAS will also identify areas for training to ensure effective implementation of the MFP model.

BEAS will build its capacity to implement its MFP model by procuring and contracting with technical experts from the field. For example, BEAS aims to build its ability to assess institutional capacity and determine how the state could better use these resources. BEAS also intends to assess HCBS system capacity and determine how additional providers and services might be needed, including self-directed services and providers that serve communities of color and other underrepresented populations. BEAS aims to improve its capacity to assess racial, ethnic, and other disparities in the state's HCBS system and develop strategies to address them. Moreover, BEAS will utilize experts to help assess and implement changes to reimbursement rates and payment methodologies to expand HCBS provider capacity and improve quality.

At the conclusion of the planning phase, BEAS will create a draft MFP Operational Protocol that incorporates all required sections, including Organization and Administration, Target Population, Transition Benchmarks, Participant Recruitment and Enrollment, Targeted Outreach to Underserved Populations, Informed Consent and Guardianship, Outreach /Marketing/Education, Stakeholder Involvement, Benefits and Services, Consumer Supports, Self-Direction, Quality Measurement/ Assurance/Monitoring, Housing, Continuity of Care Post Transition, and Budget Projections. The demonstration design will align with the goals of the

MFP initiative; it will address the challenges and circumstances identified in the need statement of this proposal and additional data obtained through the system assessment and gap analysis.

The Operational Protocol will be specific enough for project launch upon announcement of a cooperative agreement. The document will present a clear plan for using funds to advance state rebalancing strategies, including direct service workforce challenges and workforce capacity, recruitment, retention, and training needs. The protocol will present a clear strategy for identifying and enrolling participants, including partnering with and training transition coordination and housing support providers. The protocol will also outline how BEAS will collaborate with other providers to ensure services are delivered in a person-centered, coordinated fashion and leverage cross-agency collaboration with state and local housing agencies, community-based organizations, social service agencies, aging and disability networks, and HCBS beneficiaries. Finally, the protocol will incorporate potential equity, legal and policy barriers, and mitigation strategies

NH's current SPOA ends in September 2023 and the planning phase for the MFP demonstration will be concurrent with the timeline for NH's next SPOA. Many of the same stakeholders and leaders in the field of aging and LTSS are vital to effectively developing appropriate plans for each of these efforts. DHHS will seek to derive efficiencies from an integrated approach to revise the SPOA while devising the MFP demonstration plan.

The Project Plan and Timeline are as follows:

- Objective 1 (Months 1-3): Within 90 days, establish infrastructure for planning and operating the MFP initiative in NH. Activities include: recruiting and hiring a Project Director and Data and Quality Analyst and contracting with CACL at UNH. Milestones include hired staff and an executed contract.

- Objective 2 (Months 4-16): Engage stakeholders monthly to inform and guide the planning process. Activities include convening the MFP Consultative Group and hosting monthly meetings. Milestones include a convened group and meetings held monthly.
- Objective 3 (Months 6-13): Conduct an 8-month HCBS system assessment and gap analysis. Activities include collecting and reviewing data and engaging stakeholders. Milestones include completed stakeholder sessions and surveys and a completed assessment.
- Objective 4 (Months 6-13): Conduct an assessment of institutional capacity for current and future needs of the state. Milestone is a completed assessment.
- Objective 5 (Months 6-13): Procure technical assistance experts to build NH's capacity for MFP implementation. Activities include creating a procurement process and selecting consultants with subject matter expertise. Milestones include hired consultants and completed training and technical assistance.
- Objective 6 (Months 14-16): Develop an Operational Protocol for the implementation of MFP, including the Glencliff Home pilot. Activities include convening the MFP Consultative Group, procured experts, and internal staff to develop the protocol. Milestone is a completed and approved Operational Protocol.

D. Data Collection, Reporting, and Evaluation

Data Collection Plan: DHHS will also contract with the Institute for Health Policy and Practice (IHPP) at UNH to work with CACL to develop and implement a plan to conduct National Core Indicators for Aging and Disabilities (NCI-AD)[30] For the CFI Waiver. NCI-AD is a consumer experience survey that participating states use to collect and maintain valid and

[30] https://nci-ad.org/images/uploads/NCI-AD_Project_Overview_2021-2023.pdf

reliable person-reported data about the impact that publicly funded LTSS has on consumers' quality of life and outcomes.

