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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LONG TERM SUPPORTS AND SERVICES

Lori A. Shibinette
Commissioner

Nancy L. Rollins
Interim Director

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November 23, 2021

The Honorable Karen Umberger, Chairman
Fiscal Committee of the General Court and

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Pursuant to the provisions of RSA 14:30-a, VI, authorize the Department of Health and Human Services, Division of Long Term Supports and Services to accept and expend federal funds in the amount of \$73,307,508 from the Centers for Medicare and Medicaid Services to fund the State's Home and Community Based Services Plan created pursuant to the American Rescue Plan Act of 2021 (ARPA) effective upon approval by the Fiscal Committee and Governor and Council through June 30, 2023 and further authorize the allocation of these funds in the accounts below. 100% Federal Funds.

05-095-093-930010-24XXXXXX HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS;
HHS: DLTSS-DIV OF DEVELOPMENTAL SERVICES; DEVELOPMENTAL SERVICES; HCBS ENHANCED
FMAP

Class/Object	Class Title	Current Adjusted Authorized Budget	Increase / (Decrease) Amount	Revised Budget
Revenue				
000-400146	Federal Funds	\$0	\$73,307,508	\$73,307,508
	General Funds	\$0	\$0	\$0
	Total Revenue	\$0	\$73,307,508	\$73,307,508
Expense				
041-500801	Audit Fund Set Aside	\$0	\$73,308	\$73,308
502-500891	Payments to Providers	\$0	\$73,234,200	\$73,234,200
	Total Expense	\$0	\$73,307,508	\$73,307,508

EXPLANATION

The Department is requesting to accept and expend American Rescue Plan Act (ARPA), Section 9817 funding based on additional FMAP (Federal Medical Assistance Percentage) earnings made available to states on services related to Home and Community Based Services (HCBS) that have been and are currently being provided. HCBS services are those services that support individuals to receive necessary services in the community and include, but are not limited to: personal care, day habilitation, private duty nursing, and substance misuse residential treatment. The expected enhanced earnings are summarized below. Earnings for a portion of year one estimates are included in this request, with the expectation that future requests will be made as the spending plan of the funds evolves which may enable the Department to claim additional dollars.

Section 9817 of the ARPA temporarily increases the FMAP by 10 percentage points for certain eligible Medicaid HCBS expenditures beginning April 1, 2021 through March 31, 2022 approved under the applicable state plan, waiver or managed care authority by CMS. CMS in a letter to the nation's Medicaid Directors outlines how states can use this FMAP increase to strengthen the HCBS system to maintain or increase access to HCBS services for Medicaid beneficiaries, adequately protect the HCBS workforce, safeguard financial stability for HCBS providers, and accelerate long-term services and supports (LTSS) reform under section 9817 of the ARP as well as respond to the impacts on HCBS related to the federal Public Health Emergency (PHE).

In accordance with section 9817 of ARPA, to receive the increased FMAP for HCBS expenditures, states need to utilize federal funds attributable to the increased FMAP to supplement existing state funds expended for Medicaid HCBS in effect as of April 1, 2021. In addition, the state equivalent of the amount of federal funds attributable to the increased FMAP are to be utilized to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program beyond what was under the Medicaid program as of April 1, 2021.

The amounts listed in the charts and narrative within this letter are estimates, based on actual expenditures through September 30, 2021 and trend for October 1, 2021 through March 31, 2022. The actual dollars will depend on current and future billing levels. An accounting with actual amounts will be provided to Fiscal Committee in May 2022.

	Year 1 4/1/21 - 3/31/22	Year 2 4/1/22 - 3/31/23	Year 3 4/1/23 - 3/31/24	Total
State Reinvestment Allocation By Year (%)	40%	30%	30%	100%
Federal Funds from Reinvestment (*)	\$ 45,234,200	\$ 23,985,400	\$ 23,985,400	\$ 93,205,000
Plus Directed Payment (&)	\$ 28,000,000			\$ 28,000,000
	\$ 73,234,200	\$ 23,985,400	\$ 23,985,400	\$ 121,205,000
	(@)			
(#) Percentage of Federal Funds from Reinvestment earned below to be spent by Federal Fiscal Year				
(*) - Federal Funds from Reinvestment is the total amount the State estimates it will earn via the 10% enhanced FMAP on eligible services from 4/1/21-3/31/22 along with the subsequent reinvestment of those funds				
(&) - Amount attributable to MCO Directed Payments				
(@) See Payment to Providers expense line 502-500891 in Accounting Table above.				

These funds will be used to improve and enhance the services listed below within HCBS throughout the State of New Hampshire. These services and improvements described below are an eligible use of ARPA HCBS funds because they enhance, expand, or strengthen HCBS.

The HCBS workforce provides necessary direct care services to Medicaid recipients living in the community. HCBS services allow individuals to remain in their home or other community-based setting instead of in an institutional setting.

1. Home and Community Based Services through the 1915 c Waivers.

- a. The Department requests to utilize American Rescue Plan Act (ARPA) funds to distribute funds to direct care providers under the 1915 c Waiver Programs, specifically, to Choices for Independence (CFI) Providers that provide the following direct care services: home health aide, adult day care, adult foster care, skilled nursing, supported home maker, personal care, and mid-level residential

services; the Developmental Disabilities (DD)/Acquired Brain Disorder (ABD)/In Home Support (IHS) Providers that provide the following direct care services: community support services, residential personal care services, supported employment services, and day habilitation services.

- b. The Department will distribute \$43,234,200 to the CFI, DD, ABD and IHS providers identified above. Each agency that receives a distribution will be required to direct at a minimum, 80% of the funding received to the eligible workforce.

2. Medicaid State Plan Providers under Fee For Service (FFS) and Medicaid Care Management(MCM)

- a. The Department requests to utilize American Rescue Plan Act (ARPA) funds to distribute funds to direct care providers under the Medicaid State Plan. Specifically, additional payments to FFS providers and MCM providers (through the Managed Care contract) that provide private duty nursing, personal care, adult community mental health services, behavioral health residential services, home care providers, durable medical equipment providers, substance use disorder inpatient treatment, and community-based wraparound services.
- b. The Department estimates it will be able to pay out to providers through a directed payment in the Managed Care contract and fee for service \$28,000,000 to the MCO providers and FFS providers identified above. Each agency that receives these payments will be required to direct at a minimum, 80% of the funding received to enhance the eligible direct care workforce.

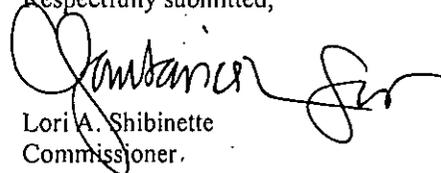
3. Medicaid to Schools Providers

- a. The Department requests to utilize American Rescue Plan Act (ARPA) funds to provide an additional Medicaid to Schools payment in the eligible period through an enhanced certified public expenditure claim method for eligible rehab services delivered in the applicable enhanced period.
- b. The Department estimates that up to \$2,000,000 could possibly be available to the Medicaid to Schools Program depending on the level of eligible billing activity through the schools.

In summary, additional funding is requested to aid the Department in making rapid, marked improvement relative to the HCBS workforce issues facing many providers within the State of New Hampshire. The Source of Funds is 100% Federal Funds.

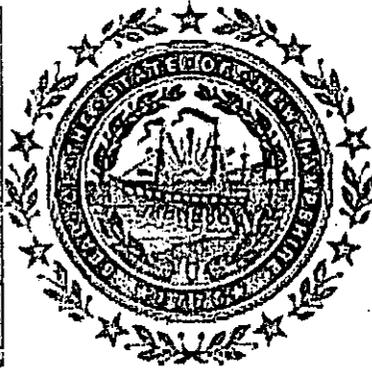
In the event that these Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,



Lori A. Shibinette
Commissioner.

Spending Plan for Implementation of the American Rescue Plan Act of 2021, Sect. 9817



July 2021

New Hampshire

Additional support for Medicaid home and community based services
during the COVID-19 public health emergency.



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

Lori A. Shabinette
Commissioner

Henry D. Lipman
Director

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July 9, 2021

Mr. Dan Tsai
Deputy Administrator and Director
Centers for Medicaid and CHIP Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Home and Community-Based Services Spending Plan to Implement the American Rescue Plan Act of 2021

Dear Mr. Tsai:

New Hampshire appreciates the opportunity to submit the following spending plan for the HCBS funds as described in Section 9817 of the American Rescue Plan Act. As the designated point of contact and State Medicaid Director I attest that New Hampshire will submit a quarterly spending plan and narrative submissions and assure the following:

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;
- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021.

New Hampshire will continue to update CMS on its implementation of section 9817 via quarterly spending plan submissions. Nancy Rollins will coordinate our quarterly submissions. Please direct any questions to me and Nancy Rollins at Nancy.L.Rollins@dhhs.nh.gov. New Hampshire appreciates this opportunity and your partnership in this effort.

Sincerely,

Henry D. Lipman
Medicaid Director

Attachments

Spending Plan for Implementation of the American Rescue Plan Act of 2021, Sect. 9817

New Hampshire

Executive Summary

President Biden signed the American Rescue Plan Act of 2021 (ARPA) on March 22, 2021. Section 9817 of the ARPA temporarily increases the federal medical assistance percentage (FMAP) by 10 percentage points for certain Medicaid expenditures for home and community based services (HCBS) beginning April 1, 2021, and ending March 31, 2022. The increased FMAP is available for person-centered care delivered in the community or home to support people who need assistance with everyday activities.

States must use the federal funds attributed to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021. States are required to use funds equivalent to the amount of federal funds available through the increased FMAP to enhance, expand, or strengthen HCBS.

