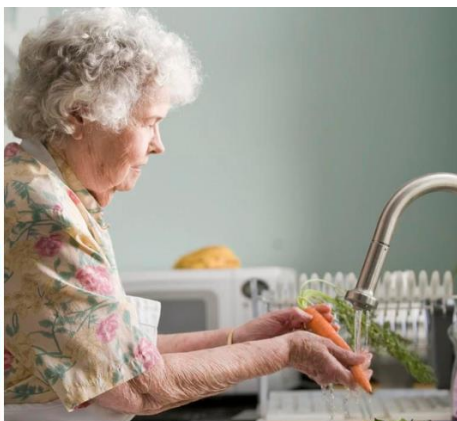




Long-Term Services and Supports in New Hampshire

*A Review of the State's Medicaid Funding for
Older Adults and Adults with Physical Disabilities*

July 2022



Long-Term Services and Supports in New Hampshire: A Review of the State's Medicaid Funding for Older Adults and Adults with Physical Disabilities

New Hampshire Fiscal Policy Institute

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Founded in 2009, the New Hampshire Fiscal Policy Institute (NHFPI) is an independent nonprofit organization dedicated to exploring, developing, and promoting public policies that foster economic opportunity and prosperity for all New Hampshire residents, with an emphasis on low- and moderate-income families and individuals. Based in Concord, NHFPI produces regular reports on the fiscal and economic challenges facing New Hampshire and strives to serve as a resource to anyone interested in meeting those challenges in a fair and sound fashion.

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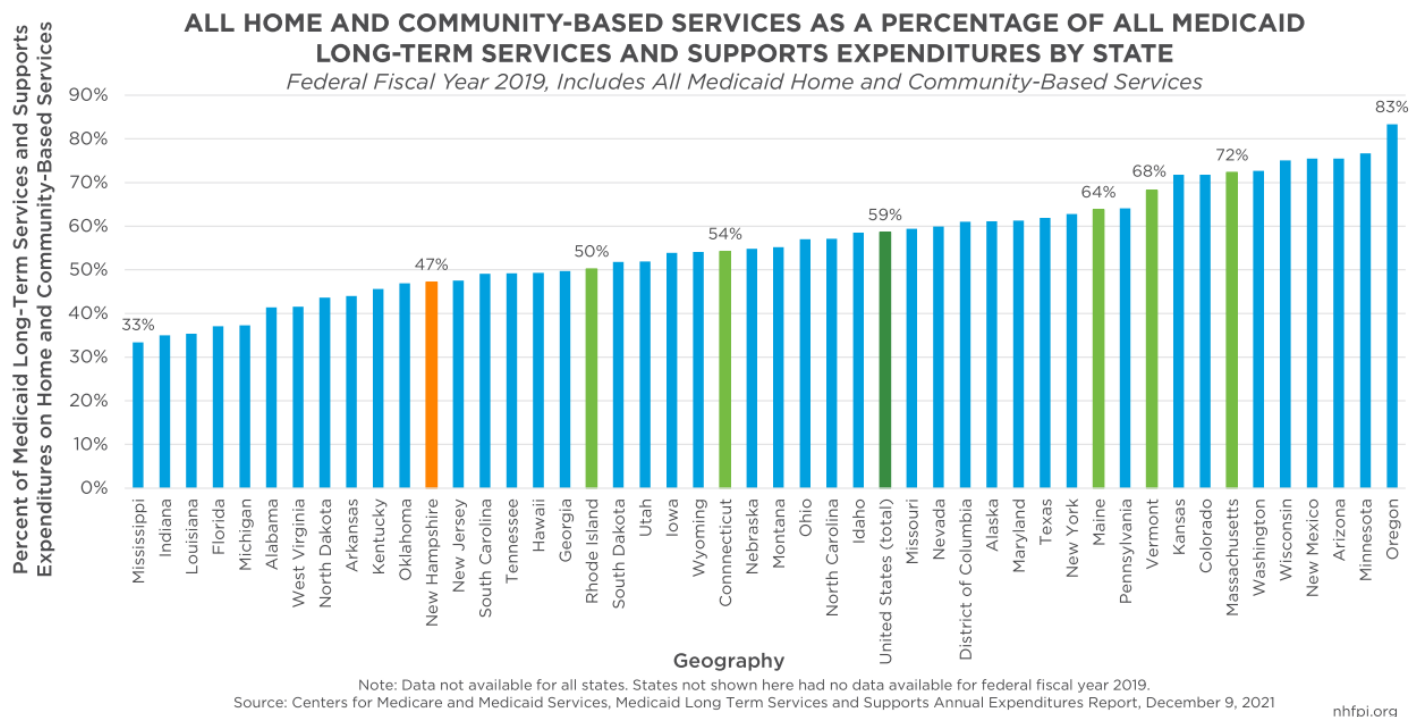
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EXECUTIVE SUMMARY

Older adults and adults with physical disabilities, including those who have trouble performing day-to-day tasks, may require long-term services and supports, which can be provided through professional health and personal care providers. For adults who are financially eligible, Medicaid can cover the cost for long-term supports and services. In New Hampshire, these services are provided primarily in two settings: nursing facilities and in home or community-based settings.

Nursing facilities provide 24-hour care to their residents in an institutional setting. In New Hampshire, Medicaid funded an average of 3,624 enrollees in nursing facility beds monthly in State Fiscal Year 2021. Home and community-based care providers deliver services to people in their homes, in assisted living facilities, or in other settings. These Medicaid services for older adults and adults with physical disabilities are funded through the Choices for Independence Medicaid waiver program. Medicaid home and community-based services for people with developmental disabilities or adults with acquired brain disorders are funded through separate programs. In State Fiscal Year 2021, the average number of older adults and adults with physical disabilities enrolled in Choices for Independence each month and benefitting from home and community-based services totaled 3,795 people.

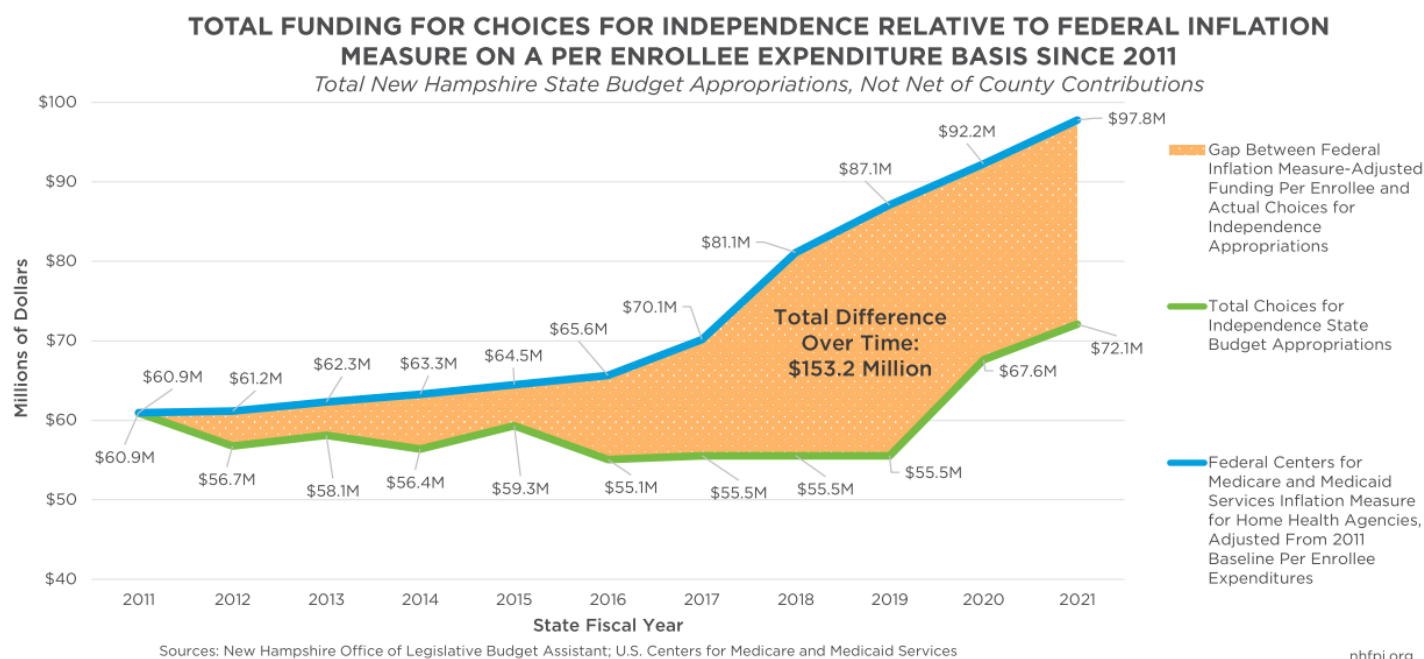
Medicaid is the largest provider of funding for long-term services and supports nationally, working to help ensure eligible people, particularly those with low incomes and limited resources, have access to needed health services. Medicaid funded 42.9 percent of all formal long-term services and supports in 2019. Home and community-based services were a key part of those expenditures. In Federal Fiscal Year 2019, home and community-based services were 58.6 percent of Medicaid long-term services and supports expenditures, including services for older adults, adults with physical disabilities, and people with developmental disabilities, and certain other populations. The other expenditures were for services delivered in institutional settings, such as nursing homes. In New Hampshire, Medicaid home and community-based services were a smaller portion of all Medicaid long-term services and supports expenditures than nationally, totaling 47.2 percent, which was also lower than all other New England states.



