December 13, 2021

Senator John Reagan, Chair
Representative Carol McGuire, Vice Chair
Joint Legislative Committee on Administrative Rules
Office of Legislative Services
Administrative Rules
25 Capitol Street, Room 219
Concord, NH 03301-6312

In Re: Final Proposal 2021-55, He-E 801, Choices for Independence Program

Senator Reagan and Representative McGuire:

I submit the following testimony relative to the above identified rule. All comments have been previously made, some repeatedly, through a very lengthy rulemaking process that began in 2019 and ran through multiple personnel changes at the Department. While improvements to the rule have been made during that time, many issues remain.

In introduction, I am an independent health policy analyst who has worked in the New Hampshire Medicaid long-term care arena since the middle of the 1990s. I have been working on the He-E 801 rule since the summer of 2019. My comments here are a compilation of concerns raised by multiple providers, program participants, and advocates, including Members of the New Hampshire Medical Care Advisory Committee, the federally required advisory body to New Hampshire's Medicaid agency.

I think it important to note that the He-E 801 rule is the procedural backbone for the administration of the Choices for Independence (CFI) program. The CFI program is a Medicaid home and community-based care program providing service coverage to financially eligible individuals who require a nursing facility level of care but choose instead to access those services in their own homes or in a residential care facility.

Importantly, the He-E 801 rule does not operate in a bubble. It interplays with and thereby impacts important environmental factors. Key among these—

- The rule impacts access to services and the safety of a population with significant care needs.
- The rule impacts the State's cost for long-term care, as well as the State's reliance on a 50% federal funding match.
- The rule impacts the stability of the long-term care provider infrastructure for all the people of New Hampshire, as Medicaid is the largest payor in the long-term care arena.

The conclusion here must be that the rule should not negatively impact any of these, as much as possible. Addressing the concerns identified in the attachments to this letter is important towards that end.

Respectfully,
Michelle M. Winchester, JD

Attachments: Attachment A – Issues of Overarching Concern
Attachment B – Additional Issues Remaining
Attachment C – Definitions of "Activities of Daily Living" & "Instrumental Activities of Daily Living" in New Hampshire Law

ISSUES OF OVERARCHING CONCERN

1. No Service Authorization Standards

Unlike what we find with any other health care coverage in New Hampshire today, as is required by law, there are no standards of coverage identified for any of the services listed in the He-E 801 rule.

The Department explains: "eligibility criteria for any service is to have the service be identified as being necessary in the comprehensive care plan. Additionally, the service limit for any service is the extent it is specified as necessary in the comprehensive care plan."

From this statement one might assume, but cannot definitively conclude, that the case manager developing the comprehensive care plan will determine whether a service is "necessary" for the participant. Pursuant to He-E 801 and 805, the case manager performs a comprehensive assessment of the individual's abilities and needs and, in turn, develops a comprehensive care plan that identifies the strengths, capacities, preferences, and goals of the participant, as well as services to be provided.

If this were the full process, I would present no objection.

However, this is not the case. The Department then "authorizes" services if they "meet the needs" identified in the participant's clinical eligibility assessment, as well as "other later established needs."

> He-E 801.06(a)
> Upon review of the information provided in He-E 801.05(c) and within 6 business days, the department shall authorize services that *meet the needs* identified in the clinical assessment in He-E 801.04(a) and other later established needs.
>
> He-E 801.07(d)
> Upon a redetermination of eligibility, the department shall review and update, as necessary, the service authorization(s).

The authorization process in the rule provides no further detail. The basis or standard for the Department to find that services "meet the needs" of the participant is unknown. In effect, "meets the need" is equivalent to the undefined standard "determined by the agency."

While this commenter recognizes that the Medicaid State Plan definition of "medical necessity" is not appropriate here, some standard of need should be part of the authorization process or associated with the individual services to prevent indiscriminate authorization or denial of services. The only standard under the proposed rule is "needed or not needed, as determined by the Department." How would any provider or participant show otherwise when they have no knowledge of how need is measured, in general or for each service? Importantly, what is the likelihood that multiple Department personnel will make these decisions uniformly?

No health insurer is allowed to do this. Nor would an insurer think it financially wise.

Applicable objections:

In accordance with JLCAR 403.01, the Committee may object to a proposed rule as contrary to the public interest if the Committee determines that the rule is not responsive to a public need. A proposed rule shall be considered not responsive to a public need if the Committee determines that the agency has used broad language when a more specific requirement is needed, as may be indicated by such phrases in the

proposed rules as "to be determined by the agency," when the rule itself is the proper place to make such a determination.

In accordance with JLCAR 403.02, the Committee may object to a proposed rule as contrary to the public interest if the Committee determines that the proposed rule cannot be uniformly applied once it is adopted. The rule cannot be uniformly enforced by the agency.

2. Lack of Distinction between CFI Services and Similar State Plan Services

Federal regulators explain: "Waiver services may not duplicate the services that are provided under the Medicaid State Plan but a waiver may expand upon the amount, duration, and frequency of services provided under the State Plan except for EPSDT[1] services."[2] Several He-E 801 service rules fail to even suggest a distinction between the CFI service and the comparable State Plan service. These include adult day, home health aide, personal care, skilled nursing, and specialized medical equipment services. This situation subjects case managers to repeated run-arounds between the Department and Medicaid Managed Care Organizations when seeking service authorizations. Other providers also raise this issue. In the end, it wastes provider time and, more importantly, it delays participant access to needed services.

The Department explains: "This rule is regarding the Choices for Independence (CFI) program. The services are described in the rule. Identical services may be covered under the medicaid state plan. CFI has clarified that it will not cover services that are covered by medicaid state plan. He-W 500 contains rules regarding what services are covered under medicaid state plan. The department declines to reiterate every state plan service eligibility rule, in the CFI program rule."

However, Federal Medicaid law requires that a *single State agency* administers Medicaid.

> A State plan for medical assistance must-- . . . either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan . . . . [42 USC § 1396a(a)(5).]

Each Medicaid program is *not* and *may not* be an entity unto itself. In turn, it may not plead ignorance of the other or dissociation. They should operate as one unit.

No distinction between the Medicaid State Plan and CFI services is made anywhere. Nor are the differences in any way obvious in the rules as written. The Department leaves it to a baffled community to make sense of it. The Department must operate as one Medicaid agency and should make the distinction clear.

Applicable objection:

In accordance with JLCAR 403.01, the Committee may object to a proposed rule as contrary to the public interest if the Committee determines that the rule is not responsive to a public need. A proposed rule shall be considered not responsive to a public need if the Committee determines that: The rule is not drafted in clear and understandable language and the rule is designed to benefit the administrative convenience of the agency to the detriment of the public.

[1] EPSDT services are a category of services for individuals aged birth to 21.

[2] Centers for Medicare and Medicaid Services, Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019], Instructions, Technical Guide and Review Criteria, Appendix C-3: Waiver Services Specifications, p. 116.

3. Incorrectly Labeled Cost of Care Contribution for Residential Care Participants [He-E 801.10(b)]

He-E 801.10(b) provides a formula for a "cost of care" contribution for residential care participants, which, in practice, is actually used instead as a calculation for a "room and board" contribution. This is problematic in two ways. One, federal law requires the calculation of a "cost of care" contribution. Two, Medicaid may not pay for room and board costs in residential care facilities.

As to the first matter, Federal law[3] requires the Department "reduce its payment for home and community-based services provided to an individual . . ., by the amount that remains after deducting the amounts specified in . . . [federal rule] from the individual's income." The remaining income is the participant's cost of care contribution. For example, if the outcome of the calculation is that the resident has a $500 remainder and the State normally pays $1000 for residential care services each month, the State would pay only $500 and the resident the other $500. However, this does not happen.

Instead, the "cost of care" calculation is used in New Hampshire to arrive at a "room and board" payment. This raises the second matter above— federal requirements prohibit Medicaid payment for room and board in residential care. Therefore, using a "cost of care" contribution to pay for room and board is not allowed.

The Department explains:

> *Response:* For participants that are not residing in residential care facilities, the department calculates a participant's cost of care liabilities. **For participants residing in residential care facilities, the facility calculates participant liability and then bills the participant.**
>
> *Response:* **A residential care facility will bill a participant directly for room and board**. When a participant who does not reside in a residential care facility has a cost of care liability greater than $0, the department will notify the participant of their monthly liability and the participant will remit payment to the department."
>
> *Response:* Prior to 2013, the department paid residential care facilities a set rate based on the costs of operating a residentialcare facility, which included both waiver services and room and board, and reduced the payment by the participant's cost of care liability. However, CMS determined that this method of payment could use Medicaid funds for room and board, which is not allowed under federal Medicaid rules. Since 2013, CFI has reimbursed RCFs at a daily rate regardless of the participant's income. **The department** does not reduce the daily rate paid to residential care facilities by any cost of care liability but **has left the rule in place as a way to suggest how much residential care facilities should charge for room and board.**
>
> [Emphasis added.]

Clearly, one hopes this could be explained satisfactorily to a Federal auditor, who may not be so generous when seeing a "cost of care" calculation used for room and board fees. Additionally, I would note that the calculation in He-E 801.10(b) is not included in the State's approved application for its 1915(c) home and community-based care waiver, unlike the cost of care calculation in 801.10(a) for all other participants.

The actual process and the correct characterization of the "room and board" calculation should be included in this rule, as should the actual formula for calculating the participant's funds that are available for the federally required "cost of care" contribution.

[3] 42 CFR § 435.735 (2020).

Applicable objection:
In accordance with JLCAR 402.02, the Committee may object to a proposed rule as contrary to legislative intent if the Committee determines that the rule violates or otherwise conflicts with a specific state or federal statutory provision or federal regulation.

Definitions

- **Activities of Daily Living (ADLs) [He-E 801.02(a).]**
  As in every other definition of ADLs in State law (see Attachment C), this rule should recognize that there will be daily activity needs unique to an individual that may not easily fit within these six identified categories. In line with other state definitions of ADLs, this definition should read: "Activities of daily living (ADLs)" means the primary activities necessary to carry out daily self-care activities that ~~involve~~ include, but are not limited to, eating, ..."

  The DHHS errs in its explanation: "The department will not revise the definition of 'activities of daily living.' State law defined ADLs more narrowly." The Department provides no citation to the referenced law, either in its explanation or in Appendix B to the rule.

  The assumption is made here that the Department refers to RSA 151-E:3, as that statute lists the same narrow array of tasks.[4] If so, the DHHS inappropriately interprets this as a definition of ADLs. RSA 151-E:3 is instead an eligibility threshold. It is merely a listing of the level of assistance that would qualify an individual for CFI or nursing facility services.

  In the 2005 HB 691 legislative process, the prime sponsor insisted on raising the bar on *eligibility* for nursing facilities and home and community-based care services, which at the time listed no ADLs specifically. He wanted only the "more serious ADLs" measured for that purpose. I personally supplied the House HHSEA committee with the list from the National Association of Insurance Commissioners model law on long-term care insurance policies which required all policies cover assistance with *at least* these specific ADLs. These were accepted as the "more serious" ADLs and included in HB 691. There was no intent to restrict service coverage to that list post-eligibility.

