GRANITE STATE HOME HEALTH & HOSPICE ASSOCIATION

June 24, 2021

Allyson Zinno
Administrator, Administrative Rules Unit
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

RE: He-E 801, Choices for Independence

Ms. Zinno:

The Granite State Home Health & Hospice Association (GSHHA) appreciates the opportunity to submit written comments on the Initial Proposal (3/30/21) for revision of the He-E 801 Rules for the Choices for Independence (CFI) program. Our Association advocates on behalf of New Hampshire's home care, hospice and palliative care providers and the people they serve. Many of our member agencies provide services to CFI participants, including skilled nursing, home health aide, personal care, and homemaker services. GSHHA convened a committee of providers to review the Initial Proposal in detail. This letter supplements and details our oral testimony presented at the public hearing on June 17, 2021. Below are our recommendations:

801.02 Definitions

- **Page 1, (h) (1)** We suggest revising the definition of "care plan" to "is developed and maintained by the service provide in consultation with the participant, his or her legal representative, if any, or both, ***and the participant's primary care provider, if applicable."*** The last section would apply to care plans that include skilled nursing services and home health aide services, as these care plans are informed by physician guidance.
- **Page 3, (t) (3)** We recommend adding "Hospice" to the list of home-base services. "Hospice" is a Medicaid state plan service that is most often delivered in a home setting.
- **Page 3, (x)** "In-home care" references "adult in-home care," but adult in-home is not defined in 801.02. In addition, this definition seems to be similar to personal care services. However, there is also "in-home care" provided in the Title XX and IIIB programs which is essentially homemaking and prohibits "hands-on" assistance. There are agencies that provide both Title XX and IIIB services, so the mismatch between the definitions is confusing. We urge the department to clarify the distinction.
- **Page 3 (y)** We agree with comments made by Granite State Independent Living that the definition of IADL, as well as ADL (page 1, a), should be the same as the federal definitions.

- **Page 4 (ad)** The definition of "non-medical transportation" references a "person-centered plan." It is unclear if this is the "comprehensive care plan" or the service specific "care plan." He-E 801.2 includes "person-centered planning" as a process to support the participant, but it does not define a "person-centered plan." We ask the Department to clarify which plan is referenced.
- **Page 5, (am)** The definition of "skilled nursing services" references services listed in the "comprehensive care plan." Home care agencies often do not receive the comprehensive care plan from independent case managers. They utilize the service specific "care plan" that is developed by the agency. We recommend deleting the word "comprehensive."
- **Page 5 (ai)** This definition states that personal care assistance includes accompanying a participant into the community to access necessary services. What are "necessary services?" This needs further clarification.

He-E 801.05 Development of a Comprehensive Care Plan

- **Page 9** We recommend that the Department add a section ***(f) The case manager shall provide a copy of the comprehensive care plan to any service provider, when requested, consist with federal HIPAA requirements."*** This is especially important for providers that are delivering medical services, as they often need to be aware of wrap-around services that impact the client's health, including nutrition and safety.

He-E 801.06 Service Authorizations

- **Page 9, (e)** When a participant requests reconsideration of a service denial, do the services continue during reconsideration? Is the agency obligated to continue the service? Will DHHS continue to pay claims? This is an area of confusion for providers. The process must be further delineated.

He-E 801.07 Redetermination of Eligibility and Service Authorizations

- **Page 10, (a)** This section states that redeterminations shall be done "at least annually." This is vague. Is there a deadline for this to occur? What happens when a redetermination is not done on a timely basis? Is there a process for continued authorization of services for the client and payment to providers? We recommend the Department clarify this section, so clients and providers know what happens when there is a lack of redetermination.
- **Page 10 (e)** A major problem in the CFI program is that providers are not informed when a client becomes ineligible for services or has services reduced. (e)(2) requires that written notice be provided to the participant, the legal representative and the participant's case manager. However, a case manager testified that they are often not informed of eligibility changes. We recommend the Department add a time frame for notification of the parties above. In addition, we recommend a new section ***(e)(3) The case manager shall inform service providers of any change in eligibility or reduction of services within 3 business day of notification from the Department.***

He-E 801.10 Commissioner Pre-Approval Process

- **Pages 11 and 12**, This section should be deleted in its entirety. RSA 151-E, 1, II was amended effective January 1, 2021. There is no longer a requirement for the Commissioner to approve LTSS costs in excess of 80% of nursing home costs.