Medicaid services provided by nursing facilities and through the Choices for Independence program are funded by a combination of federal, State, and county revenue. The federal government pays for the largest share of total Medicaid spending in New Hampshire, and the State government pays for most of the rest of health care for Medicaid

enrollees in most parts of the program. However, New Hampshire counties are required to pay for a significant portion of the costs of long-term services and supports for their residents in nursing facilities or enrolled in Choices for Independence. Nursing facilities, including nursing facilities operated by the counties, also pay the State additional funds through mechanisms called the Nursing Facility Quality Assessment and, for county nursing facilities, through a program typically called ProShare. These funds are then used to draw more federal funds through the Medicaid program, which are then disbursed back to nursing facilities through the Medicaid Quality Incentive Program and two types of ProShare payments.

Within the requirements of the Medicaid program, the State sets reimbursement rates. These rates determine the amount of money paid to the organizations providing Medicaid services. These reimbursements are funded through the New Hampshire State Budget. In the case of nursing facilities, the State collects complex cost reporting data to set reimbursement rates, and provides funding to nursing facilities based primarily on the number of people living at a nursing facility and their health status. The funding levels for the Choices for Independence program, however, are not informed by a similar complex cost reporting structure. The amount of money in the State Budget to support people enrolled in Medicaid in nursing facilities appears to have better kept pace with the growth in costs over the last decade than funding for the Choices of Independence program. Adjusting for a key measure of inflation and for the number of program enrollees suggests that, from State Fiscal Years 2011 to 2021, State Budgets have included a total of \$153.2 million fewer dollars directed to Choices for Independence services than the amount that would have kept funding for services at the same relative level. Commonly used reimbursement rates for specific Choices for Independence services also fell behind several measures of inflation for most of the last decade.



Home and community-based services are typically less expensive than nursing facilities for each enrollee funded. While individuals may receive different care in different settings, to be eligible for the Choices for Independence program, a person must be clinically eligible for a nursing home level of care. In State Fiscal Year 2021, State Budget funding appropriated for each actual Choices for Independence enrollee totaled \$18,997, while for nursing facilities, funding from all sources per actual enrollee was \$98,111.

State Budget funding for long-term supports and services, including both nursing facilities and home and community-based services, will become more important in New Hampshire, especially in the next two decades. More than 200,000 adults were estimated to be between age 55 and 64 years in 2019, the largest group of any other ten-year age demographic in the state. Survey data from New Hampshire indicate that more than one in five adults aged

65 to 74 years experience a disability, and more than two in five people who are age 75 years or older do as well. Providing effective services to Granite Staters, particularly including people who are more likely to need long-term services and supports, will be important for the well-being of all New Hampshire residents.

However, these services can currently be difficult to access, primarily because providers cannot find enough workers to provide all the services needed. The demographic group reaching traditional retirement age and other ongoing impacts from the pandemic have led to the size of New Hampshire's labor force declining relative to 2019. As prices and wages quickly change with inflation accelerating, nursing facilities and home and community-based services agencies that depend on fixed Medicaid reimbursement rates for paying their staff's wages report struggling to attract and retain workers. Recent wage data for home health and personal care aides in New Hampshire show hourly pay in the Granite State for low-wage workers is less than it is in neighboring states for the same work, which could make keeping workers in New Hampshire, or working in home and community-based services, more difficult.

Granite Staters may also have trouble accessing services due to application processes. Financial eligibility for Medicaid can be very complex. Individuals seeking to access services, either directly for themselves or people they were assisting, reported long waits for documentation and approval, and difficulty finding the right information or methods for applying for Medicaid. State data showed the median processing time for Medicaid application approval in October 2021 was 36 days for nursing facilities and 45 days for Choices for Independence waiver services. Some earlier applications reviewed by State researchers took longer than 90 days to process. These long delays mean people may not receive critically needed services.

Ongoing investments in nursing facility services and increased investments in Choices for Independence home- and community-based services, as well as the workforce that powers those industries, will be key for supporting New Hampshire's aging population in the coming years and decades. New Hampshire has an opportunity to assess existing long-term services and supports and make thoughtful, coordinated policy decisions to help ensure investments in this essential infrastructure make progress toward a vision for improved care. Making foundational, cost-effective investments in the near-term will help create a more efficient, organized, and robust system to serve Granite Staters in need of long-term services and supports.

Policy Recommendations:

1. Use flexible federal funds provided through the American Rescue Plan Act to hire public benefit navigators to help people applying for Medicaid services.
2. Consider additional, systemic help for people accessing services beyond the existing frameworks for long-term services and supports in New Hampshire.
3. Support home care providers with a form of payment, or commitment of future payment, prior to the formal establishment of Medicaid eligibility, or implement a form of presumptive eligibility.
4. Reduce wait times for providing certain services by designating approved service providers with a pre-approved range of costs for service provision.
5. Consider updates to the NH Easy system for applying for services and provide additional trainings for professionals who frequently assist people applying for services.
6. Establish a centralized information portal or dashboard for providers, case managers, and navigators to quickly understand which services are available to help connect people to services faster.
7. Consider a long-term program to provide a stipend or other additional funding for workforce supports to Medicaid providers, potentially funded with flexible federal funds that can be used through the end of 2026.
8. Include flexibility in public wage enhancement programs for Medicaid providers to reflect related costs.
9. Establish a set and more sophisticated methodology for estimating CFI waiver service delivery costs that will help inform decisions regarding reimbursement rates and help to better align future investment levels with cost changes.
10. Use flexible federal funds and other resources to establish and support initiatives to grow and develop the workforce for nursing facilities and home and community-based services.

INTRODUCTION

Medicaid in New Hampshire funds key services designed to support older adults and adults with physical disabilities. These services are delivered within nursing facilities to residents, in community-based care settings like adult day centers, or inside people's homes by home care providers. Provision of these services often enables family members or other unpaid caregivers to step away from those roles and participate more in the economy through paid employment in other areas of work.

Medicaid is the largest single funder of long-term services and supports, paying 42.9 percent of all formal services of this type nationally in 2019. The program works to help ensure eligible adults and children have access to needed health services, particularly those with low incomes and limited resources. With funding from the federal government and both State and local matching funds, Medicaid covers health services by providing reimbursements for the services delivered by providers. Both nursing facilities and organizations providing eligible home health services can receive reimbursements for providing services through Medicaid. While nursing facilities services to Medicaid enrollees are funded through the traditional Medicaid policy structure, home- and community-based services are funded through the Choices for Independence Medicaid waiver program.

Funding for both nursing facilities and Choices for Independence waiver services are impacted by policymaker State Budget decisions, as Medicaid reimbursements are set primarily through State policy. Complex, comprehensive cost reporting for nursing facilities may have helped State funding for nursing facility Medicaid expenses better match overall increases in costs relative to Choices for Independence waiver services. Funding for Choices for Independence Medicaid waiver services in the State Budget appears to have fallen behind relevant inflation indices over the last decade, and wages for workers at the lower end of the income spectrum have fallen behind those in neighboring states. Compared to costs estimated by a key relevant measure of inflation and adjusted for changes in enrollment, Medicaid funding for Choices for Independence waiver services in the State Budget have been \$153.2 million lower than cost increases since State Fiscal Year 2011. New Hampshire spends a smaller fraction of its Medicaid long-term services and supports expenditures on home- and community-based services, rather than institutional care, than the nation overall and compared to all other New England states.

Projected demographic shifts suggest funding these Medicaid services will become more important during the next two decades in New Hampshire. As New Hampshire's population ages, the aggregate need for these services rises. More than 200,000 adults were estimated to be between age 55 and 64 years in 2019. Survey data suggest more of these adults will experience some form of disability as they age, with more than two out of every five New Hampshire adults over the age of 74 years reporting some form of disability in the most recent data.

The delivery of these critical services is currently challenged by a lack of available workforce for both nursing facilities and home and community-based services providers. New Hampshire's low unemployment rate and limited housing availability, as well as fast-rising costs, constrain the capacities of these providers. As a result, service underutilization is common, particularly in the Choices for Independence program, and appears to be due more to a lack of supply for these services than a lack of need or interest. Survey data suggest the majority of older adults prefer to stay in their current residences and home communities for as long as they can.

Ongoing investments in nursing facility services and increased investments in Choices for Independence home- and community-based services, as well as the workforce that powers both of those industries, will be critical for supporting New Hampshire's aging population in the coming years and decades. Making foundational, cost-effective investments in the near-term will help create a more efficient, organized, and robust system to care for Granite Staters as more of them begin to need these services, particularly in the next two decades.

This report incorporates available research, information, and data published and provided to the authors regarding long-term services and supports in New Hampshire. The research for this report also included interviews with stakeholders in long-term care in New Hampshire. These interviews included 25 individuals, incorporating the perspectives of staff from the New Hampshire Department of Health and Human Services, county government and

nursing home officials, a municipal welfare official, nursing facilities, home and community-based services case managers, hospitals and hospital discharge personnel, home health providers, personnel of the navigation assistance program ServiceLink, an economist, and an individual directly receiving home-based long-term health services. Both cited, published materials and these confidential interviews inform this report.