- **Instrumental Activities of Daily Living (IADLs) [He-E 801.02(z)]**
  Commenters recommended a revision to the IADLs definition that would allow for assistance with needs unique to individuals, but outside of the proposed all or nothing list. The Department response is that such a revision "may have unintended consequences." Such a response can only come from a Department that clearly does not have a standard for coverage for these services. When a good coverage standard is in place, there are no or minimal unintended consequences.

  The instrumental activities of daily living listed in the proposed definition are those necessary for the average person to live independently. The definition should be flexible enough to recognize that CFI participants often have additional essential tasks. For example, this might include cleaning adaptive equipment or basic wheelchair maintenance or assistance with obtaining and keeping appointments (as in supportive housing). The definition might read—

  > "Instrumental Activities of Daily Living" (IADL) means basic tasks that are essential to the ability to live independently, such as light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

[4] 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: . . .
(4) *Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence*; . . . . NH RSA 151-E:3, I.

IADLs also include other supportive activities as specified in the comprehensive care plan which promote and support health, wellness, dignity, and autonomy within a community setting.

Note that the last sentence uses the language in the final rule on Supportive Housing Services, He-E 801.02(aq) and 801.30(c). It is unclear why this would be a standard in supportive housing only.

- **Authorized Representative [He-E 801.02(g)]**
This definition restricts the authorized representative designation more so than for any other Medicaid program or eligibility group. The inclusion of "other than a department staff member or provider representative" makes the definition more restrictive. See the comparison below.

Final Proposal, He-E 801.02(g)	Current Medicaid Law, He-W 601.01(w)
"Authorized representative" **means any adult other than a department staff member or provider representative** who is 18 years of age or older, and who, with the applicant's or participant's permission, acts on behalf of the individual for CFI waiver services. [Emphasis added.]	"Authorized representative (AR)" means an individual acting on behalf of the casehead in some or all of the aspects of initial and continuing eligibility.

Additionally, the definition conflicts with the use of the term in the He-E 801 rule. The term is used only in the He-E 801.02 definition of "legal representative," where that provision references He-W 803.01, which in turn references the definition above in He-W 601.01(w).

> (aa) "Legal representative" means one of the following individuals, duly appointed or designated in the manner required by law to act on behalf of another individual, and who is acting within the scope ofhis or her authority:
> (1) An attorney; . . .
> (2) A guardian or conservator;
> (3) An agent acting under a power of attorney;
> (4) An authorized representative acting on behalf of an applicant in some or all of the aspects of initial and continuing eligibility in accordance with He-W 803.01;

The definitions are in direct conflict.

The Department explains: The department is removing from the definition of "authorized representative" the requirement that authorized representatives be designate for "all aspects of initial or continuing eligibility determination." The response is elusive at best.

No basis for the proposed definition is given or obvious. He-E 801.02(g) should be corrected as it conflicts with current law.

- **Conflict of Interest [He-E 801.02(o)]**

> "Conflict of interest" means a conflict between the private interests and the official professional responsibilities of a person, such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant.

The term "conflict of interest" is used only in the definition of "case manager" in He-E 801.02(j). As such the term should reflect case management as a whole to increase the efficacy of the provision.

The definition should be amended to read:

> "Conflict of interest" means a conflict between the private interests and the official or professional responsibilities of a person, entity, agency, or organization such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant.

- **Skilled Nursing Services [He-E 801.02(an)]**

> "Skilled nursing services" means services listed in the comprehensive plan of care that are within the scope of RSA 326-B and are provided by a registered professional nurse, or licensed practical nurse **under the supervision of a registered nurse** licensed to practice in New Hampshire within the scope of RSA 326-B. This service provides intermittent skilled nursing services for the purpose of **administering injections, medical monitoring of wounds that are not healing, providing wound care, physical therapy, monitoring vital signs, obtaining laboratory specimens when a chronic condition exacerbates, or overseeing a bowel program**. [Emphasis added.]

First Sentence of the Definition

Under RSA 326-B the LPN may also work under the supervision of a physician, advanced practice registered nurse, or dentist. The Department should not limit service delivery options, particularly given the workforce shortage issues that are seriously impacting care delivery. Removing the limitation, the paragraph should read as follows:

> "Skilled nursing services" means services . . . that are within the scope of RSA 326-B and are provided by a registered professional nurse~~,~~ or licensed practical nurse ~~under the supervision of a registered nurse licensed to practice in New Hampshire~~.

Second Sentence of the Definition

Added in the final proposal, the second sentence inappropriately appears to be limiting. No other care may be characterized as "skilled nursing services"? This would bar, for example, catheter care, intravenous or tube feeding, patient education, medication setup, administration of the first dose of a new medication by any route, assessment, and more. Furthermore, why are nurses providing physical therapy? The second sentence should be removed.

Skilled Nursing Services [(He-E 801.028(b)]

> (b) Skilled nursing services shall be covered for the provision of chronic long-term care and not short-term ~~or intermittent~~ care.

It is unclear why the term "intermittent" is struck from the skilled nursing services rule in He-E 801.28(b) but inserted into the definition of 801.02(an) (see above). This should be corrected for consistency. Both should recognize the intermittent nature of the service.

Case Management Services for Participants in Short-Term Institutional Stays [He-E 801.03(e)(1)]

In response to the initial proposal, the following edit to par. (e)(1) was recommended for consistency with paragraph 801.03(c) and RSA 151-E:17.[5]

[5] **151-E:17 Availability of Targeted Management Services. –** The department shall make available to and advise **all Medicaid recipients** who require a nursing facility level of care or are at risk of needing such care and who are patients in hospitals, rehabilitation hospitals, or nursing facilities of the availability of targeted case management

> Services described in He-E 801.12(d) shall not be provided while the participant is in the facility, except for services that have been prior authorized for the purpose of enabling the participant to transition back to his or her community and targeted case management in accordance with RSA 151-E:17;

The Department declines to edit and explains: "Targeted case management in accordance with RSA 151-E-17 is a type of case management available to non-CFI participants who receive state plan medicaid to explore discharge from a hospital or nursing facility to the community."

As the author of RSA 151-E:17, I respectfully disagree with the Department response. RSA 151-E:17 was intended for "*all* Medicaid recipients who require a nursing facility level of care." [Emphasis added.] For the CFI participant, this is important, for example, when significant health changes have occurred. He-E 801.03(e)(1) should be amended to ensure independent case management assistance to any CFI participant for transition back to their homes or another community setting.

Unintended Removal of Paragraph (b) in He-E 801.04

Relative to the initial proposal, the Department reports that a "commenter suggested we remove paragraph 801.04(b) requiring an initial estimate of costs of the provision of home-based services, because HB 578 (2020) removed the requirement that individuals with costs greater than 80% of the average NF cost obtain commissioner approval." In turn the Department response was "HB 578 did eliminate the need for obtaining commissioner approval for individuals with home based services cost exceeding 80% of average statewide nursing facility rate. However, there is still a clinical eligibility requirement that estimated costs be the same or less than the average nursing facility rate. . . . **the department will not be removing paragraph (b) from He-E 801.04**. The department will revise the FP to eliminate the mention that the initial cost estimate be compared to the 80% limit."

There is no disagreement here with the Department response. However, it appears paragraph (b) was deleted and the remaining paragraphs re-lettered. The provision should be restored.

Introduction of Undefined Term "Comprehensive Assessment" in He-E 801.05

In the final proposal, the Department adds the term "comprehensive assessment" to paragraph (b) without definition or reference. To ensure consistency in the use of the term, the paragraph should be amended to read:

> The participant shall review the identified needs section of the comprehensive assessment, as defined in He-E 805.02(f), indicating his or her agreement or disagreement with the identified needs.

Vehicle Adaptation Missing from He-E 801.17

The CFI waiver application defines this service as including coverage of adaptations to the participant's vehicle. The definition in He-E 801.02 has been revised in the final rule to correct this omission of this coverage. Par. (b) in He-E 801.17 also should be revised to include such adaptations.

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services provided by independent case managers, to explore the feasibility of transitioning to home and community-based care. [Emphasis added.]

Qualifications for Home-Delivered Meals Services Missing from He-E 801.19(c)

In response to a question on provider qualifications, relative to home-delivered meals, the DHHS responded: "a dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutritional services. . . . The department has revised the FP to clarify."

The clarification is not and should be included in the final rule. It should also be noted that the draft application for the 1915(c) waiver renewal calls for a dietician license.

Potentially Problematic Reference to Nur 700 in He-E 801.20(a)

He-E 801.20(a) provides: "Home health aide services, as defined in He-E 801.02(v) shall be covered when provided by a licensed nursing assistant (LNA) licensed in accordance with RSA 326-B and Nur 700 . . . ." The Nur 700 reference is redundant and not the only nursing rule regulating the LNA practice. Also, as Nur 700 is vague on nurse delegation, for clarity it perhaps should not be referenced here or it may be read as restricting the availability of the delegated task, an important avenue of service delivery in the home and community settings.

No Standard to Determine "Medical Condition Necessitates Performance of Personal Care Services" by Home Health Aide in He-E 801.20(b)

He-E 801.20(b) calls for personal care services to be performed by a licensed nursing assistant (LNA) only when a "medical condition necessitates the performance" of personal care tasks by an LNA. The "medical condition" standard is not distinguished in nursing statute, rule, or guidance. The standard should be made clear, to provide a basis for Department authorization or denial of the service.

No Coverage of Specialized Medical Equipment for Residential Care Residents in He-E 801.29(d)

He-E 801.29(d) bars coverage of specialized medical equipment for participants receiving residential care facility services. However, these facilities are not required or expected to routinely provide all types of specialized medical equipment. New Hampshire Medicaid rules do not even require that of nursing facilities. (See, for example, He-W 571.02(b) allowing Medicaid coverage of durable medical equipment not already included in the nursing facility rate.)

There will be times when a residential care resident may require specialized medical equipment that the facility should not otherwise be required to provide. The standard should be no different for participants in residential care facilities than for participants in nursing facilities.

Suggested text amendment:

> Specialized medical equipment services shall not be covered separately for participants receiving residential care facility services if the facility is otherwise required to provide the equipment pursuant to He-P 804, He-P 805, or a residential services agreement or the equipment is included in the residential care facility services rate.

Prohibition on Use of Participant's Vehicle for Non-Medical Transportation in He-E 801.22(e)(1)

He-E 801.22(e)(1) prohibits coverage of non-medical transportation when the transportation is provided with the participant's vehicle. The Department provides: "The non-medical transportation service was added to the CFI waiver to reimburse personal care providers for the cost of maintaining a fleet of vehicles. When a personal care provider provides transportation but utilizes the participant's vehicle, the provider does not incur the costs that the non-medical transportation service was meant to reimburse for, and the provider should not be eligible for the higher rate."

Community providers and consumers are not aware of the "fleet of vehicles" maintained by providers. Using the vehicle of the personal care provider appears to be the practice at hand. As an individual who was involved in the development of this service over time, I strongly disagree with the Department response; the use of the attendant's vehicle or the waiver participant's vehicle was always a goal. This rule should be revisited.