New Hampshire's spending plan outlines three (3) key spending priorities:

- Workforce investment
- Improve/increase access to services
- Pilot new services to promote, expand, and enhance HCBS

The initiatives contained in this plan are intended to address both the short-term and long-term goals of New Hampshire residents, always with an eye toward sustainability.

New Hampshire will receive an estimated \$44 million in additional federal funding due to FMAP enhancement and in addition, potentially the matching of the state share equivalent could contribute an additional \$10 to \$12 million. The estimated budget for the New Hampshire plan is \$54 to \$56 million. New Hampshire requests the flexibility, as circumstances evolve, to transfer up to 20% of funding among and between the three (3) spending categories.

In accordance with New Hampshire law the Department will seek approval when required from the New Hampshire General Court's Fiscal Committee, the Joint Health Care Reform Oversight Committee as well as the Governor and Council. Further, the Department may be required to consult with, or seek approval from, several entities prior to being authorized to implement components of this plan. Specifically, the Department may need to present aspects of this plan to, among others, the New Hampshire General Court's House of Representatives' Health, Human Services and Elderly Affairs committee and the Senate Health and Human Services Committee for review and comment. These consultations and approvals, when required, can extend implementation timelines. The Department, however, will begin the consultation and approval process in conjunction with the plan's submission to CMS in order to avoid any unnecessary delay in implementation upon CMS approval.

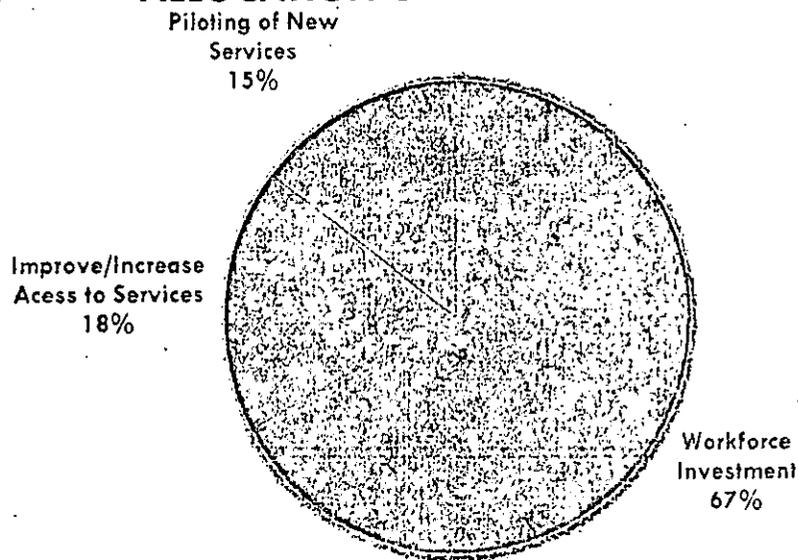
Spending Plan for Implementation of the American Rescue Plan Act of 2021, Sect. 9817

	Year 1	Year 2	Year 3
Workforce Investment	\$30 million	Spend down of remaining funds	Spend down of remaining funds
Improve/Increase Access to Services	\$8.1 million	Spend down of remaining funds	Spend down of remaining funds
Piloting of New Services	--	\$6.5 million	Spend down of remaining funds

*The dates in the chart are target dates in which we expect spending will begin.

**A portion of funds may transfer between spending categories as circumstances evolve.

ALLOCATION OF ENHANCED FMAP



I. Workforce Investment

A robust workforce is essential for the success of HCBS programs. The plan strives to develop and expand programs to support training, recruitment, and retention of the workforce.

HCBS Workforce Incentives and Payment Enhancements: \$30,000,000

Goal: Increase access and quality of services for beneficiaries by expanding workforce capacity through recruiting, retaining, and career laddering HCBS workforce using means such as payments for sign-on bonuses, retention bonuses, ladder advancement stipends, and competency/education/training support stipends.

Sustainability: Providing necessary services to Medicaid beneficiaries coming out of the pandemic in HCBS settings now avoids higher long-term costs.

Stakeholder support: Commissioner, AARP, NH AHA, AAs/CSNI, PPN, GSHHA, NH State Commission on Aging, NH Community Behavioral Health Association

Authority: Section 1915(c), 1905(a)(13), 1905(a)(8), 1905(a)(24)

Timing: Year 1

Support HCBS direct care workers under the state's waiver programs as the state enters and completes a recalibration of its rate setting budget methodology. Payments for HCBS services under waiver would have pools for supplemental type payments with a required payment percentage to go to direct care workers using means such as payments for sign-on bonuses, retention bonuses, ladder advancement stipends, and competency/training support stipends.

Under the state's managed care program, through directed payments, create a pool of funds by targeted HCBS provider types. The directed payments would cover the rating periods ending June 30, 2021 and June 30, 2022 to encompass services delivered in the HCBS EFMAP period of April 1, 2021 to March 31, 2022. The funds will be distributed based on both the percentage of services and the delivery of services to added beneficiaries for a respective category (e.g. private duty nurse takes on a Medicaid beneficiary previously not served). Funds in these pools would be required to be substantially used for targeted staff (e.g. Direct Support Professionals, Personal Care Workers, Rehabilitative Professionals, Enhanced Family Care Givers, Case Managers, Private Duty Nurses, and residential care direct workforce such as supportive housing, residential SUD and mental health) in accordance with the goals outlined above.

II. Improve/Increase Access to Services

The initiatives discussed in this section will enhance and expand existing community-based programs. Building upon existing, vital programs will further provide for the health and wellness of the State's most vulnerable populations including the elderly and disabled, individuals with behavioral health needs, and those experiencing homelessness.

Lift CFI Home and Vehicle Modification Cap: \$1,000,000

Goal: More extensive home and vehicle modifications allow for fewer or shorter institutional services.

Sustainability: Additional home and vehicle modifications should support a longer home tenure of beneficiaries versus institutional level care, which is historically more expensive.

Stakeholder support: AARP, HOMES

Authority: Section 1915(c)

Timing: Year 1

Waiver authority found at section 1915(c) of the Act gives states the option to offer long-term services and supports (LTSS) in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act. For example, services may include home and vehicle accessibility modifications (e.g., installing a wheelchair ramp or grab bars in a shower) to improve individuals' ability to remain in their homes and prevent institutional admission.

Spending Plan for Implementation of the American Rescue Plan Act of 2021, Sect. 9817

School Based and Early Support Services: \$2,500,000

Goal: Help schools recover services for Medicaid covered children forgone during COVID-19 PHE.

Sustainability: Services to help restore higher levels of function or prevent further deterioration to moderate future costs in Medicaid.

Stakeholder support: NH Department of Education, School Districts, and the Healthy Students Promising Future Learning Collaborative

Authority: 1905(a)

Timing: Year 1

These services include medical assistance for covered services under section 1905(a) that are furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan. As a result of the COVID-19 pandemic, schools throughout the state saw a significant decrease in billable services. It is expected that as students return to in-person learning for school year 2021-2022, there will be an increase in services delivered in the school setting.

Integrated Healthcare Clinic for Individuals Experiencing Homelessness: \$4,600,000

Goal: Provide whole person and integrated care in the community to those experiencing homelessness.

Sustainability: Increasing the health status of the beneficiaries in order to moderate long term costs and improve overall health.

Stakeholder support: Commissioner, Council on Housing Stability Strategic Plan, 1915i public comment

Authority: 1915(i), 1915(b)

Timing: Year 1

This project will replicate a successful program that is currently operating in the state's largest city to implement the model throughout the state. The program will provide for a clinic in each homeless shelter and through homeless outreach contracts managed by the Department. The Department will engage our community partners to operate the clinics; they will provide on-site care at shelters and agreed upon locations for the outreach programs weekly. Included in the clinics can be a medical practitioner (MD, PA, or ARPN), Nurse Coordinator or Medical Assistant, Behavioral Health Therapist, Substance Misuse Counselor, and Case Manager. This program will provide whole person and integrated care. The program will work in conjunction with the local homeless shelters and outreach providers to ensure the clinic is provided at the right time and location for maximum participation and access.

III. Piloting of New Services to Promote, Expand, and Enhance HCBS

The investments in this section are pilot projects that will be explored in order to reduce the amount of time an individual is waiting for services and to trial new delivery models.

Presumptive Eligibility: \$2,000,000

Goal: Initiating beneficiary access to services more timely to maintain functional and health status, and avoid otherwise avoidable deterioration that could lead to longer-term institutionalization.

Sustainability: Reducing the level of acuity or institutionalization.

Stakeholder support: AARP, AHA, NH State Commission on Aging, Commissioner

Authority: CMS approval and NH legislative authorization

Timing: Year 2-3

Implementing new eligibility policies and/or procedures, such as expedited eligibility determinations for HCBS (subject to CMS approval), or streamline application and enrollment processes in LTSS.

Under presumptive eligibility, designated entities such as DHHS staff, ServiceLink, hospitals, etc. can use basic financial information and screening tools to quickly presume a low-income individual is eligible for Medicaid and commence services, even before an official Medicaid determination is made. A decision is made within a short timeframe. (Example: five days business days).

Presumptive eligibility allows applicants who appear likely to be eligible for Medicaid to start receiving Home and Community Based Services (HCBS) when a need arises. In states with presumptive eligibility, an individual can receive services in his or her home while his or her Medicaid application is being processed. The Department recommends a limited service array be offered during the presumptive eligibility period.

Program of All-Inclusive Care for the Elderly (PACE) or Dual Eligible Special Need Plan (D-SNP) Pilots: \$3,000,000

Goal: New Hampshire is looking to develop experience in the integration of Medicare and Medicaid coverage to learn how that integration can help meet the overall needs of dual eligible beneficiaries and to do so in the community versus in institutional settings, whether it be an avoidable hospitalization or a stay in a nursing facility long-term.