MEDICAID IN NEW HAMPSHIRE

The Medicaid program is a partnership between the federal and state governments to provide health coverage for eligible people. Medicaid eligibility is generally designed to cover people with low incomes, with limited assets, or experiencing certain specific health conditions or disabilities.¹ At the end of February 2020, immediately prior to the impacts of the COVID-19 pandemic reaching New Hampshire, Medicaid provided health coverage to 178,930 children, parents, pregnant women, people with disabilities, older residents receiving long-term services and supports, nursing home residents, and other individuals with low incomes in the state. By the end of April 2022, the number of people accessing health services through Medicaid increased to 238,802, with 60.9 percent of that increase attributable to the growth in the New Hampshire Granite Advantage Health Care Program.²

Medicaid covers services required by the federal government for participation in the program and optional services that states can decide to establish and receive approval for federal matching payments. These services may be considered part of the Medicaid State Plan, which describes the scope and nature of the state's Medicaid programs. Nursing facility services are required by the federal government for participation in the Medicaid program, and are included in the State Plan. Certain home and community-based services (HCBS) can be optionally provided through the State Plan, or they can be provided through Medicaid waivers, which authorize programs that deviate from the baseline policies originally established by the federal Medicaid program.³

Significant portions of the Medicaid-eligible population receive certain services permitted through Medicaid waivers granted to New Hampshire by the federal government. Currently, New Hampshire has four active Medicaid waivers, which include the:⁴

- Choices for Independence Waiver, which provides home or community-based adult medical day services, home health aide and personal care services, in-home services and supports, skilled nursing, residential care, and other services for adults with disabilities and older adults
- Developmental Disabilities Waiver, which provides community-based specialty services, community participation, supported employment, residential habilitation, crisis response, assistive technology, and other services to individuals with intellectual or developmental disabilities or autism
- In Home Supports for Children with Development Disabilities Waiver, which provides residential habilitation, service coordination, assistive technology, community integration services, environmental modifications, and respite services for children and adults aged 18 to 21 with intellectual or developmental disabilities or autism
- Acquired Brain Disorder Waiver, which provides similar services as the Developmental Disabilities Waiver to adults aged 22 years and older who have brain injuries

Generally, Medicaid costs are shared evenly between the state and federal governments. In the components of the program for which costs are evenly shared, for every dollar of funding the State provides to support eligible Medicaid services, the federal government also provides a dollar, resulting in two dollars of investment in the health of Granite Staters.⁵

Certain programs within Medicaid provide higher federal matching rates than the common 50 percent match, including the Children's Health Insurance Program (CHIP) and expanded Medicaid for adults with low incomes under the Patient Protection and Affordable Care Act, which is currently called the New Hampshire Granite Advantage

Health Care Program in New Hampshire.⁶ In Federal Fiscal Year 2020, the Kaiser Family Foundation estimated that 61 percent of Medicaid expenditures in New Hampshire were federally-funded, while 39 percent were funded by State and local revenue sources.⁷

Medicaid is a major payer of long-term services and supports (LTSS) nationally. LTSS are programs that help people in need of health and health-related services or certain other types of assistance over a long period of time, including nursing facility care, developmental services, personal care and meal preparation, in-home and community-based services, and other help to perform daily activities or access health services. An individual may need LTSS at any age, but the probability of needing LTSS increases with age. In 2019, Medicaid was the largest payer of LTSS, with 42.9 percent of all formal LTSS financing was paid by Medicaid, and the share of LTSS paid by Medicaid increased between 1999 and 2019.⁸

REIMBURSEMENTS FOR MEDICAID SERVICES

Medicaid reimburses providers for delivering services, such as case management, specific medical services, and health-supporting home visits. Within the scope of the federal Medicaid program, the State of New Hampshire sets the reimbursement rates that define the amount of revenue a health care service provider agency can collect for each service delivered to a Medicaid enrollee. These authorized services are then paid in part with federal matching dollars.⁹ For certain Medicaid services, the State contracts with managed care organizations to administer the provision of these services.¹⁰

Medicaid reimbursement rates for provider services are typically lower than reimbursement rates from Medicare or private-sector insurance companies. Medicaid may also provide coverage for different types of services than other types of insurance. An analysis conducted by the federal Medicaid and CHIP Payment and Access Commission (MACPAC) found that, between 1999 and 2014, Medicaid costs per enrollee grew more slowly than Medicare or private insurance coverage, and more slowly than a key measure for the average rate of price inflation for medical service costs called the Consumer Price Index for All Urban Consumers for Medical Care. These lower rates of cost growth were maintained even while Medicaid served some patients that were at particularly high risk or had high service needs relative to patients overall.¹¹

Medicaid reimbursement rates are set using differing methodologies across programs. Medicaid services delivered through private managed care organizations contracting with the State are paid on a per member per month basis. The managed care organizations subsequently may pay providers on a fee-for-service basis.¹² However, LTSS funded by Medicaid in New Hampshire, including LTSS at nursing facilities or in a home or community-based setting, are not funded through managed care organizations. New Hampshire policymakers stopped a planned shift of LTSS services to managed care through legislation in 2018.¹³ Other specific services outside of managed care have identified reimbursements directly paid to providers from the State including Choices for Independence waiver services, while nursing facilities are reimbursed based on cost reporting.¹⁴

Reimbursement rates may be set differently across waiver programs as well, even for similar services. State fee-for-service reimbursements are typically set to dollar amounts per certain service units, such as per instance of certain types of medical care provided, prescription drug administered, period of time, occurrence of a certain type of service visit or check-in, or other reimbursable service.¹⁵ Differences in reimbursements for similar services may affect enrollee program choices, service delivery, and workforce retention and recruitment.

Funding reimbursements stem from a mix of federal, State, and county revenues in New Hampshire. Counties are responsible for most of the non-federal share of Medicaid costs for nursing facility services and Choices for Independence Medicaid waiver services provided to residents of their counties.¹⁶

NURSING FACILITIES IN NEW HAMPSHIRE

Nursing facilities, also commonly known as nursing homes, provide a set of residentially-based services to Granite Staters. These facilities are regulated by the State of New Hampshire and, for facilities with Medicaid patients, the federal government.¹⁷ Residents of nursing homes receive comprehensive services covering their medical and housing needs.¹⁸ As defined in State statute, a nursing facility is an institution or facility, or a distinct portion of a larger one, that is primarily providing 24-hour care for residents in need of skilled nursing care, medical monitoring, rehabilitation, instructed or supervised medication administration, or other health care services beyond housing and food that can only be provided in a 24-hour care setting.¹⁹

Nursing facility services are a mandated benefit service under the federal Medicaid program.²⁰ As a result, New Hampshire must make these services available, and fund the non-federal portion, to participate in the federal Medicaid program. Medicaid nursing facility services are not part of a waiver and are incorporated into the State Plan for traditional Medicaid. Generally, the federal government pays for 50 percent of Medicaid nursing facility services, and counties are responsible for most of the non-federal share; the non-federal share of most other Medicaid services are paid by the State.²¹

Nursing facilities may be either private or public. In addition to privately-operated nursing facilities in New Hampshire, eleven nursing homes in the state are operated by the ten county governments, with one in each county and an additional facility in Coos County.²²

Individuals must submit an application to the New Hampshire Department of Health and Human Services to enroll in Medicaid-funded nursing facility services.²³ To be eligible for these services, a person must be identified as both financially eligible for Medicaid and clinically eligible for nursing facility services. State law defines clinically eligible as needing 24-hour care for one or more of the following purposes:²⁴

- medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services
- restorative nursing or rehabilitative care with patient-specific goals
- medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention
- assistance with two or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence

During State Fiscal Year (SFY) 2021, which encompassed the 12 months from July 1, 2020 to June 30, 2021, the average monthly number of Medicaid enrollees in nursing home beds in New Hampshire was 3,624.²⁵

CHOICES FOR INDEPENDENCE MEDICAID WAIVER

New Hampshire's Choices for Independence (CFI) Medicaid waiver provides certain home- and community-based long-term care services to eligible adults. The CFI Medicaid waiver is designed to be an alternative to nursing home care, with the goal of helping to support residents who choose to stay in their own homes, or in a residential or assisted living facility that is not a nursing home while receiving a nursing home level of care.²⁶

As with many other Medicaid services, the federal government pays for 50 percent of the costs for CFI Medicaid waiver services, and counties in New Hampshire are responsible for most of the non-federal share of costs under State law.²⁷ As a waiver service, the CFI Medicaid waiver program must be renewed every five years. The federal government's Center for Medicare and Medicaid Services (CMS) oversees the Medicaid program and the waiver approval process.²⁸

To be eligible for CFI, residents must be age 18 or older, have a chronic illness or disability, be clinically in need of care at the level provided in a nursing home, and be financially eligible for Medicaid.²⁹ Individuals aged 18 to 64 years must have a disability, whereas those aged 65 or older do not necessarily have to be determined to have a disability but must still be clinically eligible for a nursing home level of care.³⁰ Federal rules for waiver services require that people who are eligible must be those who, in the absence of those services, would otherwise require institutional placement in a long-term care nursing facility, a hospital, or an intermediate care or intellectual or developmental services facility.³¹

Enrollees receiving services through the CFI Medicaid Waiver must meet the same clinical eligibility criteria as those who are receiving services in nursing facilities, and they have chosen to live in their homes or in the community while accessing care. Medicaid enrollees do not receive services through multiple waivers simultaneously, so individuals with developmental disabilities or acquired brain disorders would typically receive services outside of the CFI Medicaid Waiver and through separate waivers.