There should be exceptions in (e)(1) for the use of the participant's vehicle when, for example:

- The participant has a vehicle but is unable to drive;
- The participant's vehicle is a better, more reliable vehicle; or
- The participant cannot easily board a traditional vehicle, or otherwise requires a specialized vehicle, such as a wheelchair van.

The DHHS further responds that "[w]hen a personal care provider provides transportation but utilizes the participant's vehicle, the provider does not incur the costs that the non-medical transportation service was meant to reimburse for, and the provider should not be eligible for the higher rate." Historically we were told that the rate paid is for the provider's time and the service of driving, as well as the cost of the drive.

New Hampshire Statutes	
IV. "Personal assistance" means providing or assisting a resident in obtaining one or more of the following services: (a) Assistance with activities of daily living such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, or monitoring or supervision of medications. (b) Assistance with instrumental activities of daily living such as doing laundry, cleaning of living areas, food preparation, managing money and conducting business affairs, using public transportation, writing letters, obtaining appointments, using the telephone, or engaging in recreational or leisure activities.	N.H. Rev. Stat. Ann. § 161-J:2 (Assisted Living Residences, Independent Living Retirement Communities, and Housing For Older Persons)
III. "Chronically ill" means: (a) Being unable to perform at least 2 activities of daily living, including eating, toileting, transferring, bathing, dressing, or continence;	N.H. Rev. Stat. Ann. § 408-D:2 (Life Settlements Act)
(h) Personal treatment or care, including assistance with activities of daily living such as bathing, dressing, eating, range of motion, toileting, transferring, and ambulation.	N.H. Rev. Stat. Ann. § 464-D:4 (Supported Decision Making)
New Hampshire Administrative Rules	
(a) "Activities of daily living (ADL)" means activities such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, and monitoring and supervision of medications. . . . (u) "Instrumental activities of daily living" means activities performed on a regular basis, including, but not limited to, doing laundry, cleaning, managing money, shopping, using transportation, correspondence, making telephone calls, obtaining and keeping appointments, socializing, and recreation.	N.H. Code Admin. R. He-E § 501.02 (Social Services Block Grant)
(a) "Activities of daily living (ADLs)" means activities such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, and monitoring and supervision of medications.	N.H. Code Admin. R. He-E §§ 502.02 (Disease Prevention and Health Promotion Services, Older Americans Act Services), 801.02 (Choices for Independence Program, expired)
(a) "Activities of daily living (ADL)" means basic daily routine tasks such as eating, transferring, toileting, bathing, dressing and self-management of medications.	N.H. Code Admin. R. He-E § 803.02 (Adult Medical Day Care) **Note: This is a service covered under He-E 801.** N.H. Code Admin. R. He-P §§ 803.03 (New Hampshire Nursing Home Rules), 807.03 (Rules for Residential Treatment and Rehabilitation Facilities), 809.03 (Home Health Care Providers), 818.03 (Adult Day Programs) **Note: Some of these licensure standards are required for providers of services under the Choices for Independence program under He-E 801.**
(a) "Activities of daily living" means those activities associated with personal care, including personal hygiene, bathing, eating, dressing, toilet use, walking, transferring from one surface to another, moving between locations, and bed mobility. . . .	N.H. Code Admin. R. He-E § 805.02 (Targeted Case Management) **Note: This is a service provided to participants in the Choices for Independence program under He-E 801.**

(m) "Instrumental activities of daily living" means those activities associated with home management, including grocery shopping, meal preparation, telephone use, and managing finances, and routine housework such as washing dishes, making beds, dusting, and laundry.	
(b) "Activities of daily living (ADL)" means basic daily routine tasks common to the average individual, such as personal hygiene, transfers and walking.	N.H. Code Admin. R. He-P § 813.03 (Adult Family Care Residence) **Note: This is a service provided only to participants in the Choices for Independence program under He-E 801.**
(c) "Activities of daily living (ADL)" means basic daily routine tasks such as: (1) Walking; (2) Bathing; . . . . (av) "Personal assistance" means providing or assisting an individual in obtaining one or more of the following services: (1) Assistance with ADL, such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, or monitoring, supervision, or administration of medication; (2) Assistance with instrumental activities of daily living such as doing laundry, food preparation, obtaining appointments, or engaging in recreational or leisure activities;	N.H. Code Admin. R. He-P § 814.03 (Residential Care and Health Facilities Rules) **Note: This is a setting in which participants in the Choices for Independence program under He-E 801 may live.**
(k) "Personal care services" means non-medical, hands-on services provided to a client, including, but not limited to, helping with activities of daily living such as grooming, toileting, eating, dressing, bathing, getting into or out of a bed or chair, walking, or reminding the client to take medications.	N.H. Code Admin. R. He-P § 820.03 (Individual Home Care Service Providers)
(b) "Activities of daily living (ADL)" means basic daily routine tasks such as grooming, eating, transferring, toileting, bathing, dressing, and self-management of medications.	N.H. Code Admin. R. He-P § 822.03 (Home Care Service Provider Agencies)
(b) "Activities of daily living (ADL)" means basic daily routine tasks such as eating, transferring, toileting, bathing, dressing, self-management, and monitoring or supervision of medications.	N.H. Code Admin. R. He-P §§ 823.03 (Home Hospice Care Provider), 824.03 (Hospice House)
(bk) "Personal care" means personal care services that are non-medical, hands-on services provided to a patient to assist with activities of daily living such as grooming, toileting, eating, dressing, bathing, getting into or out of a bed or chair, or walking.	N.H. Code Admin. R. He-P § 827.03 (Free Standing Megavoltage Radiation Therapy Facility)
(b) "Activities of daily living (ADL)" means basic daily routine tasks such as eating, transferring, toileting, bathing, dressing, and medication management.	N.H. Code Admin. R. He-P §§ 802.03 (Rules for Hospitals and Special Health Care Services), 804.03 (Assisted Living Residence-Residential Care Licensing), 805.03 (Supported Residential Care Facility Licensing Rules), 826.03 (Substance Use Disorder Residential Treatment Facilities), & 830.03 (Psychiatric Residential Treatment Programs) **Note: Some of these are settings in which participants in the Choices for Independence program under He-E 801 may live.**
(b) Services that consist only of assistance with activities of daily living or other non-skilled services needed to live at home that do not require a nurse, including but not limited to assistance with grooming, toileting, eating, dressing, getting into or out of a bed or chair, and walking shall not be covered as PDN.	N.H. Code Admin. R. He-W § 540.05 (Private Duty Nursing, Non-Covered Services)
(5) Is able to participate fully in activities of daily living (ADLs), which are the basic self-care tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring;	N.H. Code Admin. R. He-W § 552.03 (Personal Care Attendant Services, Medicaid)

	Note: This is a service provided to participants in the Choices for Independence program under He-E 801.
(10) At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery: a. For purposes of this benefit, the following definitions shall apply: 1. “Activities of daily living” include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings; . . .	N.H. Code Admin. R. Ins § 1905.07 (Minimum Standards for Medicare Supplement Policies)
(a) “Activities of daily living” means at least bathing, continence, dressing, eating, toileting and transferring;	N.H. Code Admin. R. Ins § 3601.04
(b) (1) Activities of daily living shall include at least the following as defined in Ins 3601.04 and in the policy; a. Bathing; b. Continence; c. Dressing; d. Eating; e. Toileting; and f. Transferring;	N.H. Code Admin. R. Ins § 3601.28
(a) “Activities of daily living (ADL)” means activities related to personal care, such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating;	N.H. Code Admin. R. Ins § 6001.03 (Standard Definitions and Policy Provisions, Provisions Applicable to All Ancillary Health and Blanket Insurance)
(g) “Medical technician”' means “medical technician” as defined in RSA 328-I, VI. The term does not include nurses licensed in another state who are working in New Hampshire under the Nurse Licensure Compact. The term also does not include those staff who perform non-medical functions supporting the clients or residents of those facilities with activities of daily living such as housekeeping, security, maintenance, dietary, cooking, bathing, dressing, and administration of the clients' or residents' prescribed medications.	N.H. Code Admin. R. Mtec § 301.01 (Board of Registration of Medical Technicians)

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
801.06		**No Service Authorization Standards** Unlike what we find with any other health care coverage in New Hampshire today, as is required by law, there are no standards of coverage identified for any of the services listed in the He-E 801 rule. The Department explains: "eligibility criteria for any service is to have the service be identified as being necessary in the comprehensive care plan. Additionally, the service limit for any service is the extent it is specified as necessary in the comprehensive care plan." From this statement one might assume, but cannot definitively conclude, that the case manager developing the comprehensive care plan will determine whether a service is "necessary" for the participant. Pursuant to He-E 801 and 805, the case manager performs a comprehensive assessment of the individual's abilities and needs and, in turn, develops a comprehensive care plan that identifies the strengths, capacities, preferences, and goals of the participant, as well as services to be provided. If this were the full process, I would present no objection. However, this is not the case. The Department then "authorizes" services if they "meet the needs" identified in the participant's clinical eligibility assessment, as well as "other later established needs." He-E 801.06(a) Upon review of the information provided in He-E 801.05(c) and within 6 business days, the department shall authorize services that *meet the needs* identified in the clinical assessment in He-E 801.04(a) and other later established needs. He-E 801.07(d)	Action Taken Response that He-E 805 will be readopted when waiver is renewed and include clarification on establishing needs	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		Upon a redetermination of eligibility, the department shall review and update, as necessary, the service authorization(s). The authorization process in the rule provides no further detail. The basis or standard for the Department to find that services "meet the needs" of the participant is unknown. In effect, "meets the need" is equivalent to the undefined standard "determined by the agency." While this commenter recognizes that the Medicaid State Plan definition of "medical necessity" is not appropriate here, some standard of need should be part of the authorization process or associated with the individual services to prevent indiscriminate authorization or denial of services. The only standard under the proposed rule is "needed or not needed, as determined by the Department." How would any provider or participant show otherwise when they have no knowledge of how need is measured, in general or for each service? Importantly, what is the likelihood that multiple Department personnel will make these decisions uniformly? No health insurer is allowed to do this. Nor would an insurer think it financially wise.		
various		**Lack of Distinction between CFI Services and Similar State Plan Services** Federal regulators explain: "Waiver services may not duplicate the services that are provided under the Medicaid State Plan but a waiver may expand upon the amount, duration, and frequency of services provided under the State Plan except for EPSDT[1] services."[2] Several He-E 801 service rules fail to even suggest a distinction between the CFI service and the comparable State Plan service. These include adult day, home health aide, personal care, skilled nursing, and specialized medical equipment services. This situation subjects case managers to repeated run-arounds between the Department and Medicaid Managed Care	Actions Taken 1. Revisions to Amended CA Request to clarify adult day, home health aide, personal care, skilled nursing, and specialized medical equipment are "for non-acute needs" 2. Response that this rule is regarding the CFI waiver services. Confusion as to what constitutes "acute" is appropriate for He-W 500 where state plan rules are located.	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		Organizations when seeking service authorizations. Other providers also raise this issue. In the end, it wastes provider time and, more importantly, it delays participant access to needed services. The Department explains: "This rule is regarding the Choices for Independence (CFI) program. The services are described in the rule. Identical services may be covered under the medicaid state plan. CFI has clarified that it will not cover services that are covered by medicaid state plan. He-W 500 contains rules regarding what services are covered under medicaid state plan. The department declines to reiterate every state plan service eligibility rule, in the CFI program rule." However, Federal Medicaid law requires that a *single State agency* administers Medicaid. > A State plan for medical assistance must-- . . . either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan . . . . [42 USC § 1396a(a)(5).] Each Medicaid program is *not* and *may not* be an entity unto itself. In turn, it may not plead ignorance of the other or dissociation. They should operate as one unit. No distinction between the Medicaid State Plan and CFI services is made anywhere. Nor are the differences in any way obvious in the rules as written. The Department leaves it to a baffled community to make sense of it. The Department must operate as one Medicaid agency and should make the distinction clear.		