Sustainability: Integration of the Medicare and Medicaid benefit with strong care coordination has the promise of a higher level of community-based care over institutionalization and the possibility to reduce costs within the state's managed care program.

Stakeholder support: AARP, Counties

Authority: Section 1915(c)

Timing: Year 2-3

PACE provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. An interdisciplinary team of health professionals provides PACE participants with coordinated care. D-SNP integrates the benefits under a Medicare Advantage Plan with the

Spending Plan for Implementation of the American Rescue Plan Act of 2021, Sect. 9817

Medicaid Managed Care benefits, typically with social determinants of health supports and added benefits beyond those in an unintegrated platform.

Service Delivery Reform Enhanced Family Care: \$750,000

Goal: To build statewide residential capacity for individuals that are living in staffed residences who may be able to step down to a lesser restrictive model based in the community.

Sustainability: Making caring for an individual in the community a sustainable model of care will allow more beneficiaries to remain in the community and is less expensive than institutional care.

Stakeholder support: Commissioner, AARP, Disability Rights Center, Community Support Network Inc.

Authority: Section 1915(c)

Timing: Year 2

The Enhanced Family Care Model (EFC) model of support (also known as Shared Living or Adult Foster Care) is a community-based support model that is less intensive than a staffed residence but provides more support than an independent living model. The EFC Model is an arrangement in which a contracted home care provider (HCP) opens his/her home to an eligible individual and the individual receives supports in the HCP's home. Within the EFC Model, an individual may receive very limited support or they may receive up to 24 hours, 7 days a week, as this model is individualized and is based on the person's specific needs.

The majority of residential support for individuals with Developmental Disabilities in NH is provided through this model (approx. 80%). The expansion of this model to the elderly and behavioral health populations will create capacity and step down options for those living in institutional or facility based settings, resulting in higher quality of life and reduced cost for supports.

Acquired Brain Disorder and/or Traumatic Brain Injury "Club House-Like Model" Pilot: \$750,000

Goal: Provide greater opportunity for psychosocial rehabilitation for the Acquired Brain Disorder (ABD) and/or Traumatic Brain Injury (TBI) populations to support employment, housing tenancy, quality of life, and a higher level of wellness and functional status.

Sustainability: Higher level of functional and health status supports lower acuity. This pilot would expand on a similar model currently operating in the state. Estimated pilot of 12 supported members expected to serve up to 25. Ongoing funding may be sustained through NH State Medicaid Plan or 1915(c) ABD Waiver.

Stakeholder support: Commissioner, Area Agencies / Community Support Network Inc., Brain Injury Association, NH Brain and Spinal Cord Injury Advisory Council

Authority: Section: SPA and/or Waiver needed.

Timing: Year 2-3

This member-centered approach enables ABD/TBI survivors to participate in all aspects of their care, including design, planning, and implementation of services. This will be an integrated, social support center designed after a Club House model. Survivors participate in the establishment of policies, governance, and procedures used at the "Clubhouse." The Clubhouse design is unique because members and staff develop and implement daily activities together.

Group discussions and activities in the Clubhouse typically focus on variety of topics, such as understanding brain injury, the challenges of being a survivor, coping with one's own unique family circumstances, independent living, vocational skills, pursuing healthy lifestyles, improving communication and social skills, returning to work, recreation, arts and crafts, and participation in community projects and social events.

IV. Spending Plan Projection

Attached to this plan as Appendix A are the spending projections for the plan.

V. Stakeholder Engagement

New Hampshire is grateful for the commitment of our stakeholders. We received feedback from many advocacy groups, provider representatives/associations, and providers. There were a number of common themes we heard from our stakeholders. Chief among them were the need for workforce support, incentives, and development as well as expansion or amendments to existing programs for services that allow New Hampshire residents to remain in their homes safely.

Attached to this plan as Appendix B are letters New Hampshire received from stakeholders during the development of this plan.

Appendix A

Financial Impact Projection of Supplemental Funding from ARPA 10% HCBS FMAP Increase
ARPA Pub. L. 117-2 Sec. 9817

a. BASELINE EXPENDITURES THAT QUALIFY FOR 10% HCBS FMAP (Not including CMS Letter SMD#21-003 Appendix B Items pending further guidance)

Federal Fiscal Year Federal Fiscal Quarter	FFY 21		FFY 22		Total
	Q3: Apr to Jun	Q4: Jul to Sep	Q1: Oct to Dec	Q2: Jan to Mar	
	QE 06/2020 Data	QE 09/2020 Data	QE 12/2020 Data	QE 03/2021 Data	
Total Computable Base Expenditures	\$ 104,587,770	\$ 92,456,269	\$ 104,121,702	\$ 108,719,033	\$ 409,884,774
Total State Share	\$ 35,350,666	\$ 31,250,219	\$ 35,193,135	\$ 43,487,613	\$ 145,281,634
Total Federal Share (Including 10% FMAP Increase)	\$ 69,237,104	\$ 61,206,050	\$ 68,928,567	\$ 65,231,420	\$ 264,603,141
* (1). Funds Attributable to the HCBS FMAP Increase	\$ 10,458,777	\$ 9,245,627	\$ 10,412,170	\$ 10,871,903	\$ 40,988,477

BASELINE EXPENDITURES THAT QUALIFY FOR 10% HCBS FMAP (Including CMS Letter SMD#21-003 Appendix B Items pending further guidance)

Total Computable Base Expenditures	\$ 119,319,675	\$ 104,683,410	\$ 121,824,094	\$ 125,141,973	\$ 470,969,152
Total State Share	\$ 40,330,050	\$ 35,382,992	\$ 41,176,544	\$ 50,056,789	\$ 166,946,376
Total Federal Share (Including 10% FMAP Increase)	\$ 78,989,625	\$ 69,300,417	\$ 80,647,550	\$ 75,085,184	\$ 304,022,776
* (2). Funds Attributable to the HCBS FMAP Increase	\$ 11,931,967	\$ 10,468,341	\$ 12,182,409	\$ 12,514,197	\$ 47,096,915

* Average of (1) and (2)

\$ 11,195,372	\$ 9,856,984	\$ 11,297,290	\$ 11,693,050	\$ 44,042,696
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FMAP Assumptions

State's Base FMAP	50.00%	50.00%	50.00%	50.00%
*FFCRA Increase	6.20%	6.20%	6.20%	0.00%
ARPA Increase	10.00%	10.00%	10.00%	10.00%
Combined FMAP	66.20%	66.20%	66.20%	60.00%

b. ADDED FUNDING FOR HCBS REINVESTMENT

Year of Reinvestment Time Period	Year 1	Year 2	Year 3	Total
	4/1/21 - 3/31/22	4/1/22 - 3/31/23	4/1/23 - 3/31/24	
State Reinvestment Allocation By Year	33%	33%	33%	100%
State Reinvestment by Year	\$ 14,680,900	\$ 14,680,900	\$ 14,680,900	\$ 44,042,700

FMAP Assumptions

State's Base FMAP	50.00%	50.00%	50.00%
*FFCRA Increase	4.65%	0.00%	0.00%
ARPA Increase	10.00%	0.00%	0.00%
Combined FMAP	64.65%	50.00%	50.00%

Supplemental Funding

Reinvested State Share	\$ 14,680,900	\$ 14,680,900	\$ 14,680,900	\$ 44,042,700
Federal Match on Reinvestment	\$ 26,849,200	\$ 14,680,900	\$ 14,680,900	\$ 56,211,000
Subtotal: Supplemental Funding	\$ 41,530,100	\$ 29,361,800	\$ 29,361,800	\$ 100,253,700

Federal Match Attributable to FMAP Components

Base FMAP	\$ 14,680,900	\$ 14,680,900	\$ 14,680,900	\$ 44,042,700
FMAP Increases (ARPA + FFCRA)	\$ 12,168,300	\$ -	\$ -	\$ 12,168,300
Subtotal: Federal Match	\$ 26,849,200	\$ 14,680,900	\$ 14,680,900	\$ 56,211,000

* 1. The projection is based on historical expenditure data from April 2020 to March 2021. Actual HCBS Section 9817 FMAP may differ.

* 2. Assumption is based on FFCRA 6.2% increase available through 12/31/2021.

* 3. The State will submit our managed care claiming methodology for the increased FMAP to CMS for review and approval. The estimated impact could be approximately \$2.8 million potential FMAP increase. This figure is not included in the model at this time because the methodology has not yet been approved.

Appendix B



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aarp.org/nh | nh@aarp.org | twitter: @aarpnh
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April 20, 2021

Lori Shabinette
Commissioner
Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301

Governor Chris Sununu
c/o Elliot W. Gault
Office of the Governor
State House
107 North Main Street
Concord, NH 03301
(603) 271-2121

Re: Some Innovative Uses for Incoming ARPA Funding

Dear Governor Sununu and Commissioner Shabinette:

AARP New Hampshire, on behalf of our over 215,000 members and all older Granite Staters, urges you to take advantage of new federal resources to expand access to in-home and community-based care. Governor Sununu has (on many occasions) indicated a desire to augment the funding and work in this area and this seems to be a great time to be both forward-thinking, innovative, and to use incoming resources to leverage lasting change. With these things in mind, we submit this proposal to you with optimism and excitement.

With an estimated 880 COVID-related deaths occurring in Granite State nursing homes and long-term care facilities, representing 70% percent of deaths in our state (data from 4/14/21 state dashboard), this help is urgently needed. Equally important is building infrastructure to honor the preferences of New Hampshire's burgeoning older adult population to age in their homes and communities and to build an infrastructure to make that preference a reality.