CACL will support DHHS to field the survey at least once between 2023-2026 and complete the following critical steps: 1) collaborate with NCI-AD technical assistance providers for project planning at the state level; 2) ensure coordination with the State's Medicaid, Disability, and Aging agencies on all aspects of the project; 3) engage NH's aging and disability stakeholders to inform and prepare for the rollout of NCI-AD; 4) survey a random sample of at least 400 participants; and 5) collect predetermined demographic and service-related information on each individual interviewed, using administrative data sources to the extent possible.

The planning year will begin in June 2023. The NCI-AD project team will provide intense technical assistance and work with NH to prepare for project implementation and successful data collection. For each year of data collection, the NCI-AD project team provides participating states with the benefits of centralized project direction (including continued assistance with the state's survey sample population), data management, analysis, and reporting. The first data collection year will begin in June 2024 and be completed in May 2025.

The NCI-AD project team annually prepares and distributes state-specific and national reports and works with participating NCI-AD states to examine implications and best utilization of data, prepare publications, and participate in research opportunities. While the exact schedule for the NCI-AD reports has not yet been determined, BEAS anticipates a state-specific report in Fall/Winter 2025 and a national report in Spring 2026.

T-MSIS Data Submission Status: While NH passed on the critical priority criterion for T-MSIS; we did not meet at least one of the targets for the high priority and/or expenditures data

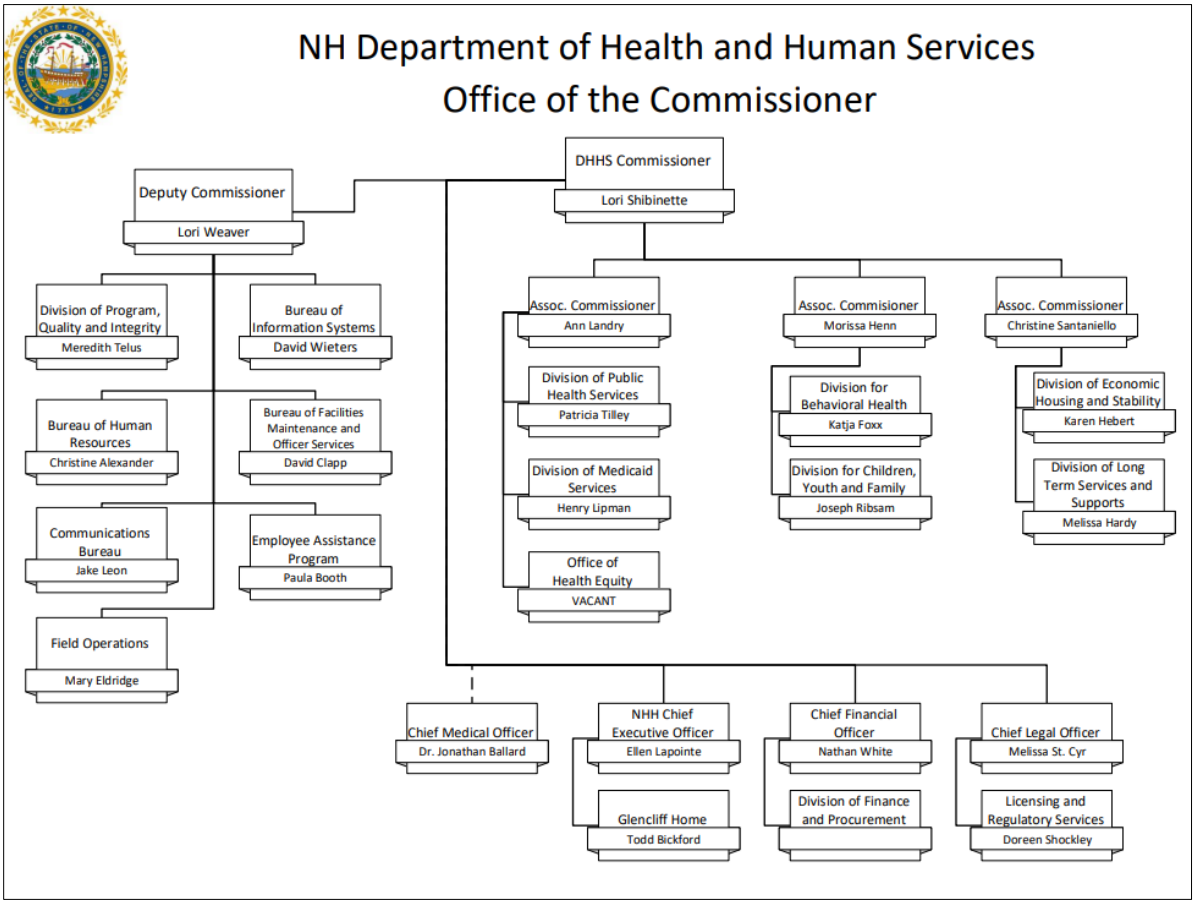
content category per the Data Quality Progress for Outcomes Based Assessment (OBA).[31] As of March 2022, NH had data quality issues with 3-5 of the T-MSIS priority items, with file submission status of current and complete.