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
801.10		**Incorrectly Labeled Cost of Care Contribution for Residential Care Participants [He-E 801.10(b)]** He-E 801.10(b) provides a formula for a "cost of care" contribution for residential care participants, which, in practice, is actually used instead as a calculation for a "room and board" contribution. This is problematic in two ways. One, federal law requires the calculation of a "cost of care" contribution. Two, Medicaid may not pay for room and board costs in residential care facilities. As to the first matter, Federal law[3] requires the Department "reduce its payment for home and community- based services provided to an individual . . ., by the amount that remains after deducting the amounts specified in . . . [federal rule] from the individual's income." The remaining income is the participant's cost of care contribution. For example, if the outcome of the calculation is that the resident has a $500 remainder and the State normally pays $1000 for residential care services each month, the State would pay only $500 and the resident the other $500. However, this does not happen. Instead, the "cost of care" calculation is used in New Hampshire to arrive at a "room and board" payment. This raises the second matter above—federal requirements prohibit Medicaid payment for room and board in residential care. Therefore, using a "cost of care" contribution to pay for room and board is not allowed.	BDS is somewhat able to limit room and board charges that facilities charge by contract. BDS has general funds to contract with some providers providing room and board services to waiver participants. BDS waiver participants residing at facilities that are not contracted to provide room and board services face the same problems of free market regulation of room and board costs. Action Taken 1. Revise Amended CA Request to make cost of care calculation the same as for non RCF residents and RCF residents Open Questions 1. Do we need to retract GM 13-17? 2. Can NH restrict Room and Board charges without specific legislative authority? RSA 541-A:22 III.(c) prohibits state agencies from requiring fees without specific legislative authority	MCAC
801.02(a)		**Activities of Daily Living (ADLs) [He-E 801.02(a).]** As in every other definition of ADLs in State law (see Attachment C), this rule should recognize that there will be daily activity needs unique to an individual that may not easily fit within these six identified categories. In line with other state definitions of ADLs, this definition should read: "Activities of daily living (ADLs)" means the primary activities necessary	Action Taken 1. Revision made to Amended CA Request	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		to carry out daily self-care activities that ~~involve~~ include, but are not limited to, eating, ..." The DHHS errs in its explanation: "The department will not revise the definition of 'activities of daily living.' State law defined ADLs more narrowly." The Department provides no citation to the referenced law, either in its explanation or in Appendix B to the rule. The assumption is made here that the Department refers to RSA 151-E:3, as that statute lists the same narrow array of tasks.[4] If so, the DHHS inappropriately interprets this as a definition of ADLs. RSA 151-E:3 is instead an eligibility threshold. It is merely a listing of the level of assistance that would qualify an individual for CFI or nursing facility services. In the 2005 HB 691 legislative process, the prime sponsor insisted on raising the bar on *eligibility* for nursing facilities and home and community-based care services, which at the time listed no ADLs specifically. He wanted only the "more serious ADLs" measured for that purpose. I personally supplied the House HHSEA committee with the list from the National Association of Insurance Commissioners model law on long-term care insurance policies which required all policies cover assistance with *at least* these specific ADLs. These were accepted as the "more serious" ADLs and included in HB 691. There was no intent to restrict service coverage to that list post-eligibility.		
		Instrumental Activities of Daily Living (IADLs) [He-E 801.02(z)] Commenters recommended a revision to the IADLs definition that would allow for assistance with needs unique to individuals, but outside of the	Action Taken 1. Revision made to Amended CA request	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		proposed all or nothing list. The Department response is that such a revision "may have unintended consequences." Such a response can only come from a Department that clearly does not have a standard for coverage for these services. When a good coverage standard is in place, there are no or minimal unintended consequences. The instrumental activities of daily living listed in the proposed definition are those necessary for the average person to live independently. The definition should be flexible enough to recognize that CFI participants often have additional essential tasks. For example, this might include cleaning adaptive equipment or basic wheelchair maintenance or assistance with obtaining and keeping appointments (as in supportive housing). The definition might read— "Instrumental Activities of Daily Living" (IADL) means basic tasks that are essential to the ability to live independently, such as light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. IADLs also include other supportive activities as specified in the comprehensive care plan which promote and support health, wellness, dignity, and autonomy within a community setting. Note that the last sentence uses the language in the final rule on Supportive Housing Services, He-E 801.02(aq) and 801.30(c). It is unclear why this would be a standard in supportive housing only.		

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		epresentative [He-E 801.02(g)] This definition restricts the authorized representative designation more so than for any other Medicaid program or eligibility group. The inclusion of "other than a department staff member or provider representative" makes the definition more restrictive. See the comparison below. **nal Proposal, He-E 801.02(g)** | **Cu** uthorized representative" **means any adult other than a department staff member or provider representative** who is 18 years of age or older, and who, with the applicant's or participant's permission, acts on behalf of the individual for CFI waiver services. [Emphasis added.] | "A Additionally, the definition conflicts with the use of the term in the He-E 801 rule. The term is used only in the He-E 801.02 definition of "legal representative," where that provision references He-W 803.01, which in turn references the definition above in He-W 601.01(w). (aa) "Legal representative" means one of the following individuals, duly appointed or designated in the manner required by law to act on behalf of another individual, and who is acting within the scope ofhis or her authority: (1) An attorney; . . . (2) A guardian or conservator; (3) An agent acting under a power of attorney; (4) An authorized representative acting on behalf of an applicant in some or all of the aspects of initial and continuing eligibility in accordance with He-W 803.01;	Action Taken Revised Amended CA Request to refer to He-W 803.01 for definition	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		The definitions are in direct conflict. The Department explains: The department is removing from the definition of "authorized representative" the requirement that authorized representatives be designate for "all aspects of initial or continuing eligibility determination." The response is elusive at best. No basis for the proposed definition is given or obvious. He-E 801.02(g) should be corrected as it ts with current law.		
801..02 (o)		**Conflict of Interest [He-E 801.02(o)]** "Conflict of interest" means a conflict between the private interests and the official professional responsibilities of a person, such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant. The term "conflict of interest" is used only in the definition of "case manager" in He-E 801.02(j). As such the term should reflect case management as a whole to increase the efficacy of the provision. **The definition should be amended to read:** "Conflict of interest" means a conflict between the private interests and the official or professional responsibilities of a person, entity, agency, or organization such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant.	Action Take 1. Suggested Revision made to Amended CA Request	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
801.02(an)		**Skilled Nursing Services [He-E 801.02(an)]** "Skilled nursing services" means services listed in the comprehensive plan of care that are within the scope of RSA 326-B and are provided by a registered professional nurse, or licensed practical nurse **under the supervision of a registered nurse** licensed to practice in New Hampshire within the scope of RSA 326-B. This service provides intermittent skilled nursing services for the purpose of **administering injections, medical monitoring of wounds that are not healing, providing wound care, physical therapy, monitoring vital signs, obtaining laboratory specimens when a chronic condition exacerbates, or overseeing a bowel program**. [Emphasis added.] *First Sentence of the Definition* Under RSA 326-B the LPN may also work under the supervision of a physician, advanced practice registered nurse, or dentist. The Department should not limit service delivery options, particularly given the workforce shortage issues that are seriously impacting care delivery. Removing the limitation, the paragraph should read as follows: "Skilled nursing services" means services . . . that are within the scope of RSA 326-B and are provided by a registered professional nurse, or licensed practical nurse ~~under the supervision of a registered nurse licensed to practice in New Hampshire~~. *Second Sentence of the Definition* Added in the final proposal, the second sentence inappropriately appears to be limiting. No other care may be characterized as "skilled nursing services"? This would bar, for example, catheter care, intravenous or tube feeding, patient education, medication setup, administration of the first dose of a new medication by any route, assessment, and more. Furthermore, why are nurses providing physical therapy? The second	Action Taken 1. Revision to Amended CA Request	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		sentence should be removed.		
801.28(b)	(b) Skilled nursing services shall be covered for the provision of chronic long-term care and not short-term ~~or intermittent~~ care. It is unclear why the term "intermittent" is struck from the skilled nursing services rule in He-E 801.28(b) but inserted into the definition of 801.02(an) (see above). This should be corrected for consistency. Both should recognize the intermittent nature of the service.			MCAC
801.03(b)		**Case Management Services for Participants in Short-Term Institutional Stays [He-E 801.03(e)(1)]** In response to the initial proposal, the following edit to par. (e)(1) was recommended for consistency with paragraph 801.03(c) and RSA 151-E:17.[5] Services described in He-E 801.12(d) shall not be provided while the participant is in the facility, except for services that have been prior authorized for the purpose of enabling the participant to transition back to his or her community and targeted case management in accordance with RSA 151-E:17; The Department declines to edit and explains: "Targeted case management in accordance with RSA 151- E-17 is a type of case management available to non-CFI participants who receive state plan medicaid to explore discharge from a hospital or nursing facility to the community." As the author of RSA 151-E:17, I respectfully disagree with the Department response. RSA 151-E:17 was intended for "*all* Medicaid recipients who require a nursing facility level of care." [Emphasis added.] For the CFI participant, this is important, for example, when significant health changes		MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		have occurred. He-E 801.03(e)(1) should be amended to ensure independent case management assistance to any CFI participant for transition back to their homes or another community setting.		
801.04(b)		**Unintended Removal of Paragraph (b) in He-E 801.04** Relative to the initial proposal, the Department reports that a "commenter suggested we remove paragraph 801.04(b) requiring an initial estimate of costs of the provision of home-based services, because HB 578 (2020) removed the requirement that individuals with costs greater than 80% of the average NF cost obtain commissioner approval." In turn the Department response was "HB 578 did eliminate the need for obtaining commissioner approval for individuals with home based services cost exceeding 80% of average statewide nursing facility rate. However, there is still a clinical eligibility requirement that estimated costs be the same or less than the average nursing facility rate. . . . **the department will not be removing paragraph (b) from He-E 801.04**. The department will revise the FP to eliminate the mention that the initial cost estimate be compared to the 80% limit." There is no disagreement here with the Department response. However, it appears p ragraph (b) was deleted and the remaining paragraphs re-lettered. The provision should be restored.	Action Taken 1. Revision to Amended CA Request	MCAC
801.05		**Introduction of Undefined Term "Comprehensive Assessment" in He-E 801.05** In the final proposal, the Department adds the term "comprehensive assessment" to paragraph (b) without definition or reference. To ensure consistency in the use of the term, the paragraph should be amended to read: The participant shall review the identified needs section of the	Action Taken Revision to Amended CA Request	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		comprehensive assessment, as defined in He-E 805.02(f), indicating his or her agreement or disagreement with the identified needs.		
		Potentially Problematic Reference to Nur 700 in He-E 801.20(a) He-E 801.20(a) provides: "Home health aide services, as defined in He-E 801.02(v) shall be covered when provided by a licensed nursing assistant (LNA) licensed in accordance with RSA 326-B and Nur 700 . . . ." The Nur 700 reference is redundant and not the only nursing rule regulating the LNA practice. Also, as Nur 700 is vague on nurse delegation, for clarity it perhaps should not be referenced here or it may be read as restricting the availability of the delegated task, an important avenue of service delivery in the home and community settings.	Action Taken Revision to Amended CA Request	MCAC
		No Coverage of Specialized Medical Equipment for Residential Care Residents in He-E 801.29(d) He-E 801.29(d) bars coverage of specialized medical equipment for participants receiving residential care facility services. However, these facilities are not required or expected to routinely provide all types of specialized medical equipment. New Hampshire Medicaid rules do not even require that of nursing facilities. (See, for example, He-W 571.02(b) allowing Medicaid coverage of durable medical equipment not already included in the nursing facility rate.) There will be times when a residential care resident may require specialized medical equipment that the facility should not otherwise be required to provide. The standard should be no different for participants in residential care facilities than for participants in nursing facilities. Suggested text amendment:	Action Taken Revision to Amended CA Request	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		Specialized medical equipment services shall not be covered separately for participants receiving residential care facility services if the facility is otherwise required to provide the equipment pursuant to He-P 804, He-P 805, or a residential services agreement or the equipment is included in the residential care facility services rate.		
		Prohibition on Use of Participant's Vehicle for Non-Medical Transportation in He-E 801.22(e)(1) He-E 801.22(e)(1) prohibits coverage of non-medical transportation when the transportation is provided with the participant's vehicle. The Department provides: "The non-medical transportation service was added to the CFI waiver to reimburse personal care providers for the cost of maintaining a fleet of vehicles. When a personal care provider provides transportation but utilizes the participant's vehicle, the provider does not incur the costs that the non-medical transportation service was meant to reimburse for, and the provider should not be eligible for the higher rate." Community providers and consumers are not aware of the "fleet of vehicles" maintained by providers. Using the vehicle of the personal care provider appears to be the practice at hand. As an individual who was involved in the development of this service over time, I strongly disagree with the Department response; the use of the attendant's vehicle or the waiver participant's vehicle was always a goal. This rule should be revisited. There should be exceptions in (e)(1) for the use of the participant's vehicle when, for example: (1) The participant has a vehicle but is unable to drive;	Action Taken Explain that NMT is allowed on top of personal care services and transportation was added to personal care services.	MCAC