He-E 801.13 Non-Covered Services

- **Page 14, (a)(1)** Home care agencies are concerned about how this language impacts skilled nursing services that are part of long-term care CFI services. The Home Care, Hospice & Palliative Care Alliance of New Hampshire (our affiliated organization) spent many hours working with DHHS on a decision tree for coordination of benefits. The Alliance submitted a list of skilled nursing services on March 12, 2021, that we believe should be considered "long term care services" to be covered by CFI and not require the administrative burden of assessment and authorization for Medicaid managed care plans. For instance, a nursing visit to refill a spilled pill planner should not be a state plan nursing visit. To date BEAS has not responded to our recommended list. We ask DHHS to respond to our list. We recommend adding the words, ***"unless the Department has determined the service to be specifically related to long-term care."***

801.23 Non-Medical Transportation

- **Page 23, (a)** We are uncertain which "personal care services articulated in the "person-centered care plan" require non-medical transportation. We are uncertain which plan this is or which services require transportation. This should be clarified.
- **Page 23, (b)** We object to the word "shall" be provided by employees of agencies. Not all agencies allow their employees to drive clients. The proposed wording implies that they must provide it. We urge the Department to change the section to**: "Non-medical transportation "shall be covered *when* provided by employees of:"**
- **Page 23, (f) (1)** We agree with testimony presented by Granite State Independent Living that this section should be deleted. CFI participants should be able to utilize their own vehicle for non-medical transportation, especially those that require specialized equipment or vehicles.

801.25 Personal Care

- **Page 25, (5) and (6) (d)** references assistance and errands for necessary tasks identified in the comprehensive care plan. Most agencies do not receive the comprehensive care plan. This should be the service-specific "care plan."

801.29 Skilled Nursing Services

- **Page 28 (b)** states that nursing services are "not short-term or intermittent care." However, the definition of skilled nursing services in in 801.02 (am) includes "'intermittent skilled nursing services' on a long-term basis." These sections contradict each other and should be clarified.

801.03 Supportive Housing Services

- **Page 31 (b)(3)** This section outlines services provided by a licensed Home Health Care Provider in federally subsidized individual apartments. We note that it includes "assistance with IADLS." We are concerned that the definition of IADLs includes money management. Most home health providers do not allow their employees to assist with any money management. This may be different for agencies that provide staff for self-directed CFI participants. We believe this should be clarified and would like to work with the Department to develop language that protects CFI participants and the agencies that serve them.

He-E 801.34 Required Documentation

- **Page 35, (e)** This section requires the care plan to include specific information on the participant's health, including conditions, medications, allergies, and dietary needs. This is untenable for agencies licensed as He-P822 Health Care Service Providers, and they are non-medical agencies and do not have access to all this

information. We urge the Department to review He-P 822.15 (j), related to client assessments of HCSP providers and match the criteria in the rules.

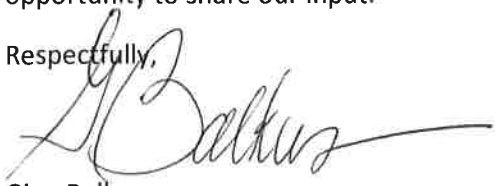
- **Page 35(a) (5)** This section requires *providers* to give the care plan to the case manager. Currently this is only done upon request by the case manager. Providing every care plan and every change is an administrative burden. This section also requires providers to make the care plan or comprehensive care plan available to the Department upon request. Providers do not maintain the comprehensive care plan, so they are unable to provide it to the Department. The comprehensive care plan should come from the case manager.
- **Page 36 (d)** This section requires signatures by the client to verify provision of services, in accordance with the federal Electronic Visit Verification law. We recognize the need for signatures, either on paper timesheets or in EVV systems. We ask the Department to confirm that this section does not yet require agencies to *implement* an EVV system, since the Department has not yet implemented it at the State level. We want to be sure that agencies are not out of compliance through no fault of their own.