In March, Congress passed a new law that includes enhanced funding for Medicaid home and community-based services (HCBS). Specifically, it establishes a temporary enhanced federal matching percentage (FMAP) for state HCBS expenditures from April 1, 2021 to

March 31, 2022. The new law stipulates that the enhanced FMAP must be used to supplement (not supplant) current state HCBS spending, and to enhance, expand, or strengthen home and community-based services under New Hampshire's Medicaid program.

We know that the vast majority of Granite Staters want to get care in their homes and communities. That is why AARP urges New Hampshire to take advantage of this unique opportunity to use this increased funding to supplement existing state HCBS efforts. Acknowledging that the ARPA is likely to be a one-time opportunity, New Hampshire AARP would like to recommend some HCBS initiatives that will significantly improve long-term HCBS access without obligating the state to annual expenditures after the ARPA funding is exhausted. Finally, to allow the majority of the ARPA funding to be used for the state's immediate emergency HCBS program needs, we have limited our HCBS long-term access improvement recommendations to less than 25% of the anticipated \$43 million in HCBS funding that New Hampshire is estimated to receive under the ARPA. Please see: <https://www.kff.org/report-section/potential-impact-of-additional-federal-funds-for-medicaid-hcbs-for-seniors-and-people-with-disabilities-table/>

While we clearly understand and acknowledge that the majority of New Hampshire's HCBS funding is for Developmental Services, because of (among other things) our rapidly aging population who prefer to live at home, plus the high death rate of nursing home residents during this pandemic, it is critical that we (as a state) now make more funding available to help people stay and keep safe in their homes as they age. We also think that some of the changes and approaches we recommend below (i) could (and should) result in some additional funding for HCBS for the aging, and; (ii) some of the changes we seek below will naturally benefit both groups.

Recommendations for Potential Activities

We respectfully suggest the following activities for your consideration for use of the enhanced federal HCBS funding.

1. **Home Modification and Maintenance**: Sufficient access to affordable home modifications, repairs, and efficiency upgrades can make a significant difference in a person's ability to remain at home when they need Medicaid long-term supports and services (LTSS). To test whether expanding the environmental modifications allowed under New Hampshire's current Choices for Independence waiver will enhance HCBS access in a cost-efficient manner, consider using \$4MM of the ARPA funds (together with any additional FMAP they can draw down) to increase the availability and scope of environmental modification to more fully address physical, cognitive, and/or financial needs as follows:
 - Create a one-year pilot program expanding the individual budget cap and scope of services allowed in the Choices for Independence environmental modification program.

- Contract for a 3-year evaluation of the program's impact on institutional diversion and Medicaid costs associated with the pilot expansion to determine if the temporary expansion should be made permanent with new state general funds.

Currently the Choices for Independence waiver pays for the installation of ramps and grab bars, widening doorways, and other "adaptations authorized by BEAS that are necessary for the health and safety of a participant that are not otherwise covered under the Medicaid State Plan." Specifically excluded are general improvements without "medical remedial benefit," electrical and plumbing work beyond a specific adaptation and outside of the home's current capacity, and anything that expands the size of the home. The one-time ARPA funding could be used to test the benefits to HCBS consumers and the state of an environmental modification program expansion that includes:

- *Budget Cap:* Raise the lifetime individual budget cap for state approved environmental modifications to the maximum allowed under Medicaid rules. This will allow for more significant modifications, additional modifications if a consumer must change residences, and capacity for general home repairs and improvements required to ensure health, safety, and affordability.
- *Home Repair and Improvements:* Specifically provide authority to fund all general home repairs required for health, safety, and affordability. Repair activities could include the following:
 - Kitchen modifications (safety and accessibility upgrades)
 - Emergency call systems
 - Home repairs and improvement such as weatherization (including storm windows or window replacement), security enhancements, insulation, roof repairs, and system reliability and/or economy upgrades for heating, air conditioning, plumbing, and electrical.
- *Expansions:* Specifically permit kitchen, bedroom, and bathroom additions if internal modifications are not practicable or as economical.

Aging and Disability Resource Center (ADRC) Public Awareness Campaign: New Hampshire's ADRC (ServiceLink) is an effective support for Medicaid eligible individuals and families working to organize HCBS to remain in the community. New Hampshire's ServiceLink program was created in the early 2000's as the result of New Hampshire citizens saying that the long term care system was fragmented and that they needed one place to go to get information about long term care needs. AARP's New Hampshire 2020 Long-Term Services and Supports (LTSS) State Scorecard
<http://www.longtermscorecard.org/databystate/state?state=NH>

shows that our Aging and Disability Resources program (ServiceLink) in New Hampshire ranked second in the country for its effectiveness. Unfortunately, it is not as widely known or understood by potential beneficiaries as would be optimal. To increase awareness of the Service Link program among current and potential Medicaid HCBS consumers, their families, and related referral sources, provide one-time funding of \$500K for a 2-year ServiceLink public awareness campaign.

Recommendations for HCBS Support Activities

If CMS allows the ARPA funds to be spent on activities that are not traditionally eligible for Medicaid funding, the following HCBS support programs should be considered as they could significantly enhance and strengthen HCBS access in the state.

1. HCBS Start-Up/Expansion Funding: Enhancing statewide access to Medicaid HCBS requires increasing access to HCBS providers and affordable housing in underserved areas. To catalyze the growth of HCBS and affordable senior housing, use \$5MM of the one-time ARPA funding to establish a low-cost revolving loan program for pre-development, start-up, and business expansion lending to viable projects that are not qualified for standard bank loans. The funds could be administered by the state finance agency or a third-party vendor experienced in non-traditional health care and real estate lending. An advantage of this proposed activity is that it allows the one-time ARPA funding to revolve, serving HCBS expansion goals well into the future. This would give the State the opportunity to creatively fund some innovative community based services that would help keep people out of nursing homes.
2. Presumptive Eligibility: New Hampshire has a presumptive eligibility statute RSA 151-E: 18, that was suspended during the current biennium. The Department testified that it was suspending the program due to the lack of funding to administer the program. We believe that this would be a very opportune time to restart the program. Medicaid eligible individuals who experience a health crisis and require LTSS often end up in a nursing home because nursing homes are generally the only LTSS providers that can be paid for their services while Medicaid eligibility is determined by the state. And, unfortunately, once someone requiring LTSS is settled in a nursing home, it is unusual for him or her to return to the community. That is why states, including New Hampshire have adopted presumptive eligibility for HCBS programs. Due to lack of funding New Hampshire wasn't to fully implement Presumptive Eligibility. There are start-up costs and a financial risk for states during the start-up of presumptive eligibility programs, most significant being that they will have to pay for the full costs of HCBS delivered during the determination period if their inexperienced staff make the wrong presumption and eligibility is not approved. To remove start-up costs and risk associated with restarting a presumptive eligibility program, the state could use \$1MM of the ARPA funding to implement the state's presumptive eligibility program, including a \$500K

loss reserve to cover any mistakes the state makes in eligibility determinations during the first 12-month of the program. At that point the state would have sufficient data and experience to show the effectiveness of the Presumptive Eligibility program. We believe that the experience will show that this program will be cost effective and get eligible people home care services so that they can more easily stay at home and be less likely to end up in an institution.

Finally, we urge you, our New Hampshire leaders, to engage the public and community partners as you consider how to apply the FMAP increase, and ensure that decisions to remain transparent in all steps of the decision-making process. We also have some ideas about how to engage the private sector as well as we seek in increase awareness of our excellent ServiceLink network. We will share these thoughts when we talk. If either of you has an appetite for further changes and innovative thoughts for use of this funding, we would be prepared to share other ideas on the subjects of (i) leveraging technology, and/or (ii) funding some novel ways to deal with our perennial direct care workforce challenges in this area to lead to bring some real and lasting change.

With so many people in New Hampshire needing home and community based care, we believe that quickly leveraging these additional resources will significantly improve the lives of many of our fellow Granite Staters. Thank you for your prompt attention to this issue. We stand ready to help in any way that we can, including with some of our own financial resources and communications channels. If you have questions, please contact me at tfahey@aarp.org or (603) 230-4109. At the very least, I'd like to have a discussion to follow up on this with key members of my team and yours.

Sincerely,

S.

Todd C. Fahey, J.D.
State Director
AARP New Hampshire
tfahey@aarp.org
(603) 738-9260 (cell)

GRANITE STATE HOME HEALTH & HOSPICE ASSOCIATION

June 18, 2021

Lori Shibinette
Commissioner
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

Commissioner Shibinette:

I am writing on behalf of home care, hospice, and palliative care providers throughout the state to suggest potential uses of the 10% FMAP funds that New Hampshire can receive through the American Rescue Plan of 2021. Our Association – the advocacy affiliate of the Home Care, Hospice & Palliative Care Alliance of New Hampshire – advocates on behalf of home-based providers and the people they serve. Our members deliver many types of care, from personal support and nursing services for Choices for Independence clients, to Medicaid state plan skilled nursing and rehabilitation therapy for Medicaid managed care enrollees, and Medicaid private duty nursing for pediatric and adult patients who require intensive, specialized nursing care.

The ARP funds present New Hampshire with a unique opportunity to enhance, strengthen and support a fragile network of home and community-based care. As you know, New Hampshire's history of low reimbursement rates for its Medicaid programs, combined with COVID challenges and a competitive employment environment, has resulted in gaps in care for Granite Staters who depend on home-based services.

After reviewing the guidance that CMS issued to State Medicaid Directors, the Association suggests the following:

Directed Payments to Medicaid and CFI Providers

NH Medicaid made directed payments to certain safety net providers in 2020, including Medicaid state plan home health providers and Medicaid private duty nursing providers. These payments were rate enhancements based on claims in a specific time period and were paid monthly. The directed payments supplemented the current rates and were much needed, especially since state plan home health nursing rates have been stagnant since 2010, and home health therapy rates have been unchanged since the late 1990s. Medicaid private duty nursing rates are also no longer sufficient to attract the specialty nurses needed to care for that population.