Rule Section	Rule Text	Comment	Action Taken (What, if any & if none, why?)	Commenter
		(2) The participant's vehicle is a better, more reliable vehicle; or (3) The participant cannot easily board a traditional vehicle, or otherwise requires a specialized vehicle, such as a wheelchair van. The DHHS further responds that "[w]hen a personal care provider provides transportation but utilizes the participant's vehicle, the provider does not incur the costs that the non-medical transportation service was meant to reimburse for, and the provider should not be eligible for the higher rate." Historically we were told that the rate paid is for the provider's time and the service of driving, as well as the cost of the drive.		

APPENDIX II-H

INCORPORATION BY REFERENCE STATEMENT

**PLEASE LIST THE FOLLOWING:

1. Name of Agency. **Department of Health and Human Services (DHHS)**

2. Person who has reviewed the material to be incorporated into the agency's rules:

Name:	**Brian Clark**	Title:	**Policy Administrator**
Address:	**Dept. of Health & Human Services Bureau of Elderly and Adults Services 129 Pleasant Street, Main Building Concord, NH 03301**	Phone #:	**271-9202**

3. Specific rule number where the material is incorporated: **He-E 801.19(b)**

**PLEASE ATTACH THE FOLLOWING, numbered to correspond to the number on this sheet (a separate sheet is not required for every item):

4. The complete title of the material which is to be incorporated including the date on which the material became effective (or a document identification number) or, if the material is undated Internet content, the date the material was accessed and printed, and the title of the entity that created or promulgated the material.

The title of the material to be incorporated is the U.S. Department of Agriculture's, "Dietary Guidelines for Americans 2020-2025" (Ninth Edition).

5. How the agency modified the text of the material incorporated, clearly identifying where amendments have been made to the text.

Not applicable.

6. How the material incorporated can be obtained by the public (include cost and the address of the unrelated third party which published the material, and the Internet source URL if it appears in the rule, for example if the material is Internet content only available online).

Publisher: United States Department of Agriculture

Cost: Free to the Public

The incorporated document is available at: https://www.dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf and can also be ordered by calling the U.S. Government Publishing Office (GPO) at (866) 512-1800 and asking for stock number 001-000-04866-0, or by accessing the GPO Online Bookstore at http://bookstore.gpo.gov.

7. Why the agency did not choose to reproduce the incorporated material in full in its rules. The discussion shall include more than the obvious reason that it is less expensive to incorporate by reference.

The information is subject to copyright restrictions.

**PLEASE SIGN THE FOLLOWING:

I, the adopting authority,* certify that the text of the material which the agency is incorporating by reference in these rules has been reviewed by this agency. To the best of my knowledge and belief, this agency has complied with the requirements of RSA 541-A:12, IV and Section 3.12 of Chapter 4 of the Drafting and Procedure Manual for Administrative Rules. I further certify that the agency has the capability and the intent to enforce the material incorporated into the rules, as identified above.

Date: 11/9/2021

Signature: Lori Shibinette

Name: **Lori A. Shibinette**

Title: **Commissioner**

*("Adopting authority" is the official empowered by statute to adopt the rule, or a member of the group of individuals empowered by statute to adopt the rule.)

NEW HAMPSHIRE DRAFTING AND PROCEDURE MANUAL

APPENDIX II-H

INCORPORATION BY REFERENCE STATEMENT

**PLEASE LIST THE FOLLOWING:

1. Name of Agency. **Department of Health and Human Services (DHHS)**

2. Person who has reviewed the material to be incorporated into the agency's rules:

Name:	**Brian Clark**	Title:	**Policy Administrator**
Address:	**Dept. of Health & Human Services** **Bureau of Elderly and Adults Services** **129 Pleasant Street, Main Building** **Concord, NH 03301**	Phone #:	**271-9202**

3. Specific rule number where the material is incorporated: **He-E 801.31(c)(1)a.**

**PLEASE ATTACH THE FOLLOWING, numbered to correspond to the number on this sheet (a separate sheet is not required for every item):

4. The complete title of the material which is to be incorporated including the date on which the material became effective (or a document identification number) or, if the material is undated Internet content, the date the material was accessed and printed, and the title of the entity that created or promulgated the material.

The title of the material to be incorporated is the Association of People Supporting Employment First's "Universal Employment Competencies" (January 2019).

5. How the agency modified the text of the material incorporated, clearly identifying where amendments have been made to the text.

Not applicable.

6. How the material incorporated can be obtained by the public (include cost and the address of the unrelated third party which published the material, and the Internet source URL if it appears in the rule, for example if the material is Internet content only available online).

Publisher: Association of People Supporting Employment First

Cost: Free to the public

The incorporated document is available at:

https://apse.org/wp-content/uploads/2019/03/Apse-universal-Comps-FINAL3-15-19.pdf

7. Why the agency did not choose to reproduce the incorporated material in full in its rules. The discussion shall include more than the obvious reason that it is less expensive to incorporate by reference.

The information is subject to copyright restrictions.

**PLEASE SIGN THE FOLLOWING:

I, the adopting authority,* certify that the text of the material which the agency is incorporating by reference in these rules has been reviewed by this agency. To the best of my knowledge and belief, this agency has complied with the requirements of RSA 541-A:12, IV and Section 3.12 of Chapter 4 of the Drafting and Procedure Manual for Administrative Rules. I further certify that the agency has the capability and the intent to enforce the material incorporated into the rules, as identified above.

Date: 11/9/2021

Signature: Lori Shibinette

Name: **Lori A. Shibinette**

Title: **Commissioner**

*("Adopting authority" is the official empowered by statute to adopt the rule, or a member of the group of individuals empowered by statute to adopt the rule.)

NEW HAMPSHIRE
MEDICAL CARE ADVISORY COMMITTEE
Department of Health & Human Services ♦ Division of Medicaid Services
129 Pleasant Street ♦ Concord, NH 03301
(603) 271-9422 ♦ Fax (603) 271-4912

Carolyn Virtue
Chair

Jonathan Routhier
Vice-Chair

December 15, 2021

Dear Senator Raegan, Representative Maguire and Members of the committee,

By way of introduction, I chair the Medical Care Advisory Committee (MCAC). On Monday December 13, 2021, the MCAC voted to object to the He-801 Choices for Independence on the basis of the issues outlined by Michelle Winchester (attached).

The MCAC is concerned about the impact the rule as presented will have on the elderly and adult citizens of New Hampshire The Choices For Independence Program serves individuals who are certified by the department to be nursing facility level of care and choose to receive care in the community in lieu of institutional nursing facility placement. This is not a program we can afford to jeopardize without impacting a citizen's right to choose where they will receive care.

Please take note the voluminous objections submitted by the public during this process and the limited if any public support given to this rule during the rule making process.

The New Hampshire Medical Care Advisory Committee, is the federally required advisory body to New Hampshire's Medicaid agency, as such we would sincerely appreciate thoughtful consideration of the concerns identified.

Sincerely,

Carolyn A Virtue, Chair

GRANITE STATE HOME HEALTH & HOSPICE ASSOCIATION

December 15, 2021

Senator John Reagan
Chairman
Joint Legislative Committee on Administrative Rules
State House
Concord, NH 03301

RE: He-E 801 Choices for Independence Program

Chairman Reagan and Members of the Committee:

I am writing on behalf of the Granite State Home Health & Hospice Association, which advocates on behalf of home care providers and the people they serve. **I ask that you preliminarily object to the He-P 801 rules**. The Department (DHHS) has not clarified portions of the rule relating to skilled nursing services and payments of rates, as requested in our public comment letter dated June 24, 2021.

Home care agencies are essential providers of medical and non-medical home-based care in the CFI program. Home care agencies provide skilled nursing care, home health aide services, personal care services and homemaker services to help vulnerable individuals who are eligible for nursing home care to live independently at home. GSHHA's members range from large, non-profit providers to small, community-based organizations and locally owned, private businesses.

In SFY 2021, which is the most recent year for which GSHHA had access to public CFI data, New Hampshire's home care agencies:

- Cared for an annual average of 3298 CFI clients
- Delivered approximately 800,000 hours of hands-on personal care services
- Performed over 17,400 skilled nursing visits
- Provided more than 42,700 hours of home health aide services for visits lasting 2 hours or more
- Conducted about 10,200 home health aide visits that lasted less than 2 hours
- Delivered 35,400 hours of homemaker services.