In SFY 2021, an average of 3,298 people were enrolled each month in CFI home support and home health care services, while another 497 were enrolled in CFI mid-level services designed to provide care in an assisted living facility; enrollment in these CFI services totaled an average of 3,795 enrollees per month during the year.³²

REIMBURSEMENTS FOR MEDICAID NURSING FACILITY SERVICES

Nursing facilities have an extensive cost-reporting system that informs State policymaking for reimbursements. Each nursing home is required to file an annual cost report, a comprehensive form which details facility expenses and resident census statistics. From this cost report, the New Hampshire Department of Health and Human Services (DHHS) determines allowable costs that are used to determine the facility reimbursement rate. The DHHS considers costs that are reasonable and necessary for service delivery and operations of the nursing facility. The DHHS does not allow certain costs, and identifies examples of costs it considers inefficient, unnecessary, and not common or acceptable costs that would not be factored into Medicaid reimbursement considerations.³³

Once those cost reports are submitted, the DHHS calculates median costs across all nursing facilities for the following cost centers:³⁴

- direct patient care costs
- administrative costs incurred in general management of facilities
- support costs, such as laundry, pharmacy, dietary, and other services
- plant maintenance, including utilities and property taxes
- capital costs, including depreciation and interest costs

To make adjustments for inflation in costs over time, the DHHS uses the CMS Market Basket for Skilled Nursing Facility input costs. The CMS Market Basket is a measure of input price changes over time, reflecting input price inflation facing providers in the provision of medical services, and is a national measure used to update payments and cost limits in various fee-for-services CMS payment systems.³⁵ The median values of each of these cost centers are adjusted by the CMS Market Basket's prospective payments for skilled nursing facility input prices index. Rather than using the median, assessments of capital costs use the 85th percentile cost for determining allowable expenses.³⁶

To establish the direct care cost median and calculate reimbursement rates on an individual facility basis, the DHHS requires reporting on the acuity, or relative illness or disability, levels of residents at each facility. These levels are determined by using a standardized CMS methodology to establish acuity levels for Medicare, Medicaid, and private payments. Acuity levels are used to determine the amount of care that is required for each resident. These acuity

scores are added up and then divided by the total number of facility residents to create an acuity level for each facility, as well as a statewide acuity level. These acuity levels are updated every six months.³⁷

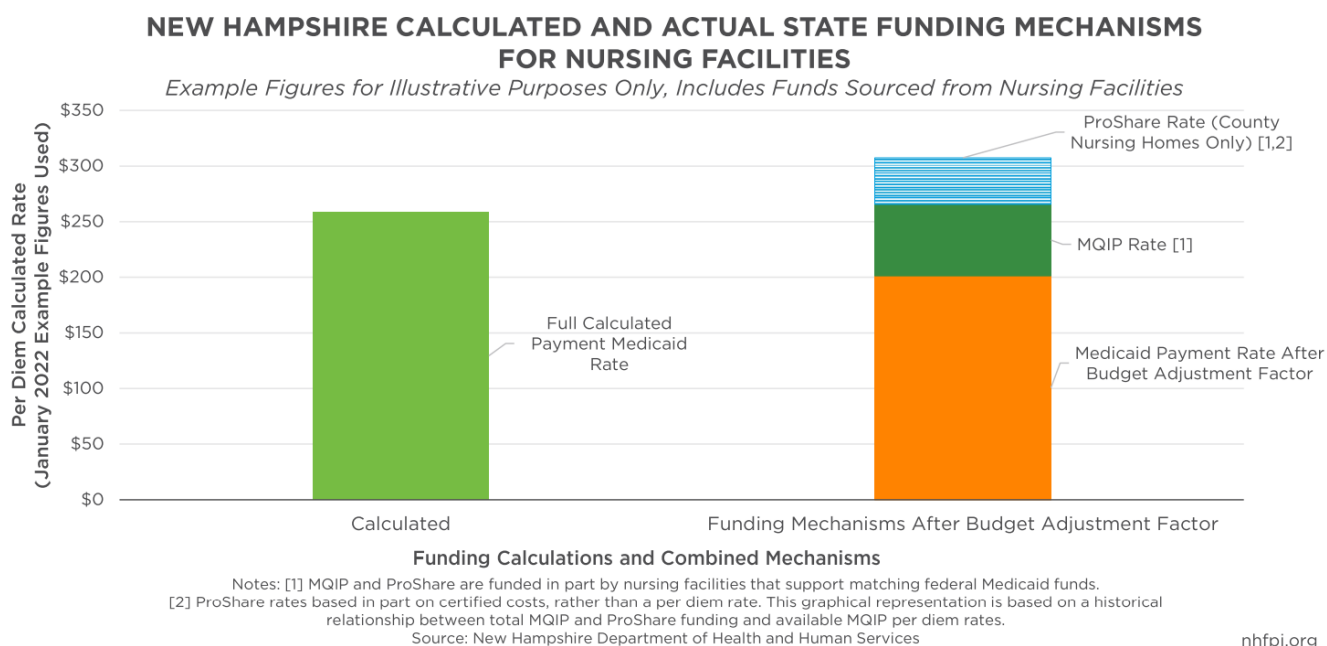
The median cost calculations and the acuity levels are used to develop per diem reimbursements for each nursing facility for each person served. These rates are then adjusted by a budget adjustment factor, also known as the budget neutrality factor, which reduces the resulting rates by 23.62 percent, according to State administrative rule.³⁸ See Appendix B for a DHHS diagram showing acuity-based rate calculations.

To help offset this budget adjustment factor, the State has established two mechanisms for enhancing Medicaid payments and to bring more revenue to nursing facilities. The first mechanism is the Medicaid Quality Incentive Payment (MQIP), which applies to both private facilities and to public county nursing homes. The second mechanism is Proportionate Share Payments (ProShare), which apply only to county nursing facilities.³⁹

MQIP is funded by a combination of revenues collected from nursing homes through the Nursing Facility Quality Assessment and matching federal Medicaid dollars, with a dollar-for-dollar match in this portion of the Medicaid program and without including any new State dollars raised outside of the nursing facility industry. The amount of MQIP funds provided to each nursing facility is based in part on the amount of MQIP funds available, the difference between the full acuity rate and the adjusted per diem rate for each facility, and the number of paid days to the facility.⁴⁰ See Appendix C for a DHHS flow chart showing the full process.

ProShare payments are directed to county nursing facilities. The non-federal portion of certain ProShare Medicaid funding is also paid by counties, although that match has varied from a dollar-for-dollar match in recent years with methodology changes. ProShare payments were previously solely based on the difference between the upper payment limit of the Medicaid rate paid per diem to each facility and the amount the facility would have received if being reimbursed by Medicare, which typically has higher reimbursement rates than Medicaid. However, ProShare currently uses two different methodologies, ProShare1 and ProShare2, to calculate funding to counties. ProShare1 continues the original Medicare reimbursement-based methodology, while ProShare2 is based on certified costs. Nine of New Hampshire's ten counties participated in ProShare2 in SFY 2021.⁴¹

These two mechanisms, MQIP and ProShare, help offset the budget adjustment factor. The budget adjustment factor reduces the full Medicaid reimbursement rate calculated by the State, but MQIP and ProShare, which are in part paid by the nursing facilities to access the federal Medicaid match, add to nursing facilities revenues independent of the budget adjustment factor. Recent data suggest that the MQIP may offset the budget adjustment factor for some



facilities for a portion of the time, not including the Nursing Facility Quality Assessment payments from nursing facilities as a fraction of the MQIP received. ProShare2 payments are not provided on a per diem basis, so estimating comparable per diem payments is more difficult, but these costs likely help further offset the budget adjustment factor for county nursing facility Medicaid payments. County nursing facilities reportedly typically have a higher proportion of their total resident populations enrolled in Medicaid relative to private facilities, which may rely more on private insurance or other private payment for services.⁴²

These additional payment mechanisms do not have equivalents in HCBS, nor do the cost reports.

Cost calculations forming the basis for nursing facility reimbursement rates must be rebased at least every five years, according to State administrative rule, with consideration for changing costs and adjustments based on the CMS Market Basket.⁴³ However, State Budget decisions can also impact funding levels for nursing facilities that supersede these processes.

The complex and targeted process for funding Medicaid services for nursing facilities in New Hampshire, including through three different and significant revenue sources, involves substantial documentation of costs and requirements to update reimbursement rates in response to changing conditions among the population being served.

CHOICES FOR INDEPENDENCE MEDICAID REIMBURSEMENT RATES

The process for determining rates for CFI waiver services involves less supporting documentation than the rate setting process for nursing facilities, and has established processes that, like nursing facility reimbursements, may be superseded in the biennial State Budget process.⁴⁴

The CFI rate-setting process has reportedly changed over time, but a methodology is provided in the CFI waiver approved by CMS. The waiver states that CFI rates shall be adjusted each biennium, and calculated based in part on the CMS Market Basket for Home Health Agency costs multiplied by the estimated utilization.⁴⁵ Using the CMS Market Basket and estimates of utilization, the total appropriation is then used to calculate rates, but may be subject to a budget neutrality provision and legislative changes to CFI rates or funding.⁴⁶

DHHS officials reported that Medicaid rules had previously resulted in a different rate-setting methodology, and also reported that the Legislature has required specific rate increases as a part of State Budget legislation in the past.

New Hampshire State law includes additional requirements relative to LTSS costs beyond rate setting for CFI and for nursing facility payments. State statute requires the DHHS to “estimate and report the full cost to the state of adequately funding long-term care services at a level which ensures all eligible individuals the quality services which they need and for which they are eligible.” The cost estimates are required to include “the cost to fund home and community-based, mid-level, and nursing facility care at a reimbursement level necessary to ensure that individuals who are eligible for Medicaid-funded long-term care services have access to quality services,” including exercising choice between these services. The DHHS estimate is also required to be based on “provider reimbursement rates that ensure a provider workforce that is sufficient to fully meet the needs of eligible consumers,” and is required to be attached to the agency budget submissions as an information addendum.⁴⁷

REIMBURSEMENT RATES AND COST INDICES OVER TIME

Medicaid reimbursement rates, which are determined by the State as a result of both DHHS policy decisions and State Budget appropriations for certain services, set payments to providers for the cost of services. However, these reimbursement rates may not cover the costs of services for all providers, particularly if detailed cost reporting is not used in setting rates.