The Association believes a similar directed payment program would again help those same providers, along with Choices for Independence providers and other qualifying providers. It would be important to allow providers the flexibility to use these funds as they deem necessary, since challenges vary from agency to agency. Options could include recruitment



and retention bonuses, stipends, temporary wage increases, overtime pay, additional benefits, additional training, as well as deficit mitigation for agencies that provide these services at a financial loss and are at risk of leaving the Medicaid or CFI provider networks.

We recommend a directed payment model rather than a "Long Term Care Stabilization Fund" stipend model because it would be less administratively burdensome on providers and would reduce work for other state agencies, such as the Department of Employment Security. While the LTCF stipends in 2020 encouraged workers to stay employed or accept more shifts, providers bore the additional costs for payroll taxes. This was a barrier for some agencies to participate in the program. The Partnership for Medicaid Home Care reported that CMS officials indicated in a meeting on June 17th that CMS expects taxes and other employer costs to be factored in when calculating any wage enhancements resulting from ARP funds.

Workforce Initiatives for Home-based Workers

Attracting and retaining staff to deliver home-based care remains the biggest challenge for Medicaid and CFI providers. Without more nurses, LNAs, and personal care providers, gaps in client services will continue to grow. We recommend that DHHS invest funds in scholarships, free training programs or supplemental benefits to attract new workers to these jobs. Specifically, we suggest:

- Establishing a grant fund for agencies to apply for financial assistance to pay wages and training costs for new employees enrolled in apprenticeship programs, such as home health LNA and LPN programs offered through the Community College System of NH. Candidates could include family members of CFI or Medicaid private duty nursing patients who would be hired by agencies as paid caregivers for their family members. The NH Department of Labor has training funds available, but many non-profit agencies cannot participate because they do not pay into the unemployment compensation fund.
- Partner with hospital-based pediatric programs to offer regular training for home care RNs and LPNs to acquire specialty skills necessary for Medicaid private duty nurse care.
- Establish a fund that agencies could apply for that could be used for supplemental employee benefits, such as tuition/student loan assistance, childcare vouchers, transportation or car repair vouchers, or other offerings.

The Association recognizes there are many worthwhile initiatives that could be considered for the ARP funds, including HCBC infrastructure projects within DHHS. We urge the Department to dedicate these funds specifically to *rescue* home and community-based providers, employees, and the people they serve.

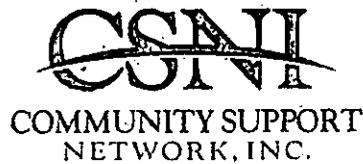
We welcome the opportunity to engage in stakeholder conversations about the ARP funds.

Respectfully,



Gina Balkus
Chief Executive Officer

Cc: Henry Lipman, Medicaid Director
Deborah Scheetz, Director of Long Term Services & Supports



Friday June 11, 2021

Lori Shibinette, Commissioner
New Hampshire Department of Health and Human Services

Dear Commissioner Shibinette,

Community Support Network, Inc. (CSNI) is the association of the ten Area Agencies serving individuals with developmental disabilities and acquired brain disorders throughout New Hampshire. I am writing to you today on behalf of our member agencies, as well as the families and individuals they support and the private providers who the Area Agencies contract with for service delivery. Specifically, I would like to offer our input as the state considers how it will implement and allocate funding from the FMAP increase that is authorized as a component of the federal American Rescue Plan Act (ARPA). CSNI believes there are many potential innovative uses for ARPA funding to support services to individuals and families, as well as to invest in the future of the service delivery system.

The current support system has withstood a wide array of challenges over the course of the COVID-19 pandemic. Impacts to individuals, families and enhanced family care providers (also referred to as home care providers, or host families) ranged from significant lifestyle and community access restrictions, to losing connections to direct support professionals who were no longer able to come into individual homes. Impacts also included the widespread adoption of remote engagement and a myriad of creative support strategies to ensure that families and individuals had access to PPE, food, medicine and other necessities. Families are at the heart of the entire service delivery system, but they also need direct support professionals (DSPs) to provide the daily supervision, care and mentorship that their adult and minor children require.

The temporary increase in FMAP represents an opportunity to help stabilize and grow the existing workforce of DSPs, Service Coordinators, Nurses and other critical positions. It is also a time to ensure that family supports and respite opportunities are enhanced. We offer the following items for consideration:

- Recruitment and retention stipends
- Funding to support training
- Supporting the expansion of innovative pipeline development strategies similar to a successful pilot model being implemented in the Greater Nashua area.
- Targeted increases in respite budgets
- Additional allocations to regional Family Support Councils for locally determined needs.



As we look to move beyond the current state of emergency and re-establish systems of supports, we also must acknowledge that many opportunities to invest in the future of the developmental services system have become apparent over the past year and a half. If New Hampshire is to remain a national leader in services, there are several items for consideration that would position us well. These include:

- Investing in the modernization of information systems that are currently in use by the Area Agencies and private providers. This also includes investing in new information systems that allow for efficient data management and workflows that truly support a strong service coordination system.
- Participating in the National Core Indicators Staff Stability Survey. This is a nationally recognized instrument that states have invested in to document staffing levels and to allow states to compare one another's results as a means to develop best practices for recruitment, retention, compensation and deployment of paid staff.
- Widespread adoption of the Charting the Life Course system of educating families, individuals, providers, school professionals and others in methods to plan for the lifelong trajectory of goal attainment for individuals with developmental disabilities.
- Expanding opportunities for individuals and families to modify their homes and vehicles in ways that optimize independent movement and activity.
- Expanding access to emerging telehealth technologies such as remote monitoring systems and responsive communication devices.

Thank you for considering the above items as you contemplate the Department's plans for implementing the FMAP increase. Please feel free to contact me directly with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Jonathan Routhier'. The signature is fluid and cursive, with a long horizontal stroke at the end.

Jonathan Routhier
Executive Director
jrouthier@csni.org
603-229-1982

Cc: Deborah Scheetz
Sandy Hunt



June 8, 2021

Commissioner Shibinette
Office Of the Commissioner
NH Department of Health & Human Services
129 Pleasant St.
Concord, NH 03301

Dear Commissioner Shibinette,

On behalf of the New Hampshire Alliance for Healthy Aging (NH AHA), we are writing to provide recommendations for the plan the Department is developing for dissemination of funds for home and community-based services from the American Rescue Plan Act of 2021 (ARPA). Given that the ARPA funding provides states an increase of 10% to their Federal Medical Assistance Percentage (FMAP) for Home and Community Based Services (HCBS) delivered during the period beginning June 1, 2021, and ending on March 31, 2022, we recommend the following:

- A presumptive **eligibility pilot** to support access to services that help older adults and people with disabilities remain in their homes. Medicaid's complex eligibility process does not account for the practical realities most individuals and family caregivers face when they wish to avoid a nursing home admission under stressful circumstances—an unexpected hospitalization or a rapid deterioration of health at home. In those situations, timely access to services can mean the difference between someone returning to the community or entering a nursing home. In addition to any necessary costs related to prompt coverage, we would like to see increased staff at ServiceLink offices to provide outreach and application assistance.
- An **innovations in long-term care program** to explore new models of in New Hampshire such as a Green House Project style nursing facility or intergenerational living arrangements. As the second oldest state in the country, we need to find creative ways to meet the needs of our communities. Fostering settings where older adults enjoy an excellent quality of life and care, can be done cost-effectively and would create an attractive workplace setting that can retain a quality workforce.
- Reinstatement of the successful **long-term care stabilization program** that enhanced the wages of the direct care workforce. We saw an increase in employees in the direct care workforce and a stabilization of shifts on evening hours and weekends when the Long-Term Care (LTC) stabilization program was put in place. There is an opportunity here with this federal funding to raise the wages of these critical workers. The LTC stabilization program results prove that low wages are a major factor limiting the ability to recruit and retain the direct care workforce to meet the needs of a growing older population at a pivotal time as we are emerging from the pandemic.

- **Coordinated outreach and application assistance** to assist the Department with the Medicaid re-determination process for 65,000 granite staters. This short-term investment would ensure people on the Medicaid waiver programs, including Choices for Independence (CFI), do not lose their services and health care coverage if they cannot effectively navigate this difficult process.
- An appropriately funded **healthy aging hub** housed at NH ServiceLink could partner with transportation, direct care providers, and community partners to make home and community-based services more accessible to older adults. By enhancing resources, staffing and community outreach at ServiceLink, the Department would capitalize on the existing infrastructure. We also envision the hub housing pilots like presumptive eligibility and the outreach and enrollment team to assist the community with eligibility and re-determinations in the communities where older adults are seeking those programs and supports.
- A **Family Caregiver pilot program** to pay family members to care for their loved ones. This is especially important with the workforce shortage. Improved participant directed services (PDS) that are in the CFI waiver right now could be assigned to 2 or 3 case management agencies with an additional staff person who would focus completely on outreach and education and enhanced access for individuals and families to use related to PDS. Right now, waiver PDS numbers represent a very low percentage of "services" used. More PDS support—using friends, family and other less traditional staff is one more tool in the toolbox. This was recently piloted successfully with the In-Home Supports Waiver due to workforce issues during Covid-19.
- Implement **performance standards** and a **case management tracking system** that the Department can use to support CFI waiver integrity. This will ensure that gaps in services are identified and addressed quickly. A waiver health and welfare special review team could regularly review those participants are getting needed services, there is communication with providers and case management, that there are choices of services, medical transportation, personal safety, and community inclusion.