In our comment letter on the rules, GSHHA asked DHHS to clarify 801.02 (an) and 801.29 (b) which contradict each other regarding skilled nursing services. DHHS edits have not resolved the problem I have highlighted the sections below.

He-E 801.02 Definitions (p. 5)

(an) "Skilled nursing services" means services listed in the comprehensive plan of care that are within the scope of RSA 326-B and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse licensed to practice in New Hampshire within the scope of RSA 326-B. This service provides intermittent skilled nursing services for the purpose of administering injections, medical monitoring of wounds that are not healing, providing wound care, physical therapy, monitoring vital signs, obtaining laboratory specimens when a chronic condition exacerbates, or overseeing a bowel program.

He-E 801.28 Skilled Nursing Services (p. 29-30)

(a) Skilled nursing services, as defined in He-E 801.02(am), shall be provided by a registered nurse (RN) or by a licensed practical nurse (LPN) who is employed by a home health care provider licensed in accordance with RSA 151:2 and He-P 809.

(b) Skilled nursing services shall be covered for the provision of chronic long-term care and not short-term or intermittent care.

(c) Skilled nursing services shall not be covered when provided:

> *(1) On the same day as the participant attends an adult day program if the identified need is within the scope of what would normally be provided by the program*
>
> *(2) For the purpose of nursing oversight of authorized LNA services;*
>
> *(3) At a residential care facility; or*
>
> *(4) When determined to be needed for the provision of acute needs under the New Hampshire medicaid state plan.*

GSHHA's concern is use of the word "intermittent." The definition describes skilled nursing as an "intermittent" service, while the description of the skilled nursing service states that it is "not intermittent." It's important to understand whether a service is intermittent or not, as it will affect which payor covers the service,. The Medicaid State Plan covers intermittent nursing services, while CFI skilled nursing services are intended for long term care. CFI enrollees with chronic conditions usually have regularly scheduled nursing visits, but there may be times when a clinical situation arises that requires intermittent extra visits as part of the patient's long-term care regimen..

We believe the definition in 801.02 attempts to address that scenario, although GSHHA is concerned that DHHS's definition implies that it is an all-inclusive list of conditions. (There certainly are other conditions that require nursing visits.) Section 28 seems to cancel out the possibility of intermittent or "as needed" nursing visits.

This leads to questions about when a nursing visit is covered by CFI and when should it be covered by the Medicaid State Plan. This has caused confusion for providers for many years, and the He-P 801 rules perpetuate this confusion. Attempts to answer coverage questions are an administrative burden for home care agencies, CFI Case Managers and for BEAS. Most importantly, it can result in delays in care for CFI enrollees. **I urge JLCAR to preliminary object to these sections and direct DHHS to clarify the definition and services for CFI skilled nursing care.**

He-E 801.37 Payment for Services (p. 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.*

GSHHA recommended that this rule also include a reference to the "*rate-setting requirements (I-2:b) in the most recent CFI waiver document approved by CMS.*" DHHS declined to make any changes to this section of the rule stating that "reimbursement rates are not part of the rule."

We agree that rates *per-se* are not part of the rule, but all *requirements to establish payment rates* should be included in the rule. New Hampshire's CFI Waiver Document, which is approved every 5 years by the Center for Medicaid and Medicare Services (CMS), 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. This federal requirement is important to include in the He-E 801 rule because DHHS has failed to comply with the requirements of NH RSA 126-A:18-a. The state statute requires the Commissioner to adopt rules to develop a rate-setting methodology for reimbursement for home health services that reflect the average cost of delivering these services, and considers the factors of economy, efficiency, and access to care. The reference to RSA 126-A:18-a is meaningless in the He-E 801 rule, because a formally adopted rate-setting methodology does not exist. **We ask JLCAR to preliminarily object to He-E 801.37 until DHHS includes all pertinent payment rates requirements. We also ask JLCAR to urge DHHS begin the rulemaking process to comply with RSA 126-A:18-a.**

New Hampshire home care agencies are committed to providing CFI enrollees with high quality care that enables them to remain in their homes with long term services and supports. We appreciate JLCAR's attention to our concerns.

Respectfully,

Gina Balkus
Chief Executive Officer

Cc: Scott Eaton, Administrative Rules Director

E-Mail, December 13, 2021

To: MCAC members
From: Michelle Winchester
In Re: He-E 801, Choices for Independence Program, Final Proposal

Good Morning-
Attached please find the issues listed in my draft response to the He-E 801 Final Proposal. Please note that this is not a complete list of issues identified, but only the more significant.

I should note that this is not a Subcommittee response. (The MCAC Subcommittee on He-E 801 began work on the rule in the summer of 2019.) As the lead on the Subcommittee, I believed that, because of the length of the rule and the volume of concerns, it would have been difficult to coordinate a Subcommittee letter in one-month time. That said, this response is a compilation of the concerns of the many providers, consumers, and advocates I've worked with on this rule over time, including Subcommittee members.

I am sharing this as a partial report of the Subcommittee.

Michelle

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ISSUES OF OVERARCHING CONCERN

1. No Service Authorization Standards

Unlike what we find with any other health care coverage in New Hampshire today, as is required by law, there are no standards of coverage identified for any of the services listed in the He-E 801 rule.

The Department explains: "eligibility criteria for any service is to have the service be identified as being necessary in the comprehensive care plan. Additionally, the service limit for any service is the extent it is specified as necessary in the comprehensive care plan."

From this statement one might assume, but cannot definitively conclude, that the case manager developing the comprehensive care plan will determine whether a service is "necessary" for the participant. Pursuant to He-E 801 and 805, the case manager performs a comprehensive assessment of the individual's abilities and needs and, in turn, develops a comprehensive care plan that identifies the strengths, capacities, preferences, and goals of the participant, as well as services to be provided.

If this were the full process, I would present no objection.

However, this is not the case. The Department then "authorizes" services if they "meet the needs" identified in the participant's clinical eligibility assessment, as well as "other later established needs."

> He-E 801.06(a)
> Upon review of the information provided in He-E 801.05(c) and within 6 business days, the department shall authorize services that *meet the needs* identified in the clinical assessment in He-E 801.04(a) and other later established needs.
>
> He-E 801.07(d)
> Upon a redetermination of eligibility, the department shall review and update, as necessary, the service authorization(s).

The authorization process in the rule provides no further detail. The basis or standard for the Department to find that services "meet the needs" of the participant is unknown. In effect, "meets the need" is equivalent to the undefined standard "determined by the agency."

While this commenter recognizes that the Medicaid State Plan definition of "medical necessity" is not appropriate here, some standard of need should be part of the authorization process or associated with the individual services to prevent indiscriminate authorization or denial of services. The only standard under the proposed rule is "needed or not needed, as determined by the Department." How would any provider or participant show otherwise when they have no knowledge of how need is measured, in general or for each service? Importantly, what is the likelihood that multiple Department personnel will make these decisions uniformly?

No health insurer is allowed to do this. Nor would an insurer think it financially wise.

2. Lack of Distinction between CFI Services and Similar State Plan Services

Federal regulators explain: "Waiver services may not duplicate the services that are provided under the Medicaid State Plan but a waiver may expand upon the amount, duration, and frequency of services

provided under the State Plan except for EPSDT[1] services."[2] Several He-E 801 service rules fail to even suggest a distinction between the CFI service and the comparable State Plan service. These include adult day, home health aide, personal care, skilled nursing, and specialized medical equipment services. This situation subjects case managers to repeated run-arounds between the Department and Medicaid Managed Care Organizations when seeking service authorizations. Other providers also raise this issue. In the end, it wastes provider time and, more importantly, it delays participant access to needed services.

The Department explains: "This rule is regarding the Choices for Independence (CFI) program. The services are described in the rule. Identical services may be covered under the medicaid state plan. CFI has clarified that it will not cover services that are covered by medicaid state plan. He-W 500 contains rules regarding what services are covered under medicaid state plan. The department declines to reiterate every state plan service eligibility rule, in the CFI program rule."

However, Federal Medicaid law requires that a *single State agency* administers Medicaid.

> A State plan for medical assistance must-- . . . either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan . . . . [42 USC § 1396a(a)(5).]

Each Medicaid program is *not* and *may not* be an entity unto itself. In turn, it may not plead ignorance of the other or dissociation. They should operate as one unit.

No distinction between the Medicaid State Plan and CFI services is made anywhere. Nor are the differences in any way obvious in the rules as written. The Department leaves it to a baffled community to make sense of it. The Department must operate as one Medicaid agency and should make the distinction clear.

3. Incorrectly Labeled Cost of Care Contribution for Residential Care Participants [He-E 801.10(b)]

He-E 801.10(b) provides a formula for a "cost of care" contribution for residential care participants, which, in practice, is actually used instead as a calculation for a "room and board" contribution. This is problematic in two ways. One, federal law requires the calculation of a "cost of care" contribution. Two, Medicaid may not pay for room and board costs in residential care facilities.

As to the first matter, Federal law[3] requires the Department "reduce its payment for home and community-based services provided to an individual . . ., by the amount that remains after deducting the amounts specified in . . . [federal rule] from the individual's income." The remaining income is the participant's cost of care contribution. For example, if the outcome of the calculation is that the resident has a $500 remainder and the State normally pays $1000 for residential care services each month, the State would pay only $500 and the resident the other $500. However, this does not happen.

Instead, the "cost of care" calculation is used in New Hampshire to arrive at a "room and board" payment. This raises the second matter above— federal requirements prohibit Medicaid payment for room and board in residential care. Therefore, using a "cost of care" contribution to pay for room and board is not allowed.

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[1] EPSDT services are a category of services for individuals aged birth to 21.

[2] Centers for Medicare and Medicaid Services, Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019], Instructions, Technical Guide and Review Criteria, Appendix C-3: Waiver Services Specifications, p. 116.

[3] 42 CFR § 435.735 (2020).

The Department explains:

> *Response:* For participants that are not residing in residential care facilities, the department calculates a participant's cost of care liabilities. **For participants residing in residential care facilities, the facility calculates participant liability and then bills the participant.**
>
> *Response:* **A residential care facility will bill a participant directly for room and board**. When a participant who does not reside in a residential care facility has a cost of care liability greater than $0, the department will notify the participant of their monthly liability and the participant will remit payment to the department."
>
> *Response:* Prior to 2013, the department paid residential care facilities a set rate based on the costs of operating a residentialcare facility, which included both waiver services and room and board, and reduced the payment by the participant's cost of care liability. However, CMS determined that this method of payment could use Medicaid funds for room and board, which is not allowed under federal Medicaid rules. Since 2013, CFI has reimbursed RCFs at a daily rate regardless of the participant's income. **The department** does not reduce the daily rate paid to residential care facilities by any cost of care liability but **has left the rule in place as a way to suggest how much residential care facilities should charge for room and board.**
>
> [Emphasis added.]