Rapid changes in prices for goods and labor can also reduce the relative value of reimbursement rates, as they may be adjusted infrequently relative to cost increases. With the United States and most of the world currently experiencing higher inflation than has been normal in recent decades, both HCBS agencies and nursing facilities may face exacerbated difficulties meeting their costs, particularly in a competitive market for a limited available workforce.⁴⁸

Over longer periods of time, national and regional price indices can offer insights into the extent to which reimbursement rates and funding levels have kept pace with changes in costs. Specific services may have changes in prices resulting from direct cost changes, and overall indices may not be reflective of all the changes in individual costs. However, several cost indices can offer valuable points of comparison for understanding New Hampshire's reimbursement rates for services over time.

While nursing facilities are paid different per diem rates based on their acuity profiles, CFI services are paid on a fee-for-service basis. The individual rates for CFI waiver services permit comparisons over time of specific reimbursement rates relative to relevant price and cost indices.

Four indices offer potentially valuable comparisons over time to understand changes in cost. The index most directly targeted at CFI-like services is the CMS Market Basket Home Health Agency index, which is calculated by CMS and reflects the input price inflation facing HCBS medical care providers.⁴⁹ The U.S. Bureau of Labor Statistics (BLS), which calculates several commonly-used measures of inflation, also has national indices to track changes in producer price costs for specific industries. Specifically, the BLS offers an index for home health care services for Medicaid patients, and a separate index for home health care services not specific to Medicaid.⁵⁰ In addition, HCBS providers also may have to pay staff in a manner that at least keeps up with the general inflation faced by consumers in New Hampshire to retain them, so the Consumer Price Index in the northeastern United States is also a relevant measure for tracking reimbursement rates, particularly those rates that directly reimburse tasks for which human labor is central.⁵¹

The table on this page uses these four measures to understand price changes over time relative to the current Medicaid reimbursement rates for certain CFI services. The services selected include the ten services that were the most commonly

CHOICES FOR INDEPENDENCE MEDICAID WAIVER SERVICES NEW HAMPSHIRE REIMBURSEMENT RATES, ACTUAL RATES AND JULY 2006 RATES INFLATION-ADJUSTED TO JANUARY 2022					
Name of Service (and Unit)	Actual Rate, January 2022	July 2006 Rate Adjusted to Match Overall Consumer Inflation (CPI-U Northeast)	July 2006 Rate Adjusted to Medicaid Home Health Producer Price Changes	July 2006 Rate Adjusted to Overall Home Health Producer Price Changes	July 2006 Rate Adjusted by CMS Market Basket for Home Health Agencies
Personal Care Services - Agency Directed (15 min)	\$5.62	\$5.89	\$5.51	\$5.45	\$6.24
Personal Care Services - Consumer Directed (15 min)	\$5.62	\$5.89	\$5.51	\$5.45	\$6.24
Case Management (per diem)*	\$8.99	\$11.23	\$10.50	\$10.38	\$11.89
Home Health Aide (15 min)	\$6.73	\$7.72	\$7.22	\$7.14	\$8.17
Homemaker (15 min)	\$5.40	\$5.89	\$5.51	\$5.45	\$6.24
Home Delivered Meals	\$8.11	\$9.20	\$8.60	\$8.50	\$9.74
Respite Care Services	\$1.94	\$2.21	\$2.06	\$2.04	\$2.33
Home Health Aide (per visit)**	\$34.68	\$36.50	\$34.13	\$34.63	\$38.18
Skilled Nursing Care**	\$105.66	\$111.18	\$103.97	\$105.49	\$116.66
Adult Day Program Services (Adult Medical Day Care)	\$75.00	\$66.24	\$61.94	\$61.23	\$70.10

Notes: Services selected based on most commonly authorized services, by counts of units, in SFY 2018. "Residential care per diem" was commonly authorized but removed from the analysis due to a change in the actual services covered per unit authorized during the analysis period.

*Translated to per diem rate from per month rate.

**Adjustment relative to July 2010, rather than July 2006.

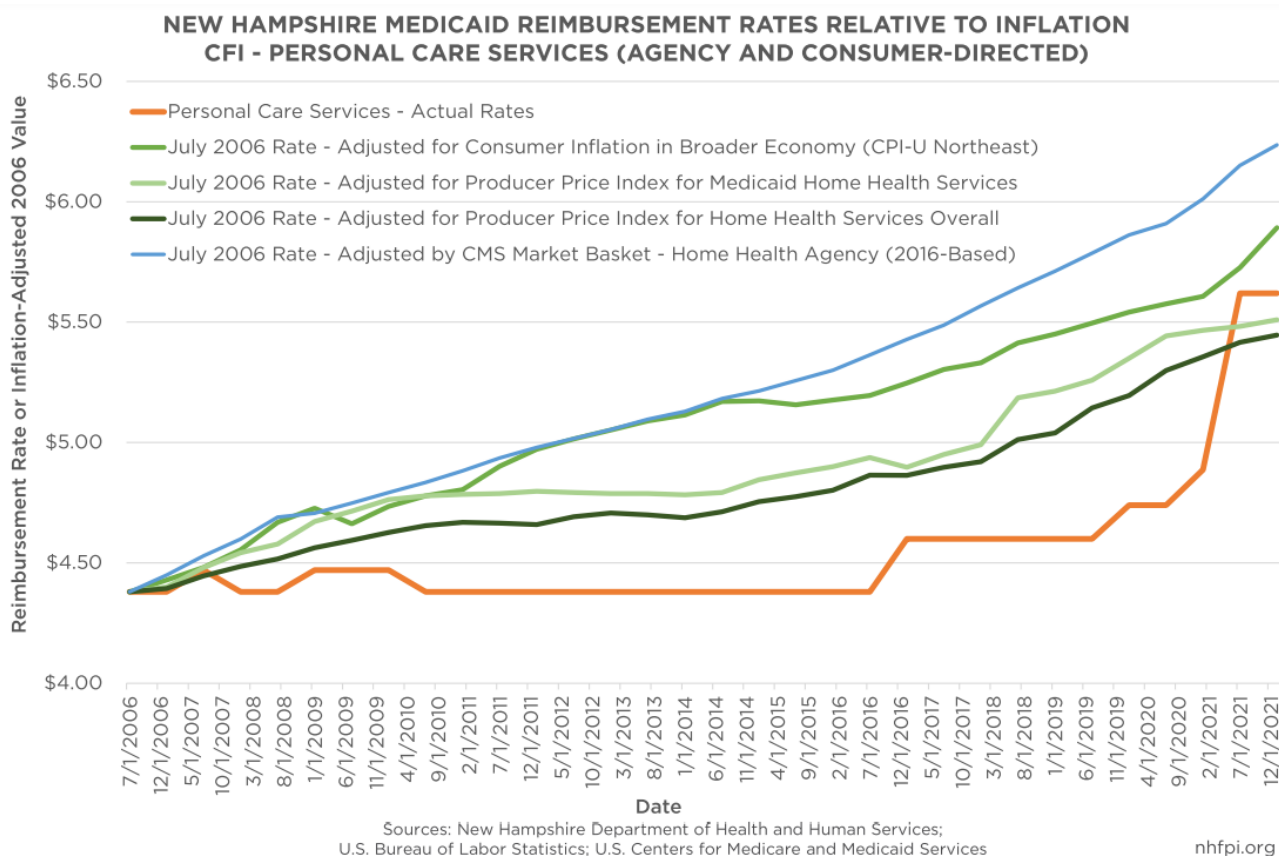
Sources: New Hampshire Department of Health and Human Services; U.S. Bureau of Labor Statistics

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authorized in SFY 2018, based on the number of authorized units.⁵² For each service, the table shows the actual Medicaid reimbursement rate in January 2022 alongside the reimbursement rates in July 2006 for those services (with two measured from July 2010, due to information limitations) adjusted for inflation to January 2022 based on those four different indices. While July 2006 is used as a starting point for this analysis, this comparison to July 2006 inflation-adjusted rates is not intended to suggest July 2006 reimbursement rates were sufficient for successfully covering the costs of service delivery at that time; July 2006 is used only as a comparison benchmark in this analysis.