Under the Allowable Use of Federal funding the requirements specify, *"The State shall implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program."* Coupled with the language in subparagraph (a) that directs states to supplement, not supplant, the existing levels of state funds, we recommend the Department focus the enhanced funding on building infrastructure that supports the HCBS workforce, accessibility for the consumer, and enhanced availability of services including transportation and affordable housing for older adults.

Thank you for your consideration of these recommendations. Please let me know if you have any questions or need more details.

Sincerely,
Heather Carroll
Director of Advocacy, NH Alliance for Healthy Aging



June 23rd 20121

Henry Lipman, Medicaid Director
129 Pleasant Street
Concord, NH 03301

cc:
Lori Shibinette
Commissioner, Dept Health & Human Services

RECEIVED

JUN 29 2021

DIRECTORS OFFICE
OMBP

Home Medical Equipment & Services Association of New England (HOMES) proposed enhancements to the Home and Community Based Services programs of Connecticut.

In response to the unprecedented COVID-19 pandemic and logistical and financial strain it has caused on the American healthcare system, Congress enacted section 9817 of the American Rescue Plan Act of 2021. Section 9871 provides a temporary 10% increase to a State's FMAP for dates between April 1, 2021 to March 31, 2022. Per CMS guidance, States may apply the 10% increase in FMAP to, among other things, "home health care services" under section 1905(a)(7), that "enhance, expand, or strengthens" beneficiary access to home and community-based services (HCBS). "Home health care services" have been broadly defined by CMS in regulations to include "medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place," such as the patient's home.

The HOMES Association along with the American Association for Homecare respectfully submit the following suggestions as opportunities to enhance or improve HCBS services through investment in the Durable Medical Equipment providers in our state. We realize that it may not be possible to implement all of these suggestions and have prioritized based on the positive impact to the HCBS / DMEPOS community.

1. Increase DMEPOS reimbursement by 10% for claims with dates of service 04/01/2021 through 03/31/2022.
2. Create reimbursement for medically necessary care provided by Respiratory Therapists.
3. Create reimbursement for Assistive Technology Professionals (ATP's) currently required evaluate, fit & train beneficiaries for complex mobility equipment.
4. Provide coverage and reimbursement for power seat elevation systems and power standing systems used with Complex Power wheelchairs.
5. Increase Rates and Coverage policy for Personal Protective Equipment (PPE)
6. Allow/Expand Continuous Glucose Monitoring (CGM) Coverage
7. Add coverage for remote monitoring services to enhance management of chronic disease states.

1. ***Increase DMEPOS reimbursement by 10% for claims with dates of service 04/01/2021 through 03/31/2022.***

- The COVID-19 Pandemic has significantly strained the supply chain for the HME Industry contributing to significant increases in the costs for HME products and creating supply shortages throughout the country.
- DME providers have been on front line servicing COVID-19 patients in their homes providing home ventilation services, oxygen therapy, and other DME equipment and supplies.
- The services provided by the DME providers have been keeping patients in their homes and out of the hospitals which has allowed hospitals to manage their capacity to be able to treat the most critically ill.
- Access to Complex Rehab Technology was protected due to the increased efforts and in-person visits by the Assistive Technology Professionals while utilizing telehealth in conjunction with the PT/OT services for the safety of the patient. This model shortens the timeline for obtaining complex rehab services.
- Increased payment rates would help DME providers that have been financially struggling, and it would allow other DMEPOS providers to expand their offerings to cover a broader patient population and/or offer a more robust supply of goods.

We request that the Department increase the Medicaid payment rates for DME providers and use the 10% FMAP increase to help offset additional costs.

2. Create reimbursement for medically necessary care provided by Respiratory Therapists.

- DME respiratory providers utilize certified or registered Respiratory Therapists (RTs) to provide value-added services such as patient monitoring, education, training, equipment set up, maintenance, and repair.
- Respiratory Therapists (RTs) make home visits and coordinate with the patient's prescribing and clinical care team to improve patient outcomes, compliance, and quality of life for the end user.
- Currently, DME respiratory providers that utilize RTs do so with no added reimbursement. RT home visits offer tremendous value to end users prescribed medically necessary oxygen equipment and related services, home mechanical ventilation therapy, tracheostomy care, positive airway pressure (PAP) therapy, and other related respiratory equipment, supplies and services.
- Additional payment that helps offset the cost of Respiratory Therapists would improve Medicaid recipient access to critical support services and other items in their homes by allowing DME providers to reinvest resources otherwise spent on absorbing the cost of RTs.

We request the Department utilize the enhanced 10% FMAP for HCBS provided by section 9817 of the American Rescue Plan Act to add coverage for DME providers to be reimbursed for sending certified or registered Respiratory Therapists to Medicaid recipient homes for medically necessary care.

3. Create reimbursement for Assistive Technology Professionals (ATP's) currently required evaluate, fit & train beneficiaries for complex mobility equipment.

- Currently DME providers of complex rehabilitation technology (CRT) are required to employ certified Assistive Technology Professionals (ATPs) to provide individually configured complex wheelchairs. While the evaluation, simulation, fitting, and training time required from these credentialed professionals is significant, there is no separate reimbursement provided for this time and expertise.
- ATPs are key participants in the CRT evaluation and provision process, working as part of a team that includes the physician and typically a physical or occupational therapist. The ATP's primary role is matching the patient's identified functional and medical needs to the appropriate CRT products and configuration. Activities include in-person evaluations, equipment trials and simulations, home environment assessments, CRT configuration

recommendations, fitting and adjusting, and training on safe operation. In addition, ongoing follow up and adjustments are provided after the delivery.

- Additional payment would help offset the cost of ATPs and improve Medicaid beneficiary access to critical support services and other items in their home by allowing DME providers to reinvest resources otherwise spent on absorbing the cost of ATPs.
- Timely access and quality outcomes from CRT has been protected due to the increased efforts by ATPs for in-person evaluations, while streamlining the evaluation process and helping ensure the safety of the patient. This model prevents extended timeframes for obtaining CRT and supporting services. For this to be a sustainable option going forward, additional reimbursement is needed to compensate for the ATP's time and expertise and ensure positive outcomes for the patient requiring CRT.

We request that the Department utilize the enhanced 10% FMAP for HCBS provided by section 9817 of the American Rescue Plan Act to provide payment for DME providers of CRT that covers the expertise and involvement of an ATP in the process of providing this complex medically necessary equipment in the home.

4. Provide coverage and reimbursement for power seat elevation systems and power standing systems used with Complex Power wheelchairs.

- Power seat elevation systems used with Complex Rehab Power Wheelchairs- this specialized technology provides significant medical and independence benefits to people with disabilities. Seat elevation is critical to activities of daily living participation and performance. Seat elevation improves transfers and reaching and reduces or eliminates neck and spine injuries from power wheelchair use.
- Power standing systems used with Complex Rehab Power wheelchairs- this specialized technology also provides significant health and independence benefits to people with disabilities. Standing systems improve joint mobility and muscle tone, increase strength and bone density, assist bladder and bowel management, enhance cardiovascular and respiratory functions, and reduce pressure injuries of the skin.
- Both systems provide medical and functional benefits while reducing costs to the Medicaid program by decreasing falls, skin breakdowns, muscle contractures, and numerous other avoidable medical complications of long term or permanent wheelchair use. They will also allow beneficiaries with mobility impairments to be more functional and less reliant on other caregivers, whether these caregivers are family members or paid homecare providers or personal assistants.

We request the Department utilize the enhanced 10% FMAP for HCBS provided by section 9817 of the American Rescue Plan Act to provide coverage and reimbursement for power seat elevation systems and power standing systems used with Complex Power wheelchairs.

5. Increase Rates and Coverage policy for Personal Protective Equipment (PPE)

- Due to the pandemic, there has been a significant rise in demand for PPE, including medical grade gloves creating a strain on the manufacturing capacity. This increased demand along with increased manufacturing restraints such as raw material shortages, constraints with global manufacturers in locations such as China and Malaysia have led to significant cost increases on PPE.

We request the Department utilize the enhanced 10% FMAP for HCBS provided by section 9817 of the American Rescue Plan Act to provide increased coverage and reimbursement for gloves and other PPE.

6. Allow/Expand Continuous Glucose Monitoring (CGM) Coverage

- The benefits of Continuous Glucose Monitoring have been shown to increase monitoring frequency, reduce time in hypoglycemia, and improve glucose control. The expansion/allowance of coverage for CGM will allow for better outcomes and lifestyle for patients diagnosed with diabetes.

We request the Department utilize the enhanced 10% FMAP for HCBS provided by section 9817 of the American Rescue Plan Act to provide/expand coverage of Continuous Glucose Monitoring.

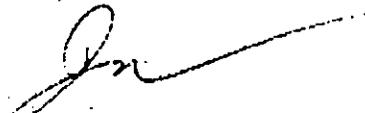
7. Add coverage for remote monitoring services to enhance management of chronic disease states.

- Allow for service and reimbursement for remote patient monitoring by DME providers.
- Allow for service and reimbursement of telehealth for ongoing monitoring of chronic disease management.
- Allow for reimbursement of PAP compliance tracking and ongoing management of sleep apnea services.

We request the Department utilize the enhanced 10% FMAP for HCBS provided by section 9817 of the American Rescue Plan Act to add coverage for remote monitoring services to enhance management of chronic disease states.

The HOMES Association and AA Homecare welcome the opportunity to discuss our suggested enhancements to the HCBS / DMEPOS programs and the positive impact these changes will have on the beneficiaries of our state.