He-E 801.37 Payment for Services

- **Page 35 (d)** Payments to providers shall be made in accordance with rates established by the Department in accordance with RSA 161:4 VI(a) and RSA 126-A:18-a.
    - We fully support this requirement. Unfortunately, the Department is currently non-compliant with RSA 126: A18-a. The Commissioner has not developed a rate-setting methodology for reimbursement for home health services that reflect the average cost of delivering these services. The Department has not considered the factors of economy, efficiency, quality of care or access to care, as required by the statute and federal law. As a result, reimbursement rates have not kept pace with market conditions, CFI providers cannot pay competitive wages, and many CFI participants cannot access the full scope of services identified in their comprehensive care plans and service-specific care plans. **We urge the Department to expedite compliance with RSA 126:18-a and He-E 801.**
    - We also recommend that this rule include a reference to the rate-setting requirements (I-2:b) in the most recent CFI waiver document approved by CMS. This includes automatic rate increases each biennium consistent with the Medicare home health market basket index in years when the Legislature does not implement a rate increase for specific CFI services.

The Granite State Home Health & Hospice Association urges the Department to adopt our recommendations. We are willing to answer any questions the Department may have about our suggestions. Thank you for the opportunity to share our input.

Respectfully,



Gina Balkus
Chief Executive Officer

Enclosures (1) March 12, 2021, Letter to Wendi Aultman, Bureau Chief, BEAS

HOME CARE, HOSPICE
& PALLIATIVE CARE ALLIANCE
OF NEW HAMPSHIRE

March 12, 2021

Wendi Aultman
Chief, Bureau of Elderly & Adult Services
NH Department of Health and Human Services
105 Pleasant Street
Concord, NH 03301

Wendi:

Thank you for engaging New Hampshire's home care agencies in conversations about coordination of benefits for skilled nursing services in the Choices for Independence Medicaid-waiver program.

Our Alliance understands the need to have services billed to the appropriate government payor. Since all programs – Medicare, Medicaid, and CFI – cover skilled nursing services, it is important that providers, CFI case managers, Medicaid managed care organizations, and staff at BEAS follow a consistent process for authorizing and billing services. Most important, for CFI clients to receive necessary nursing services without delay, this process must not be administratively burdensome or time-consuming.

After BEAS's meeting with providers on February 5th, the Alliance held a meeting with interested members. We developed a list of common nursing services that are often required for CFI clients on an "as needed" (PRN) basis. These services either do not meet Medicare criteria for coverage or are basic visits for which obtaining an MCO prior authorization would be unreasonable. We believe these skilled services are an essential component of the client's long term care services.

PRN Skilled Nursing Visits Recommended for CFI Authorization

- PT/INR rechecks; Blood glucose level (BGL) checks
- Pill Planner/Insulin Adjustments
    - Medication changes ordered by provider, which cannot wait until next RN visit, e.g., coumadin, antibiotics
    - Medication refills that were not ordered by the provider in time frame requested
    - Pill planner must be refilled due to spills
    - Trouble-shoot malfunctioned automated medication dispensers
- Nursing check requested by the provider, family, or professional caregiver
    - Assessment after a change in status ("not feeling good"; "not looking well")
    - Assessment after a fall
    - Assessment of client status due to possible UTI

    - Assessment of skin tear reported by professional caregiver
    - Minor wound care assessment
    - These checks may result in referral for Medicaid skilled nursing care
- Blood draws
    - Urgent blood draw ordered by the provider and client cannot get to lab

There may be other short term medical conditions which require a PRN visit to monitor the patient, based on the clinical judgement of the nurse. We recommend that DHHS consider these on a case-by-case basis with input from the provider and the case manager.

In addition to the recommendation above, the Alliance would like to work with DHHS to clarify the Medicaid Managed Care contract provision that the first six home care visits do not require a prior authorization. This is being interpreted differently by each MCO. It has not simplified the administrative process for home care agencies or reduced wait times for delivery of care, as it was intended. This is an important part of the coordination of benefits for CFI clients.

Thank you for the opportunity to offer input. I look forward to discussing these recommendations as part of the stakeholder engagement process.

Respectfully,

Gina Balkus
Chief Executive Officer