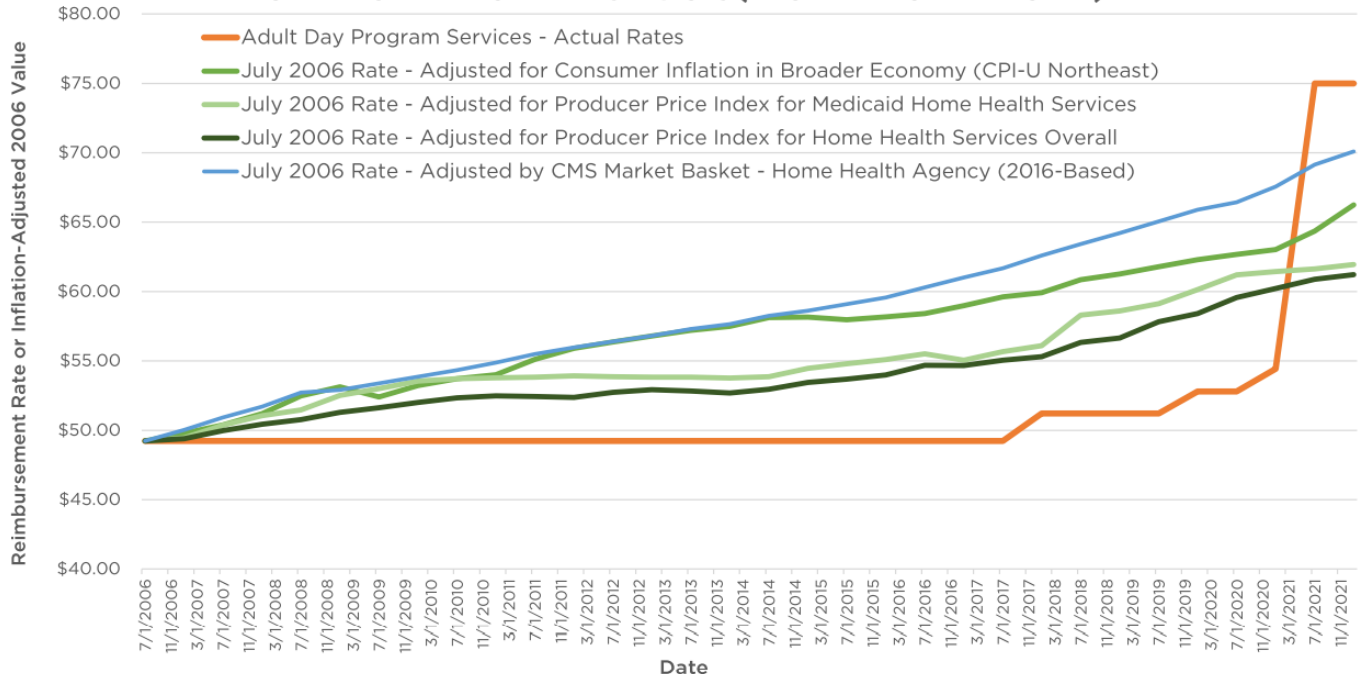
Comparing these points in time for the ten selected CFI reimbursement rates, five of the ten rates appeared to fall behind the two measures of inflation for home health services, including the Medicaid-focused measure and the measure including all home health services. Nine of the ten actual January 2022 rates had fallen behind inflation faced by consumers in the general economy and the CMS Market Basket for home health agencies.

Tracking these specific rates and inflation indices over time for four key services reveals examples of the patterns of reimbursement rate changes relative to increasing costs. The reimbursement rate for personal care services lagged behind all four measures of cost increases from 2007 to 2021, with the increase in the most recent State Budget yielding a rate above two of the four inflation measures. The nominal rate was unchanged from mid-2010, when it was lowered, to 2016, meaning the real “purchasing power” of this rate was falling during that time period. As noted previously, the reimbursement rate in 2006 was not necessarily sufficient to cover the cost of the service.



The only rate to have outpaced all four measures of inflation between 2006 and 2022, adult medical day services, shows a similar pattern. For the entire period until the most recent State Budget took effect in July 2021, this reimbursement rate lagged behind these four measures of inflation relative to 2006. Between 2006 and early 2017, the per-unit reimbursement for adult medical day services was the same nominal dollar amount, indicating a declining real value of that reimbursement rate for over a decade. The recent increase brings this reimbursement rate above all four inflation-adjustment measures from the 2006 rate, potentially beginning to offset the fifteen years during which this reimbursement rate fell behind all four measures of inflation.

NEW HAMPSHIRE MEDICAID REIMBURSEMENT RATES RELATIVE TO INFLATION CFI - ADULT MEDICAL DAY SERVICES (ADULT MEDICAL DAY CARE)

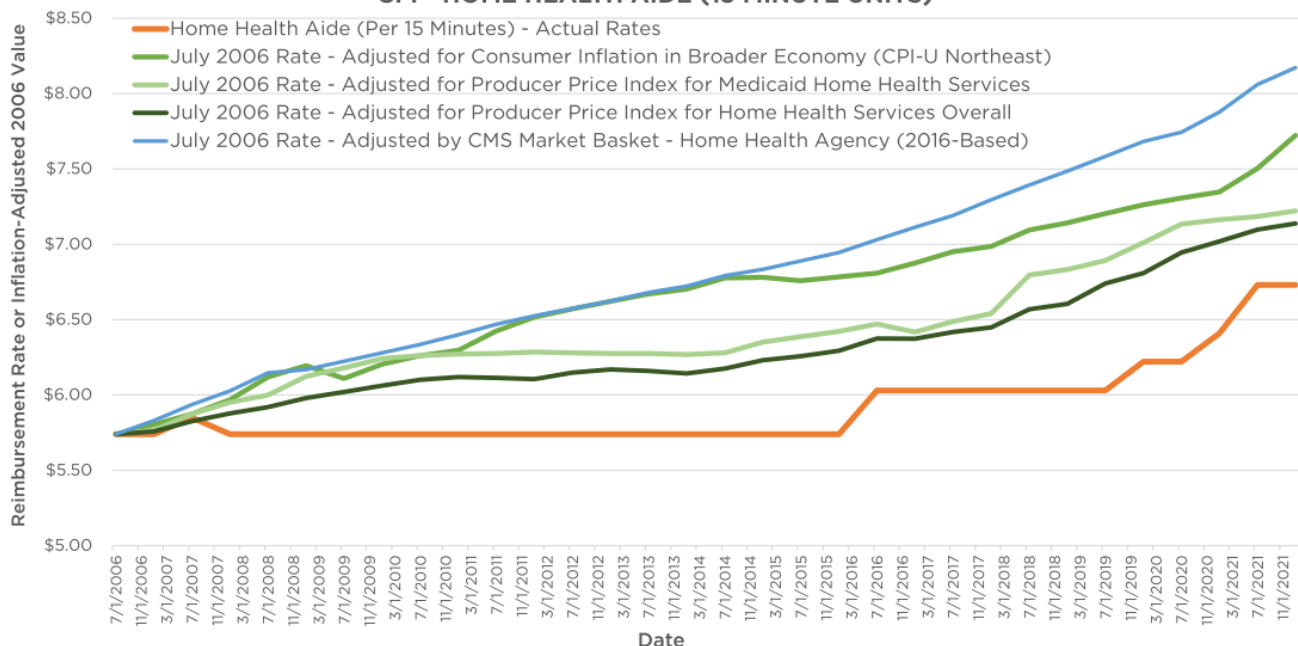


Sources: New Hampshire Department of Health and Human Services;
U.S. Bureau of Labor Statistics; U.S. Centers for Medicare and Medicaid Services

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However, rates for several commonly-reimbursed services have not followed these patterns. The reimbursement rate per 15-minute unit of home health aide time has increased since 2015, after remaining essentially unchanged for nearly a decade prior to that. However, that reimbursement rate has not climbed to meet any of the four inflation-adjusted levels of the reimbursement rate for the same service in 2006. As noted above, using July 2006 as a benchmark year for comparison is not intended to suggest that reimbursement rates were sufficient to cover costs in that month.

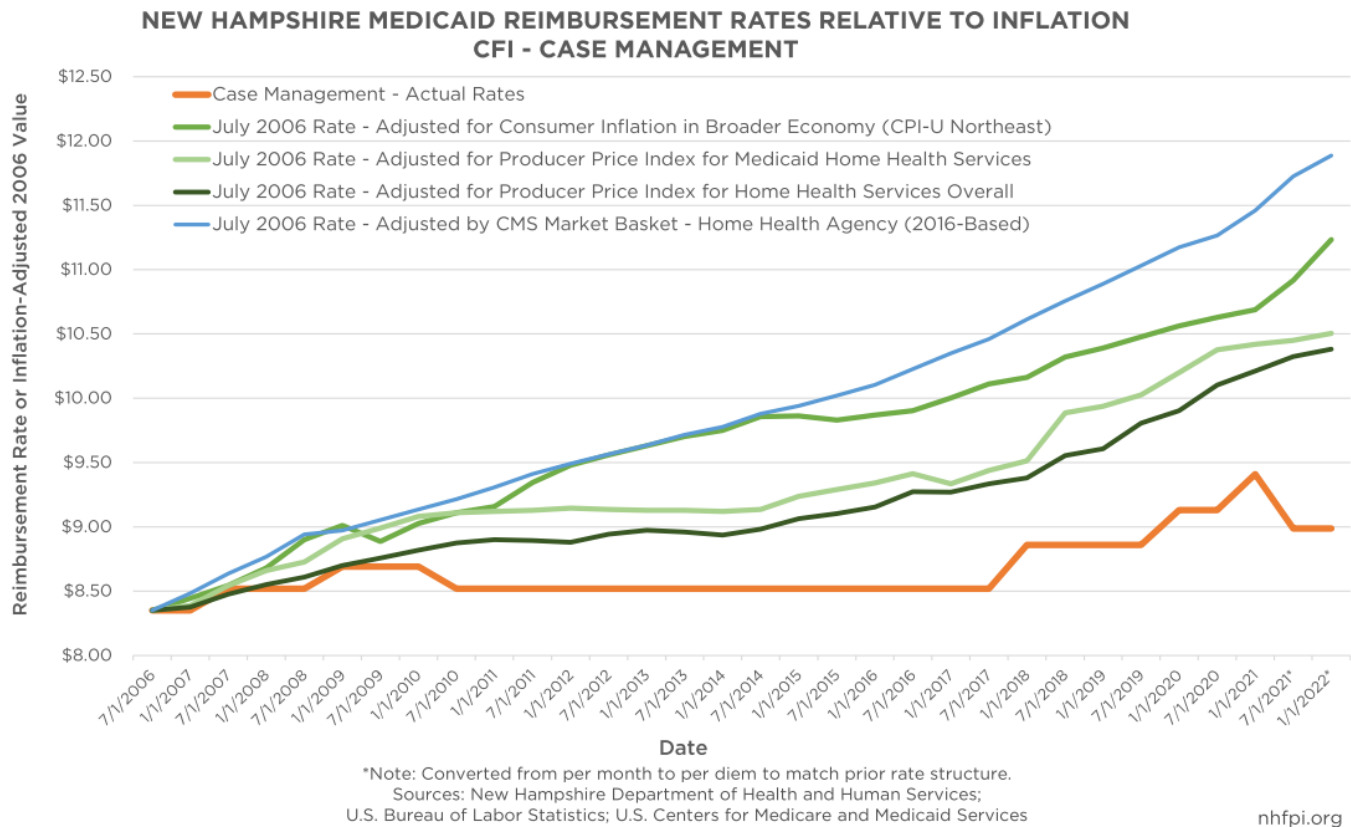
NEW HAMPSHIRE MEDICAID REIMBURSEMENT RATES RELATIVE TO INFLATION CFI - HOME HEALTH AIDE (15 MINUTE UNITS)