Sincerely,



Jason Morin MBA, RRT, CDME
President & CEO
Home Medical Equipment and Services Association of New England



Lori Shibinette, Commissioner
NH Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord, NH 03301

Via email: LORI.SHIBINETTE@DHHS.NH.GOV

January 20, 2020

Dear Commissioner Shibinette:

As you may recall, during the Governor's call with the NH Community Behavioral Health Association (CBHA) and in the follow up conversations Roland Lamy and I had with you, mental health transitional and community housing was addressed. This discussion was in the context of finding additional ways to address the wait list for involuntary admissions at New Hampshire Hospital (NHH) by facilitating an improved and efficient discharge process through added step-down care in the community.

While we are hopeful that the expansion of Mobile Crisis Units in 2021 will address key elements of emergency services and reduce admissions that comprise the wait list at local hospital emergency rooms, designated receiving facilities, and NHH, there will still be the need for some form of housing to bolster capacity and care in the community. This issue was addressed in the original Ten-Year Mental Health Plan in 2008 supported by then-DHHS Commissioner Toumpas and Governor Hassan. Given the multiple ways DHHS is addressing the wait list crisis, it is difficult to pinpoint the exact capacity necessary in the community to address the growing concern about the involuntary wait list. While we have not completed our research, it is likely that the bed count in 2021 is well below what it was in 2011 when the Governor's budget proposed and the legislature authorized the funding of 75 new beds; for a variety of reasons, the State did not appropriate those dollars.

As noted on the Community Mental Health Centers (CMHC) spreadsheet we sent you recently, the ten CMHCs currently operate 84 transitional beds and 90 community beds. However, and as detailed below, those beds/services are paid at a Medicaid rate well below costs and potentially at a rate significantly lower than other vendors providing similar services.

As you and the Governor potentially address this issue in the context of the upcoming budget, the CMHCs are ready to assist, although each of the ten centers will have its own challenges associated with any expansion. As a first step, efforts should be made to preserve the beds that currently exist by adjusting rates to reflect the cost to operate. Chief among the challenges for any center to add additional capacity is ensuring that there is an adequate rate to sustain the services and property; sufficient workforce to staff these housing needs; and the availability of capital, especially in a rising real estate market.

Outlined below are some issues we think will need to be reviewed as we develop budget recommendations:

1. Determine the number of beds that are needed.
2. Map out the location for the needed beds by region. Review existing workforce capacity issues in that region.
3. A refreshed rate analysis should be undertaken to establish a cost-based rate which can be applied to existing and new beds. It is generally understood that the existing rate for both community and transitional beds is well below the cost to operate and lower than what is reimbursed to non-CMHC entities providing similar services.
4. Determine the capital cost needed to fund the proposed number of new beds.
5. Address the complexity to funding of beds within the CMHC payment model and how to modify the current MCO payment model to incorporate investments in existing and new beds.
6. The CMHCs are developing an analysis of the workforce issues associated with expansion of transitional and community beds to help inform the needs and timelines to add beds to the system.
7. The information and data developed from this work should also be used to review the right balance of congregate housing vs. independent community housing.

Once these determinations are made, a recommendation can be offered to fund the right number of beds at the right rate of reimbursement, in order to develop a policy for the upcoming 2022-2023 State operating budget.

In addition to the actual appropriation needed to retain the current beds and add new beds in a timely fashion, we believe it will also be necessary to establish class notes in the budget to assist with channeling the money into the CMHC payment model, potentially impacting MCO future amendments between DHHS and the MCOs. It might be advisable to find a method of contracting with the CMHCs in a fashion that streamlines the procurement process and avoids any failed contracting efforts. Development of an RFP in the middle of a fiscal year while the CMHC alternative payment model has already been negotiated will not provide additional funding to support this effort.

I hope this outline of mental health housing efforts is helpful. I would like to suggest that once you and your team have reviewed it, Roland and I could have the opportunity to re-connect with you on this matter. I have also taken the liberty of copying the Governor on this note in

order to keep him informed of our responsiveness to concerns he expressed this past fall to the CMHCs.

As we observed at the beginning of this letter, no segment of service stands alone. As NH expands housing services, we will need to have adequate staff on clinical treatment teams to meet the needs of additional clients. And beyond the review of these housing issues relative to the upcoming State budget, a broader conversation about the provision of housing within the mental health arena could include CBHA, DHHS and other housing voices.

I look forward to working with you on these matters.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim Monahan". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Jim Monahan

Cc: Governor Chris Sununu
Katja Fox, Director, Division of Behavioral Health



New Hampshire
State Commission on Aging

June 28, 2021

Commissioner Shibinette
Office of the Commissioner
NH Department of Health & Human Services
129 Pleasant St.
Concord, NH 03301

Dear Commissioner Shibinette,

The New Hampshire State Commission on Aging wishes to express its endorsement of the New Hampshire Alliance for Healthy Aging (NH AHA) letter sent on June 8th to your office. The letter provided recommendations to the NH Department of Health & Human Services regarding the dissemination of the American Rescue Plan Act of 2021 (ARPA) 10% increase to the Federal Medical Assistance Percentage (FMAP) for Home and Community Based Services (HCBS) delivered during the period beginning June 1, 2021, and ending on March 31, 2022. The Alliance for Healthy Aging engaged individuals and organizations from across the State to identify the following recommendations:

- Develop a **presumptive eligibility pilot** to support access to services that help older adults and people with disabilities remain in their homes. Timely access to services can mean the difference between someone returning to the community or entering a nursing home. The pilot ideally includes costs related to prompt coverage and increased staff at ServiceLink offices to provide outreach and application assistance.
- Support programs that focus on **innovations in long-term care** in New Hampshire. A culture change initiative could build system resiliency in advance of future public health emergencies and create an attractive workplace setting that can retain a quality workforce. Other models to pull from could include the Green House Project or intergenerational living arrangements.
- Reinststate the successful **long-term care stabilization program** that enhanced the wages of the direct care workforce. This program proved that low wages are a major factor limiting the ability to recruit and retain the direct care workforce needed to meet the needs of a growing older population. The stress burden of working in long-term care continues to be high as staff remain vigilant through what we hope is the tail end of the pandemic curve. This is a pivotal time to retain and recruit the necessary workers to ensure access to services in the community and in facilities the diligent compliance with infection prevention practices supporting their safe reopening.

- Support **coordinated outreach and application assistance** to assist the Department with the Medicaid re-determination process for 65,000 Granite Staters. This short-term investment would aid people on the Medicaid waiver programs, including Choices for Independence (CFI), to navigate this difficult process avoiding unnecessary loss of needed health care benefits.
- Design and invest in a **healthy aging hub** housed at NH ServiceLink. By enhancing resources, staffing, and community outreach at ServiceLink, and developing performance standards for ServiceLink organizations, the Department could capitalize on the existing infrastructure to make home and community-based services more accessible to older adults. ServiceLink organizations could be incentivized to better partner with transportation, direct care providers, and community partners. In addition they could also house pilots like the previously mentioned presumptive eligibility pilot and an outreach and enrollment team to assist their community members with Medicaid and Medicare eligibility and re-determinations.
- Develop a robust **Family Caregiver pilot program** to pay family members to care for their loved ones. This is especially important with the workforce shortage. Improved participant directed services (PDS) in the CFI waiver now could be assigned to case management agencies. An additional staff person could focus on outreach and education and enhanced access for individuals and families to use related to PDS. Right now, waiver PDS numbers represent a very low percentage of services used. More PDS support—using friends, family and other less traditional staff is one more tool in the toolbox. A trial of this via the In-Home Supports Waiver brought about by the workforce issues during Covid-19 was successful.
- Implement **performance standards and a case management tracking system** that the Department can use to support CFI waiver integrity. This could ensure that gaps in services are identified and addressed quickly. Adding a waiver health and welfare special review team to provide oversight to the standards and troubleshoot when issues arise could ensure participants are getting needed services, that there is communication with providers and case management, that there are choices of services, medical transportation, personal safety, and community inclusion.

Collectively these recommendations focus on reinforcing the resiliency of long-term care and building infrastructure that supports access for consumers to home and community based care. Thank you for your consideration of these recommendations. The Commission welcomes further discussion on the details of these recommendations.

Sincerely,



Hon. Polly Campion, MS, RN
Chair
New Hampshire State Commission on Aging



Rebecca Sky, MPH
Executive Director
New Hampshire State Commission on Aging

cc: Nancy Rollins, Interim Director Long Term Services and Support and Wendi Aultman, Bureau Chief, Bureau of Elderly and Adult Services



July 1, 2021

Lori Shibinette, Commissioner
NH Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301

Dear Commissioner Shibinette:

We are writing to you regarding the increase in the Federal Medical Assistance Percentage (FMAP) for Home and Community Based Services made available under the American Rescue Plan Act this spring. We understand that NH will be submitting a plan to CMS for use of these funds.

Aspire Living & Learning supports approximately 100 individuals with intellectual and developmental disabilities through the waiver in NH. This includes residential services, Community Participation Services, Participant Directed and Managed Services, and specialty services. We support individuals with complex behavioral and other needs throughout the state and contract with 8 of the 10 area agencies.

As you know, the workforce crisis continues to be our number one issue in delivering quality services. The two recent 3.1% rate increases certainly helped us narrow the gap between the wages we have to offer and those found in most of our individual budgets. However, a significant gap remains. The need is great, not just for dollars for wages, but also taxes associated with those increases, benefits, and support for frontline managers.

Frontline managers are a key component of the workforce that is often overlooked in policy discussions. They end up doing significant hours of direct support due to staffing shortages, and juggle both these direct support responsibilities and supervision of DSPs. Additionally, enhanced training for these managers would go a long way to improving the DSP's experience and ultimately the individual's experience as well. We hope the NH plan for the FMAP increase will have a significant, but flexible, focus on stabilizing the workforce.