Clearly, one hopes this could be explained satisfactorily to a Federal auditor, who may not be so generous when seeing a "cost of care" calculation used for room and board fees. Additionally, I would note that the calculation in He-E 801.10(b) is not included in the State's approved application for its 1915(c) home and community-based care waiver, unlike the cost of care calculation in 801.10(a) for all other participants.

The actual process and the correct characterization of the "room and board" calculation should be included in this rule, as should the actual formula for calculating the participant's funds that are available for the federally required "cost of care" contribution.

Definitions

- **Activities of Daily Living (ADLs) [He-E 801.02(a).]**
  As in every other definition of ADLs in State law (see Attachment C), this rule should recognize that there will be daily activity needs unique to an individual that may not easily fit within these six identified categories. In line with other state definitions of ADLs, this definition should read: "Activities of daily living (ADLs)" means the primary activities necessary to carry out daily self-care activities that ~~involve~~ include, but are not limited to, eating, ..."

  The DHHS errs in its explanation: "The department will not revise the definition of 'activities of daily living.' State law defined ADLs more narrowly." The Department provides no citation to the referenced law, either in its explanation or in Appendix B to the rule.

  The assumption is made here that the Department refers to RSA 151-E:3, as that statute lists the same narrow array of tasks.[4] If so, the DHHS inappropriately interprets this as a definition of ADLs. RSA 151-E:3 is instead an eligibility threshold. It is merely a listing of the level of assistance that would qualify an individual for CFI or nursing facility services.

  In the 2005 HB 691 legislative process, the prime sponsor insisted on raising the bar on *eligibility* for nursing facilities and home and community-based care services, which at the time listed no ADLs specifically. He wanted only the "more serious ADLs" measured for that purpose. I personally supplied the House HHSEA committee with the list from the National Association of Insurance Commissioners model law on long-term care insurance policies which required all policies cover assistance with *at least* these specific ADLs. These were accepted as the "more serious" ADLs and included in HB 691. There was no intent to restrict service coverage to that list post-eligibility.

- **Instrumental Activities of Daily Living (IADLs) [He-E 801.02(z)]**
  Commenters recommended a revision to the IADLs definition that would allow for assistance with needs unique to individuals, but outside of the proposed all or nothing list. The Department response is that such a revision "may have unintended consequences." Such a response can only come from a Department that clearly does not have a standard for coverage for these services. When a good coverage standard is in place, there are no or minimal unintended consequences.

  The instrumental activities of daily living listed in the proposed definition are those necessary for the average person to live independently. The definition should be flexible enough to recognize that CFI participants often have additional essential tasks. For example, this might include cleaning adaptive equipment or basic wheelchair maintenance or assistance with obtaining and keeping appointments (as in supportive housing). The definition might read—

  > "Instrumental Activities of Daily Living" (IADL) means basic tasks that are essential to the ability to live independently, such as light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

[4] 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: . . .
(4) *Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence*; . . . . NH RSA 151-E:3, I.

IADLs also include other supportive activities as specified in the comprehensive care plan which promote and support health, wellness, dignity, and autonomy within a community setting.

Note that the last sentence uses the language in the final rule on Supportive Housing Services, He-E 801.02(aq) and 801.30(c). It is unclear why this would be a standard in supportive housing only.

- **Authorized Representative [He-E 801.02(g)]**
  This definition restricts the authorized representative designation more so than for any other Medicaid program or eligibility group. The inclusion of "other than a department staff member or provider representative" makes the definition more restrictive. See the comparison below.

Final Proposal, He-E 801.02(g)	Current Medicaid Law, He-W 601.01(w)
"Authorized representative" **means any adult other than a department staff member or provider representative** who is 18 years of age or older, and who, with the applicant's or participant's permission, acts on behalf of the individual for CFI waiver services. [Emphasis added.]	"Authorized representative (AR)" means an individual acting on behalf of the casehead in some or all of the aspects of initial and continuing eligibility.

Additionally, the definition conflicts with the use of the term in the He-E 801 rule. The term is used only in the He-E 801.02 definition of "legal representative," where that provision references He-W 803.01, which in turn references the definition above in He-W 601.01(w).

> (aa) "Legal representative" means one of the following individuals, duly appointed or designated in the manner required by law to act on behalf of another individual, and who is acting within the scope ofhis or her authority:
> (1) An attorney; . . .
> (2) A guardian or conservator;
> (3) An agent acting under a power of attorney;
> (4) An authorized representative acting on behalf of an applicant in some or all of the aspects of initial and continuing eligibility in accordance with He-W 803.01;

The definitions are in direct conflict.

The Department explains: The department is removing from the definition of "authorized representative" the requirement that authorized representatives be designate for "all aspects of initial or continuing eligibility determination." The response is elusive at best.

No basis for the proposed definition is given or obvious. He-E 801.02(g) should be corrected as it conflicts with current law.

- **Conflict of Interest [He-E 801.02(o)]**

> "Conflict of interest" means a conflict between the private interests and the official professional responsibilities of a person, such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant.

The term "conflict of interest" is used only in the definition of "case manager" in He-E 801.02(j). As such the term should reflect case management as a whole to increase the efficacy of the provision.

The definition should be amended to read:

> "Conflict of interest" means a conflict between the private interests and the official or professional responsibilities of a person, entity, agency, or organization such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant.

- **Skilled Nursing Services [He-E 801.02(an)]**

> "Skilled nursing services" means services listed in the comprehensive plan of care that are within the scope of RSA 326-B and are provided by a registered professional nurse, or licensed practical nurse **under the supervision of a registered nurse** licensed to practice in New Hampshire within the scope of RSA 326-B. This service provides intermittent skilled nursing services for the purpose of **administering injections, medical monitoring of wounds that are not healing, providing wound care, physical therapy, monitoring vital signs, obtaining laboratory specimens when a chronic condition exacerbates, or overseeing a bowel program**. [Emphasis added.]

First Sentence of the Definition

Under RSA 326-B the LPN may also work under the supervision of a physician, advanced practice registered nurse, or dentist. The Department should not limit service delivery options, particularly given the workforce shortage issues that are seriously impacting care delivery. Removing the limitation, the paragraph should read as follows:

> "Skilled nursing services" means services . . . that are within the scope of RSA 326-B and are provided by a registered professional nurse~~,~~ or licensed practical nurse ~~under the supervision of a registered nurse licensed to practice in New Hampshire~~.

Second Sentence of the Definition

Added in the final proposal, the second sentence inappropriately appears to be limiting. No other care may be characterized as "skilled nursing services"? This would bar, for example, catheter care, intravenous or tube feeding, patient education, medication setup, administration of the first dose of a new medication by any route, assessment, and more. Furthermore, why are nurses providing physical therapy? The second sentence should be removed.

Skilled Nursing Services [(He-E 801.028(b)]

> (b) Skilled nursing services shall be covered for the provision of chronic long-term care and not short-term ~~or intermittent~~ care.

It is unclear why the term "intermittent" is struck from the skilled nursing services rule in He-E 801.28(b) but inserted into the definition of 801.02(an) (see above). This should be corrected for consistency. Both should recognize the intermittent nature of the service.

Case Management Services for Participants in Short-Term Institutional Stays [He-E 801.03(e)(1)]

In response to the initial proposal, the following edit to par. (e)(1) was recommended for consistency with paragraph 801.03(c) and RSA 151-E:17.[5]

[5] **151-E:17 Availability of Targeted Management Services. –** The department shall make available to and advise **all Medicaid recipients** who require a nursing facility level of care or are at risk of needing such care and who are patients in hospitals, rehabilitation hospitals, or nursing facilities of the availability of targeted case management

> Services described in He-E 801.12(d) shall not be provided while the participant is in the facility, except for services that have been prior authorized for the purpose of enabling the participant to transition back to his or her community and targeted case management in accordance with RSA 151-E:17;

The Department declines to edit and explains: "Targeted case management in accordance with RSA 151-E-17 is a type of case management available to non-CFI participants who receive state plan medicaid to explore discharge from a hospital or nursing facility to the community."

As the author of RSA 151-E:17, I respectfully disagree with the Department response. RSA 151-E:17 was intended for "*all* Medicaid recipients who require a nursing facility level of care." [Emphasis added.] For the CFI participant, this is important, for example, when significant health changes have occurred. He-E 801.03(e)(1) should be amended to ensure independent case management assistance to any CFI participant for transition back to their homes or another community setting.

Unintended Removal of Paragraph (b) in He-E 801.04

Relative to the initial proposal, the Department reports that a "commenter suggested we remove paragraph 801.04(b) requiring an initial estimate of costs of the provision of home-based services, because HB 578 (2020) removed the requirement that individuals with costs greater than 80% of the average NF cost obtain commissioner approval." In turn the Department response was "HB 578 did eliminate the need for obtaining commissioner approval for individuals with home based services cost exceeding 80% of average statewide nursing facility rate. However, there is still a clinical eligibility requirement that estimated costs be the same or less than the average nursing facility rate. . . . **the department will not be removing paragraph (b) from He-E 801.04**. The department will revise the FP to eliminate the mention that the initial cost estimate be compared to the 80% limit."

There is no disagreement here with the Department response. However, it appears paragraph (b) was deleted and the remaining paragraphs re-lettered. The provision should be restored.

Introduction of Undefined Term "Comprehensive Assessment" in He-E 801.05

In the final proposal, the Department adds the term "comprehensive assessment" to paragraph (b) without definition or reference. To ensure consistency in the use of the term, the paragraph should be amended to read:

> The participant shall review the identified needs section of the comprehensive assessment, as defined in He-E 805.02(f), indicating his or her agreement or disagreement with the identified needs.

Vehicle Adaptation Missing from He-E 801.17

The CFI waiver application defines this service as including coverage of adaptations to the participant's vehicle. The definition in He-E 801.02 has been revised in the final rule to correct this omission of this coverage. Par. (b) in He-E 801.17 also should be revised to include such adaptations.

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services provided by independent case managers, to explore the feasibility of transitioning to home and community-based care. [Emphasis added.]

Qualifications for Home-Delivered Meals Services Missing from He-E 801.19(c)

In response to a question on provider qualifications, relative to home-delivered meals, the DHHS responded: "a dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutritional services. . . . The department has revised the FP to clarify."

The clarification is not and should be included in the final rule. It should also be noted that the draft application for the 1915(c) waiver renewal calls for a dietician license.

Potentially Problematic Reference to Nur 700 in He-E 801.20(a)

He-E 801.20(a) provides: "Home health aide services, as defined in He-E 801.02(v) shall be covered when provided by a licensed nursing assistant (LNA) licensed in accordance with RSA 326-B and Nur 700 . . . ." The Nur 700 reference is redundant and not the only nursing rule regulating the LNA practice. Also, as Nur 700 is vague on nurse delegation, for clarity it perhaps should not be referenced here or it may be read as restricting the availability of the delegated task, an important avenue of service delivery in the home and community settings.

No Standard to Determine "Medical Condition Necessitates Performance of Personal Care Services" by Home Health Aide in He-E 801.20(b)

He-E 801.20(b) calls for personal care services to be performed by a licensed nursing assistant (LNA) only when a "medical condition necessitates the performance" of personal care tasks by an LNA. The "medical condition" standard is not distinguished in nursing statute, rule, or guidance. The standard should be made clear, to provide a basis for Department authorization or denial of the service.