Sources: New Hampshire Department of Health and Human Services;
U.S. Bureau of Labor Statistics; U.S. Centers for Medicare and Medicaid Services

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Case management reimbursement rates for CFI waiver services also have fallen behind inflation. The recent increases, which were also accompanied by a change in the unit of time for the basis of reimbursement from per day to per month, have raised the nominal rate from \$8.35 per day in July 2006 to the month-based equivalent of \$8.99 per day in January 2022. This level came after the per diem rate had increased to \$9.41 per day by January 2021. The four inflation adjustment measures from the July 2006 rate of \$8.35 per day suggest that to obtain the actual value in real purchasing power of that 2006 rate in today's dollars, the rate would have to be the equivalent of a value between \$10.38 and \$11.89 per day.

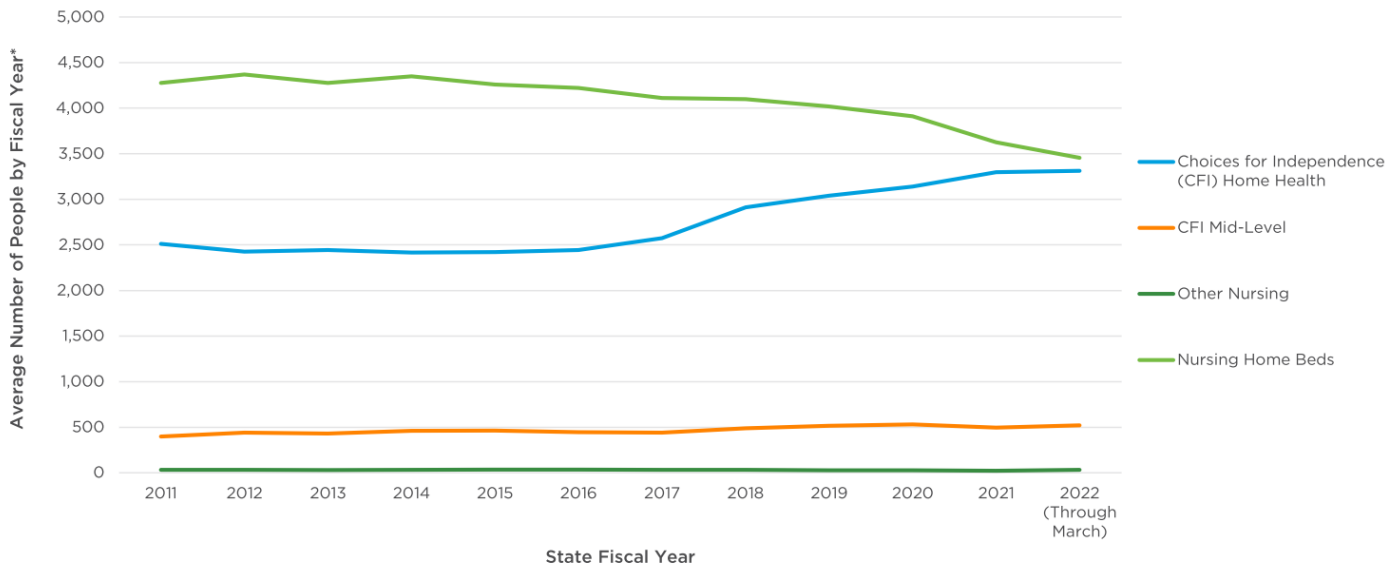


These fee-for-service individual rate comparisons indicate that key Medicaid reimbursements for CFI waiver services have fallen relative to the cost of providing these services to Granite Staters. Additional analysis would be required to determine if CFI waiver service reimbursements had kept pace relative to costs in the years preceding 2006, and these and other inflation-based analyses are not intended to suggest the initial points of comparison (in this case, July 2006 reimbursement rates) were sufficient to meet the costs of delivering quality services at the time. However, the analysis over time shows reimbursements very likely fell significantly behind rising costs faced by HCBS agencies providing these services, particularly in the decade following the Great Recession of 2007-2009 and the State Budget decisions made during and after that time.

ENROLLMENT, APPLICATION PROCESSING, AND IMPACTS FROM THE PANDEMIC

In the last ten years, enrollment in New Hampshire Medicaid LTSS for older adults and adults with physical disabilities has slowly shifted from having a majority enrolled in nursing facility services to more enrollees in CFI waiver services. The number of nursing clients, as defined by the DHHS, in nursing facility beds averaged 4,277 per month in SFY 2011. By SFY 2019, prior to the impacts of the pandemic, that number had declined to 4,019. The decline accelerated with the start of the pandemic, with that average monthly enrollment in the first nine months of SFY 2022 reported at 3,456 in nursing home beds.⁵³

ENROLLMENT IN NEW HAMPSHIRE MEDICAID NURSING CARE BY TYPE



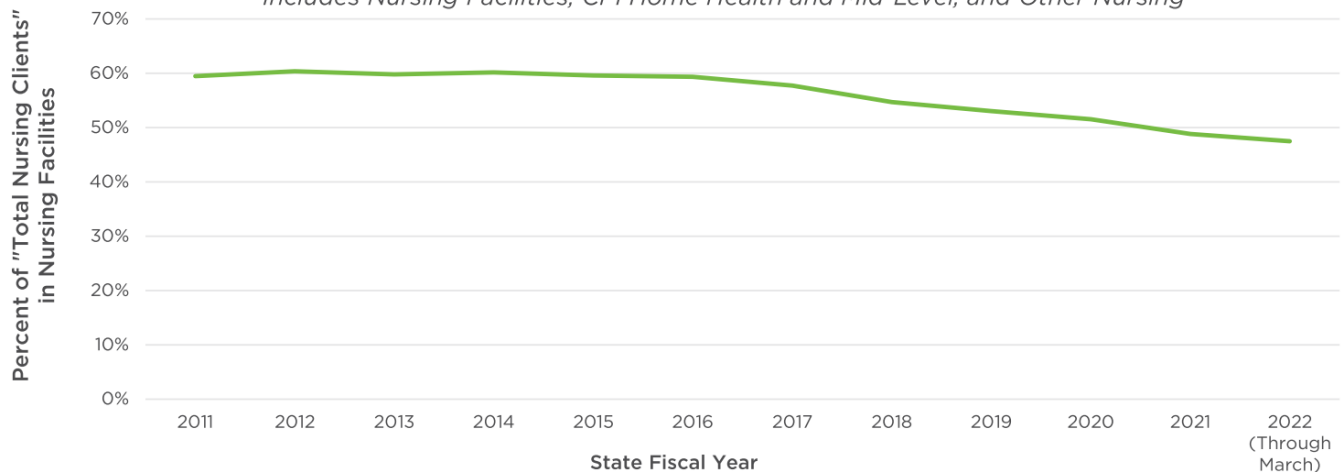
*Note: Annual average based on the 12-month average of rolling three-month averages.
Source: New Hampshire Department of Health and Human Services Operating Statistics Dashboard, April 22, 2022

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The percentage of the total number of DHHS nursing clients in nursing home beds also declined before and during the pandemic. In SFY 2011, about 60.4 percent of DHHS nursing clients were in nursing facilities. That figure fell below 50 percent during the pandemic, and averaged 47.5 percent during the first nine months of SFY 2022.

PERCENTAGE OF NEW HAMPSHIRE MEDICAID NURSING CLIENT ADULTS AND OLDER ADULTS IN NURSING FACILITIES

Includes Nursing Facilities, CFI Home Health and Mid-Level, and Other Nursing



Source: New Hampshire Department of Health and Human Services, Operating Statistics Dashboard, April 22, 2022

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The average number of CFI waiver clients served per month has increased between SFY 2011 and SFY 2022. DHHS nursing clients enrolled in CFI are categorized as either mid-level, or clients who are receiving services in an assisted living facility, or categorized as enrolled in home support and home health care services. In SFY 2011, mid-level services enrolled a monthly average of 399 clients, rising to 516 in SFY 2019 and 519 in the first nine months of SFY 2022. Home support and home health care services enrollment increased from monthly averages of 2,513 in SFY 2011 to 3,041 in SFY 2019 and 3,313 in the first nine months of SFY 2022.