One other priority stands out for improving the efficiency and effectiveness of our service system. Technology infrastructure to capture billing and clinical data for the system is being built piecemeal agency by agency, resulting in a patchwork of systems that place an enormous administrative burden on private provider agencies who operate in more than one region. The FMAP increase is an opportunity to invest in a coordinated approach that would allow all of us

to focus on improving services without the constant retraining on multiple different systems. More coordinated efforts would also allow your department to better track how funding translates to life outcomes for the people we serve.

We appreciate the opportunity to provide this information and thank you for your support of the developmental services system.

Sincerely yours,



Lou Giramma
CEO



John Whittemore
Senior Director of Program Operations

CC: Nancy Rollins, Sandy Hunt



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Disabled and Elderly Health Programs Group

September 29, 2021

Henry Lipman
Medicaid Director
Department of Health and Human Services
Division of Medicaid Services
129 Pleasant Street
Concord, NH 03301

Dear Mr. Lipman:

We are pleased to inform you that New Hampshire's initial state spending plan and spending narrative submitted on July 12, 2021, meet the requirements set forth in the May 13, 2021, Centers for Medicare & Medicaid Services (CMS) State Medicaid Director Letter (SMDL) #21-003 and are receiving partial approval. New Hampshire qualifies for a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS) under section 9817 of the American Rescue Plan Act of 2021 (ARP). We have approved the temporary 10 percentage point increase to the state's FMAP for certain Medicaid HCBS listed in Appendix B of the SMDL. The increased FMAP is available for qualifying expenditures between April 1, 2021, and March 31, 2022. However, CMS needs additional information, as described beginning on the next page.

Full approval of the state spending plan and spending narrative is conditioned upon resolving the issues described below and upon the state's continued compliance with program requirements as stated in SMDL #21-003. These requirements are in effect as of April 1, 2021, and continue until March 31, 2024, or until the state has fully expended the funds attributable to the increased FMAP, whichever comes first.

It is important to note that CMS partial approval of the initial spending plan and spending narrative solely addresses the state's compliance with the applicable requirements set forth under section 9817 and fulfillment of the requirements as stated in SMDL # 21-003. This spending plan approval does not constitute approval for purposes of claiming federal financial participation (FFP). Approval of any activity in your state's spending plan does not provide approval to claim FFP for any expenditures that are not eligible for FFP. States must continue to comply with all existing federal requirements for allowable claims, including documenting expenditures and draws to ensure a clear audit trail for the use of federal funds reported on the Form CMS-37, Medicaid Program Budget Report and the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

States should follow the applicable rules and processes for section 1915(c) waivers, other Medicaid HCBS authorities, including state plan amendments and section 1115 demonstrations, and other managed care authorities (as applicable), if they are making changes to an HCBS program and intend to use state funds equivalent to the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. CMS is available to provide continued technical assistance to states when implementing changes to HCBS programs under this provision.

Additional Information Requested

As your state further plans and develops the activities in its spending plan, CMS will need additional information on the following:

- Clearly indicate whether the following activities are targeted at providers delivering services listed in Appendix B of the SMDL or that could be listed in Appendix B (e.g., behavioral health services that are covered under another benefit but could be covered under the rehabilitative services benefit), or are focused on the services listed in Appendix B or that could be listed in Appendix B:
 - HCBS Workforce Incentives and Payment Enhancements, specifically residential care direct workforce, such as supportive housing, residential SUD, and mental health providers;
 - School Based and Early Support Services;
 - Integrated Healthcare Clinic for Individuals Experiencing Homelessness; and
 - Acquired Brain Disorder and/or Traumatic Brain Injury "Club House-Like Model" Pilot.

If these activities are not focused on providers that are delivering services listed in Appendix B or that could be listed in Appendix B, explain how the activities enhance, expand, or strengthen HCBS under Medicaid.

- Confirm that the HCBS Workforce Incentives and Payment Enhancements for private duty nursing are limited to private duty nursing services provided in the home.
- Provide more detail on the Integrated Healthcare Clinic for Individuals Experiencing Homelessness activity, including the percentage of individuals who are expected to be Medicaid eligible and the percentage of Medicaid-eligible individuals who are expected to receive the services listed in Appendix B or that could be listed in Appendix B. If the participants are not Medicaid eligible and/or are not receiving services listed in Appendix B or that could be listed in Appendix B, explain how this activity enhances, expands, or strengthens HCBS under Medicaid.
- Confirm that the presumptive eligibility activity will not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021.
- Clarify how the state intends to use ARP section 9817 funds under the Program of All-Inclusive Care for the Elderly (PACE) or Dual Eligible Special Need Plan (D-SNP) Pilots, including whether the state intends to use the funds to study, plan, and/or implement a PACE program and/or a D-SNP.

CMS will need additional information before it can determine whether these activities or uses of funds are approvable under ARP section 9817. Please update the state's spending plan and narrative to provide the information requested in this letter.

General Considerations

As part of this partial approval, CMS is noting the following:

- CMS expects your state to notify CMS as soon as possible if your state's activities to enhance, expand, or strengthen HCBS under ARP section 9817:
 - Are focused on services other than those listed in Appendix B or that could be listed in Appendix B (e.g., behavioral health services that are covered under another benefit but could be covered under the rehabilitative services benefit). If any activities are not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how those activities enhance, expand, or strengthen HCBS under Medicaid;
 - Include room and board (which CMS would not find to be a permissible use of funds); and/or
 - Include activities other than those listed in Appendices C and D.

CMS will need additional information before it can determine whether any of those activities or uses of funds are approvable under ARP section 9817.

- *HCBS provider pay increases funded through the 10 percent temporary increased FMAP will require an updated rate methodology. For section 1915(c) waiver programs, states are required to submit a waiver amendment for any rate methodology change. If retrospective approval will be required, the state should make the change in the Appendix K application.*
- *Consistent with regulations at 42 C.F.R. § 447.252(b), the state plan methodology must specify comprehensively the methods and standards used by the agency to set payment rates. The state plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections. The reimbursement methodology must be based upon actual historical utilization and actual trend factors.*
- *States providing HCBS through a managed care delivery system must comply with applicable federal requirements, including 42 C.F.R. part 438. States must also ensure that appropriate authority is granted for the services and activities to be covered as well as to deliver such services and activities through a managed care delivery system. Additionally, states will need to assess implications for its managed care plan contracts and actuarially sound capitation rates in order to operationalize any programmatic changes. States that seek to contractually require their managed care plans to increase HCBS provider payments must adhere to federal requirements for state directed payments in accordance with 42 C.F.R. § 438.6(c), including prior approval as required.*
- If your state is reducing reliance on a specific type of facility-based or congregate service and increasing beneficiary access to services that are more integrated into the community, your state should be clear with stakeholders in your state's stakeholder engagement activities, as well as in submissions to CMS of required ARP section 9817 spending plans

and narratives and any resulting waiver or state plan amendments, about how these changes enhance the availability of integrated services in the specific waiver or state plan, and offset any reductions in previously covered services, in compliance with the home and community-based settings criteria or other efforts to increase community integration.

Additional Information Related to the Quarterly Spending Plan and Narrative

CMS is clarifying that New Hampshire's next quarterly spending plan and narrative is due 75 days before the quarter beginning January 1, 2022. Please refer to SMDL #21-003 for information on the quarterly reporting process. Your state's quarterly spending plans and spending narratives should:

- Describe how the state intends to sustain the activities it is implementing to enhance, expand, or strengthen HCBS under the Medicaid program including how the state intends to sustain its planned provider payment increases;
- Provide information on the amount or percentage of any rate increase or additional payment per provider and the specific Medicaid authorities under which the state will be making those rate changes or payments;
- Provide the additional information described above;
- Clearly indicate if your state has or will be requesting approval for a change to an HCBS program and be specific about which HCBS program, which authority it operates under, and when you plan to request the change;
- Provide projected and actual spending amounts for each of the state's planned activities to enhance, expand, or strengthen HCBS. In those projections, clearly identify if the state intends to draw down additional FFP for any activities, as well as the amount of state and federal share for any activities for which the state plans to claim additional FFP and whether those activities will be eligible for the HCBS increased FMAP under ARP section 9817;
- Clearly indicate whether your state plans to pay for capital investments or ongoing internet connectivity costs as part of any activity to enhance, expand, or strengthen HCBS. Capital investments and ongoing internet connectivity costs are permissible uses of funds to enhance, expand, or strengthen HCBS under section 9817 of the ARP. However, states must demonstrate how capital investments and ongoing internet connectivity costs would enhance, expand, or strengthen HCBS and ensure that capital investments will result in settings that are fully compliant with the home and community-based settings criteria. Further, approval of capital investments and ongoing internet connectivity costs in ARP section 9817 spending plans and narratives does not authorize such activities for FFP;
- Provide updated information (as appropriate) on the status and details of the state's proposed activities to enhance, expand, or strengthen HCBS; and
- Make other revisions needed to: update the amount of funds attributable to the increase in FMAP that the state has claimed and/or anticipates claiming between April 1, 2021, and March 31, 2022; update anticipated and/or actual expenditures for the state's activities to implement, to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024; update or modify the state's planned activities to enhance, expand, or strengthen HCBS; and report on the state's progress in implementing its planned activities to enhance, expand, or strengthen HCBS.

We extend our congratulations on this partial approval and look forward to working with you further throughout the implementation of ARP section 9817. Programmatic and financial questions and state HCBS quarterly spending plan and spending narrative questions for section 9817 of the ARP can be submitted to HCBSincreasedFMAP@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jennifer Bowdoin', with a long, sweeping horizontal stroke extending to the right.

Jennifer Bowdoin
Director, Division of Community Systems Transformation

cc: Nancy Rollins