Working with the MFP Quality Analyst, the MFP Project Director will oversee the development and implementation of plans for MFP data-collection, reporting and evaluation. BEAS will contract with CACL for technical support, including identification of performance indicators and program outcome metrics. CACL will support BEAS to submit timely and complete quarterly, semi-annual, and annual reports to CMS. These reports will also be shared with the MFP Consultative Group and used for continuous quality improvement.

Both the Project Director and Quality Analyst will participate in technical assistance activities provided by MFP and the national evaluators. NH's evaluation plan will identify partners and participants including supporting agencies and subject matter experts who can inform and enhance New Hampshire's MFP evaluation strategies in alignment with the MFP national evaluation and technical assistance activities.

[31] https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html

E. Organizational Structure



As the largest State government agency, DHHS is responsible for the health, safety, and wellbeing of NH's residents. DHHS aims to improve access to health care, ensure its quality, and control costs through improved purchasing, planning, and organization of health care services. Additionally, DHHS is responsible for ensuring access to quality community-based treatment and support services for individuals with unique needs, including disabilities, mental illness, special health care needs, or substance misuse challenges. To ensure the basic needs of all residents are met, DHHS provides financial, medical, and emergency assistance and employment support services to those in need and assists individuals in reaching independence.

To protect and care for NH's most vulnerable residents, DHHS has a special responsibility to support those who, due to age, disability or circumstance, are at risk and in need of protection. Pertinent to this proposal, the Office of the Long-Term Care Ombudsman (OLTCO) represents the interests and concerns of individuals residing in NH's long-term care facilities and advocates on their behalf to ensure full realization of their rights to receive quality care and services and to experience an optimal quality of life.

DHHS meets these responsibilities by working in collaboration with advisory organizations, such as the Commission on Aging and the Council on Housing Stability. Established in 2019, The Commission on Aging advises the Governor and General Court on policy and planning related to aging. Fostering a more age-integrated NH with forward-thinking public policy and initiatives will ensure we can all thrive as we age. NH's Council on Housing Stability was established to create and implement a plan for housing stability for all residents.

F. Narrative Staffing Plan

The first position dedicated to MFP is a Project Director (1 FTE/class specification title of Administrator IV) responsible for the overall operation of the project, including implementation of project activities, coordinating with other departments within DHHS and external to the state agency, and conducting meetings. The Project Director will oversee the planning phase, including convening the MFP Consultative Group, collecting and analyzing data, engaging stakeholders, and designing the Operations Protocol. Also, the Project Director will have the authority to ensure necessary reports and documentation are submitted to CMS. Finally, the Project Director will supervise the MFP Data and Quality Analyst.

The second position is a Data, and Quality Analyst (1 FTE/class specification title of Business Systems Analyst I) to design and manage the gathering, tabulating, and interpreting of

required data needed for the system assessment and gap analysis and reporting to CMS at required intervals. BEAS will hire for both positions; classification specifications are attached.

Other staff will provide in-kind support to the cooperative agreement, contributing to the Consultative Group; the time of these stakeholders will not be tracked for grant reporting purposes.

BEAS plans to contract with UNH CACL as a sub award recipient to provide technical assistance (1 FTE) during the planning phase (Sept. 1, 2022-Dec. 31, 2023). Activities include: support MFP Project Team to develop the MFP Operational Protocol, coordinate and support stakeholder input, including logistics and meeting documentation; and provide technical assistance for development of evaluation, quality, and reporting aspects. Additionally, CACL will support planning for implementation of the NCI-AD experience survey.

During the implementation phase (Jan. 1 2024-Dec. 31, 2026), BEAS will contract CACL to provide technical assistance (.5 FTE) for the following activities: 1) support MFP Project Director in the reporting, evaluation, and quality assurance components of the MFP Operational Protocol and 2) conduct NCI-AD experience survey.