No Coverage of Specialized Medical Equipment for Residential Care Residents in He-E 801.29(d)

He-E 801.29(d) bars coverage of specialized medical equipment for participants receiving residential care facility services. However, these facilities are not required or expected to routinely provide all types of specialized medical equipment. New Hampshire Medicaid rules do not even require that of nursing facilities. (See, for example, He-W 571.02(b) allowing Medicaid coverage of durable medical equipment not already included in the nursing facility rate.)

There will be times when a residential care resident may require specialized medical equipment that the facility should not otherwise be required to provide. The standard should be no different for participants in residential care facilities than for participants in nursing facilities.

Suggested text amendment:

> Specialized medical equipment services shall not be covered separately for participants receiving residential care facility services if the facility is otherwise required to provide the equipment pursuant to He-P 804, He-P 805, or a residential services agreement or the equipment is included in the residential care facility services rate.

Prohibition on Use of Participant's Vehicle for Non-Medical Transportation in He-E 801.22(e)(1)

He-E 801.22(e)(1) prohibits coverage of non-medical transportation when the transportation is provided with the participant's vehicle. The Department provides: "The non-medical transportation service was added to the CFI waiver to reimburse personal care providers for the cost of maintaining a fleet of vehicles. When a personal care provider provides transportation but utilizes the participant's vehicle, the provider does not incur the costs that the non-medical transportation service was meant to reimburse for, and the provider should not be eligible for the higher rate."

Community providers and consumers are not aware of the "fleet of vehicles" maintained by providers. Using the vehicle of the personal care provider appears to be the practice at hand. As an individual who was involved in the development of this service over time, I strongly disagree with the Department response; the use of the attendant's vehicle or the waiver participant's vehicle was always a goal. This rule should be revisited.

There should be exceptions in (e)(1) for the use of the participant's vehicle when, for example:

- The participant has a vehicle but is unable to drive;
- The participant's vehicle is a better, more reliable vehicle; or
- The participant cannot easily board a traditional vehicle, or otherwise requires a specialized vehicle, such as a wheelchair van.

The DHHS further responds that "[w]hen a personal care provider provides transportation but utilizes the participant's vehicle, the provider does not incur the costs that the non-medical transportation service was meant to reimburse for, and the provider should not be eligible for the higher rate." Historically we were told that the rate paid is for the provider's time and the service of driving, as well as the cost of the drive.

New Hampshire Statutes	
IV. “Personal assistance” means providing or assisting a resident in obtaining one or more of the following services: (a) Assistance with activities of daily living such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, or monitoring or supervision of medications. (b) Assistance with instrumental activities of daily living such as doing laundry, cleaning of living areas, food preparation, managing money and conducting business affairs, using public transportation, writing letters, obtaining appointments, using the telephone, or engaging in recreational or leisure activities.	N.H. Rev. Stat. Ann. § 161-J:2 (Assisted Living Residences, Independent Living Retirement Communities, and Housing For Older Persons)
III. “Chronically ill” means: (a) Being unable to perform at least 2 activities of daily living, including eating, toileting, transferring, bathing, dressing, or continence;	N.H. Rev. Stat. Ann. § 408-D:2 (Life Settlements Act)
(h) Personal treatment or care, including assistance with activities of daily living such as bathing, dressing, eating, range of motion, toileting, transferring, and ambulation.	N.H. Rev. Stat. Ann. § 464-D:4 (Supported Decision Making)
New Hampshire Administrative Rules	
(a) “Activities of daily living (ADL)” means activities such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, and monitoring and supervision of medications. . . . (u) “Instrumental activities of daily living” means activities performed on a regular basis, including, but not limited to, doing laundry, cleaning, managing money, shopping, using transportation, correspondence, making telephone calls, obtaining and keeping appointments, socializing, and recreation.	N.H. Code Admin. R. He-E § 501.02 (Social Services Block Grant)
(a) “Activities of daily living (ADLs)” means activities such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, and monitoring and supervision of medications.	N.H. Code Admin. R. He-E §§ 502.02 (Disease Prevention and Health Promotion Services, Older Americans Act Services), 801.02 (Choices for Independence Program, expired)
(a) “Activities of daily living (ADL)” means basic daily routine tasks such as eating, transferring, toileting, bathing, dressing and self-management of medications.	N.H. Code Admin. R. He-E § 803.02 (Adult Medical Day Care) **Note: This is a service covered under He-E 801.** N.H. Code Admin. R. He-P §§ 803.03 (New Hampshire Nursing Home Rules), 807.03 (Rules for Residential Treatment and Rehabilitation Facilities), 809.03 (Home Health Care Providers), 818.03 (Adult Day Programs) **Note: Some of these licensure standards are required for providers of services under the Choices for Independence program under He-E 801.**
(a) “Activities of daily living” means those activities associated with personal care, including personal hygiene, bathing, eating, dressing, toilet use, walking, transferring from one surface to another, moving between locations, and bed mobility. . . .	N.H. Code Admin. R. He-E § 805.02 (Targeted Case Management) **Note: This is a service provided to participants in the Choices for Independence program under He-E 801.**

(m) “Instrumental activities of daily living” means those activities associated with home management, including grocery shopping, meal preparation, telephone use, and managing finances, and routine housework such as washing dishes, making beds, dusting, and laundry.	
(b) “Activities of daily living (ADL)” means basic daily routine tasks common to the average individual, such as personal hygiene, transfers and walking.	N.H. Code Admin. R. He-P § 813.03 (Adult Family Care Residence) **Note: This is a service provided only to participants in the Choices for Independence program under He-E 801.**
(c) “Activities of daily living (ADL)” means basic daily routine tasks such as: (1) Walking; (2) Bathing; . . . . (av) “Personal assistance” means providing or assisting an individual in obtaining one or more of the following services: (1) Assistance with ADL, such as grooming, toileting, eating, dressing, getting into or out of a bed or chair, walking, or monitoring, supervision, or administration of medication; (2) Assistance with instrumental activities of daily living such as doing laundry, food preparation, obtaining appointments, or engaging in recreational or leisure activities;	N.H. Code Admin. R. He-P § 814.03 (Residential Care and Health Facilities Rules) **Note: This is a setting in which participants in the Choices for Independence program under He-E 801 may live.**
(k) “Personal care services” means non-medical, hands-on services provided to a client, including, but not limited to, helping with activities of daily living such as grooming, toileting, eating, dressing, bathing, getting into or out of a bed or chair, walking, or reminding the client to take medications.	N.H. Code Admin. R. He-P § 820.03 (Individual Home Care Service Providers)
(b) “Activities of daily living (ADL)” means basic daily routine tasks such as grooming, eating, transferring, toileting, bathing, dressing, and self-management of medications.	N.H. Code Admin. R. He-P § 822.03 (Home Care Service Provider Agencies)
(b) “Activities of daily living (ADL)” means basic daily routine tasks such as eating, transferring, toileting, bathing, dressing, self-management, and monitoring or supervision of medications.	N.H. Code Admin. R. He-P §§ 823.03 (Home Hospice Care Provider), 824.03 (Hospice House)
(bk) “Personal care” means personal care services that are non-medical, hands-on services provided to a patient to assist with activities of daily living such as grooming, toileting, eating, dressing, bathing, getting into or out of a bed or chair, or walking.	N.H. Code Admin. R. He-P § 827.03 (Free Standing Megavoltage Radiation Therapy Facility)
(b) “Activities of daily living (ADL)” means basic daily routine tasks such as eating, transferring, toileting, bathing, dressing, and medication management.	N.H. Code Admin. R. He-P §§ 802.03 (Rules for Hospitals and Special Health Care Services), 804.03 (Assisted Living Residence-Residential Care Licensing), 805.03 (Supported Residential Care Facility Licensing Rules), 826.03 (Substance Use Disorder Residential Treatment Facilities), & 830.03 (Psychiatric Residential Treatment Programs) **Note: Some of these are settings in which participants in the Choices for Independence program under He-E 801 may live.**
(b) Services that consist only of assistance with activities of daily living or other non-skilled services needed to live at home that do not require a nurse, including but not limited to assistance with grooming, toileting, eating, dressing, getting into or out of a bed or chair, and walking shall not be covered as PDN.	N.H. Code Admin. R. He-W § 540.05 (Private Duty Nursing, Non-Covered Services)
(5) Is able to participate fully in activities of daily living (ADLs), which are the basic self-care tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring;	N.H. Code Admin. R. He-W § 552.03 (Personal Care Attendant Services, Medicaid)

	Note: This is a service provided to participants in the Choices for Independence program under He-E 801.
(10) At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery: a. For purposes of this benefit, the following definitions shall apply: 1. “Activities of daily living” include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings; . . .	N.H. Code Admin. R. Ins § 1905.07 (Minimum Standards for Medicare Supplement Policies)
(a) “Activities of daily living” means at least bathing, continence, dressing, eating, toileting and transferring;	N.H. Code Admin. R. Ins § 3601.04
(b) (1) Activities of daily living shall include at least the following as defined in Ins 3601.04 and in the policy; a. Bathing; b. Continence; c. Dressing; d. Eating; e. Toileting; and f. Transferring;	N.H. Code Admin. R. Ins § 3601.28
(a) “Activities of daily living (ADL)” means activities related to personal care, such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating;	N.H. Code Admin. R. Ins § 6001.03 (Standard Definitions and Policy Provisions, Provisions Applicable to All Ancillary Health and Blanket Insurance)
(g) “Medical technician”' means “medical technician” as defined in RSA 328-I, VI. The term does not include nurses licensed in another state who are working in New Hampshire under the Nurse Licensure Compact. The term also does not include those staff who perform non-medical functions supporting the clients or residents of those facilities with activities of daily living such as housekeeping, security, maintenance, dietary, cooking, bathing, dressing, and administration of the clients' or residents' prescribed medications.	N.H. Code Admin. R. Mtec § 301.01 (Board of Registration of Medical Technicians)

NEW HAMPSHIRE
MEDICAL CARE ADVISORY COMMITTEE
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December 15, 2021

Dear Senator Raegan, Representative Maguire and Members of the committee,

By way of introduction, I chair the Medical Care Advisory Committee (MCAC). On Monday December 13, 2021, the MCAC voted to object to the He-801 Choices for Independence on the basis of the issues outlined by Michelle Winchester (attached).

The MCAC is concerned about the impact the rule as presented will have on the elderly and adult citizens of New Hampshire The Choices For Independence Program serves individuals who are certified by the department to be nursing facility level of care and choose to receive care in the community in lieu of institutional nursing facility placement. This is not a program we can afford to jeopardize without impacting a citizen's right to choose where they will receive care.

Please take note the voluminous objections submitted by the public during this process and the limited if any public support given to this rule during the rule making process.

The New Hampshire Medical Care Advisory Committee, is the federally required advisory body to New Hampshire's Medicaid agency, as such we would sincerely appreciate thoughtful consideration of the concerns identified.

Sincerely,

Carolyn A Virtue, Chair