The recent decline in nursing facility enrollment relative to CFI waiver services was likely due in part to changes in preferences associated with the pandemic. In February 2022, the Kaiser Family Foundation calculated that more than

200,000 residents and staff in long-term care facilities nationwide had died of COVID-19, or approximately 23 percent of all COVID-19 deaths. The report noted this percentage was lower relative to the comparable figure early in the pandemic, when deaths in long-term care facilities accounted for nearly half of all deaths nationally, and that the congregate setting necessarily inherent to both nursing facilities and assisted living facilities is a higher-risk setting for virus transmission.⁵⁴ While national-level data are much more limited for COVID-19 deaths in HCBS settings and are not directly comparable, interviews with CFI service providers in New Hampshire suggested there have been relatively few COVID-19 deaths among CFI enrollees during the pandemic.⁵⁵ Many potential enrollees and their families may have considered in-home services a safer option, when available and appropriate, than in a facility or congregate setting during the pandemic.

The decline in nursing facility enrollment may also have been driven in part by staffing shortages and COVID-19 precautions at nursing facilities, leading to reduced capacity. One interviewee reported that the occupancy in New Hampshire nursing facilities on December 31, 2019 was 86 percent, but it had fallen to approximately 76 percent occupancy by November 2021. That figure was compared with a reported national rate of about 72 percent. One New Hampshire nursing facility administrator also reported the December 2021 enrollment in the facility was at approximately 47 percent of licensed capacity due to pandemic-related workforce shortages and COVID-19 mitigation measures, although enrollment had declined since staffing difficulty issues began, starting in about 2015. Other interviewees also provided information consistent with these descriptions.

While staffing may be a consideration in the long-term trends, another may be the preferences of individuals seeking services. A national survey of 1,947 adults conducted by NORC at the University of Chicago on behalf of AARP Research in March and April of 2018 found 77 percent of respondents age 50 years and older would like to remain in their community as long as possible, and 76 percent would like to stay at their current residence for as long as possible.⁵⁶ Academic researchers have also identified this preference among people in need of LTSS and among their families.⁵⁷ The long-term trend toward increased CFI enrollment may be reflecting this preference among New Hampshire residents.

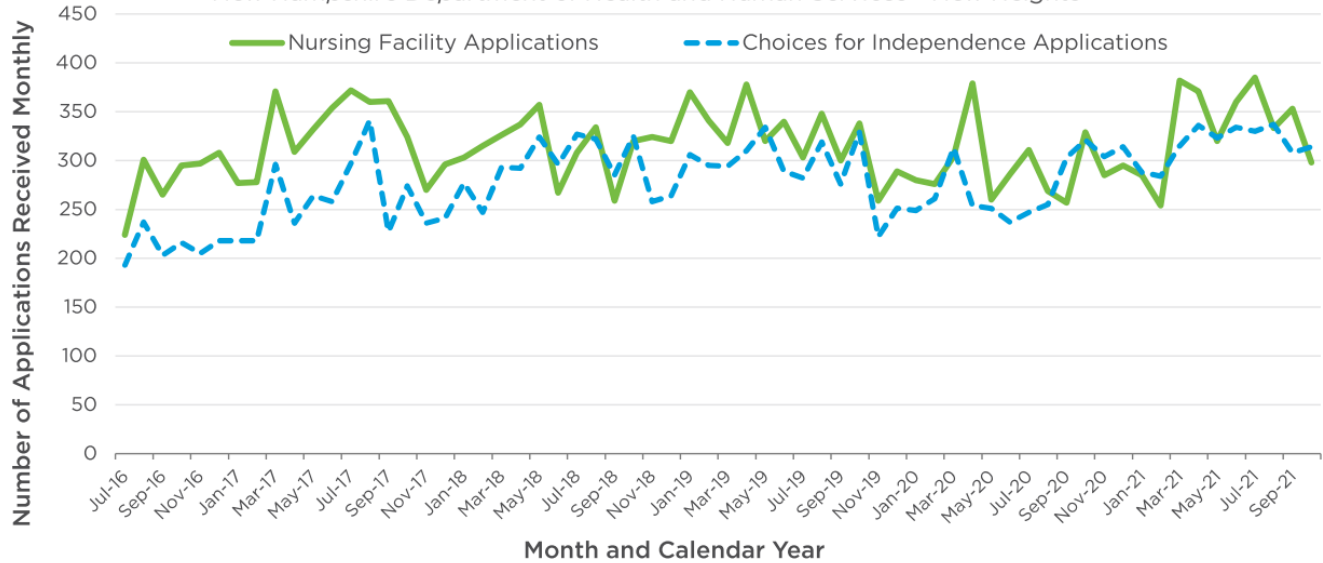
MEDICAID LTSS APPLICATION PROCESSES AND TIMELINESS

To receive Medicaid funding for LTSS, individuals in need must submit an application to the DHHS.⁵⁸ Applications are processed by the DHHS to determine eligibility, including both financial eligibility for Medicaid and clinical eligibility for, in the case of both nursing facility and CFI waiver services, nursing home care.

Data provided by the DHHS indicate the number of applications received each month has been fairly consistent in recent years, although the pandemic appears to have had an impact. Slightly more applications have been received for nursing facilities in most months during the period of July 2016 to October 2021. In this timeframe, an average of about 315 nursing facility applications were received by the DHHS monthly, while an average of 279 applications for CFI services were received monthly over the same period. In the period from July 2019 to June 2020, average monthly applications fell for both nursing facility and CFI services compared to the year beginning in July 2018, but average monthly CFI applications returned to those earlier levels while nursing facility applications had not recovered during the year beginning in July 2020. Nursing facility applications outpaced CFI waiver applications in the most recent four months available in these data, however.

LONG-TERM SUPPORTS AND SERVICES APPLICATIONS RECEIVED

New Hampshire Department of Health and Human Services - New Heights



Source: New Hampshire Department of Health and Human Services

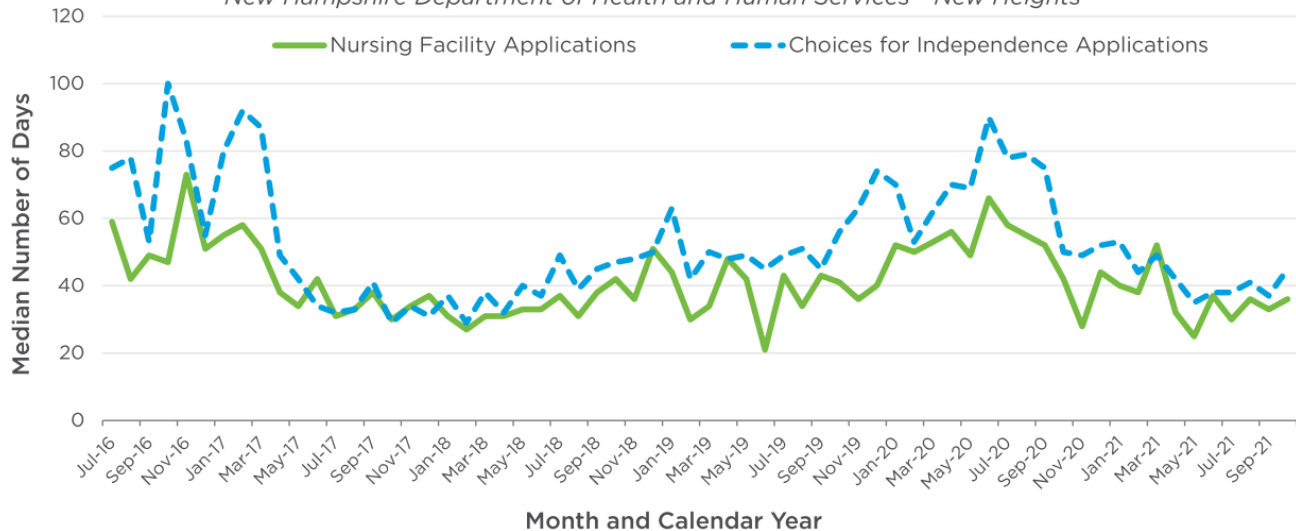
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Processing times for applications vary significantly across individuals, and are likely commonly impacted by both individual and systemic factors. Data provided by the DHHS suggest application processing times for nursing facilities may be somewhat lower than for CFI waiver services averaged over the July 2016 to October 2021 periods, but that both application processing times are similar, and both may be long relative to the urgent needs some individuals and families may face. In October 2021, the median processing times for nursing facility applications, from date of initial receipt to an outcome of any type, was 36 days. For CFI waiver services, the median processing time was 45 days. These medians fluctuated considerably across months, but the median figure indicates that about half of applications required less time to get to an outcome, while half did not reach an outcome until more time had elapsed. The pandemic appears to have increased processing times for several months, but the longest median processing times for both types of these applications in the studied period was during 2016 and early 2017, while processing times appeared to drop significantly by the middle of 2017.

APPLICATIONS CYCLE PROCESSING TIME

MEDIAN DAYS FROM APPLICATION RECEIPT TO OUTCOME

New Hampshire Department of Health and Human Services - New Heights



Source: New Hampshire Department of Health and Human Services

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PUBLIC APPROPRIATIONS OVER TIME FOR LONG-TERM CARE IN NEW HAMPSHIRE

Funding for Medicaid LTSS services requires partnership between the federal government, the State government, and county governments in New Hampshire. While the federal and state governments split the costs of Medicaid in most instances, New Hampshire funds key portions of Medicaid services, including Medicaid LTSS, with revenue streams collected from counties, often funded by county property taxes, and tax revenue from nursing facilities.

Medicaid typically matches approved expenses for enrollees and associated administrative costs in the State of New Hampshire with a dollar-for-dollar, or 50 percent, match.⁵⁹ For many Medicaid services, the State's General Fund supports the 50 percent not paid by the federal government.⁶⁰ However, the State also relies on other revenues to fund the non-federal share in certain programs.

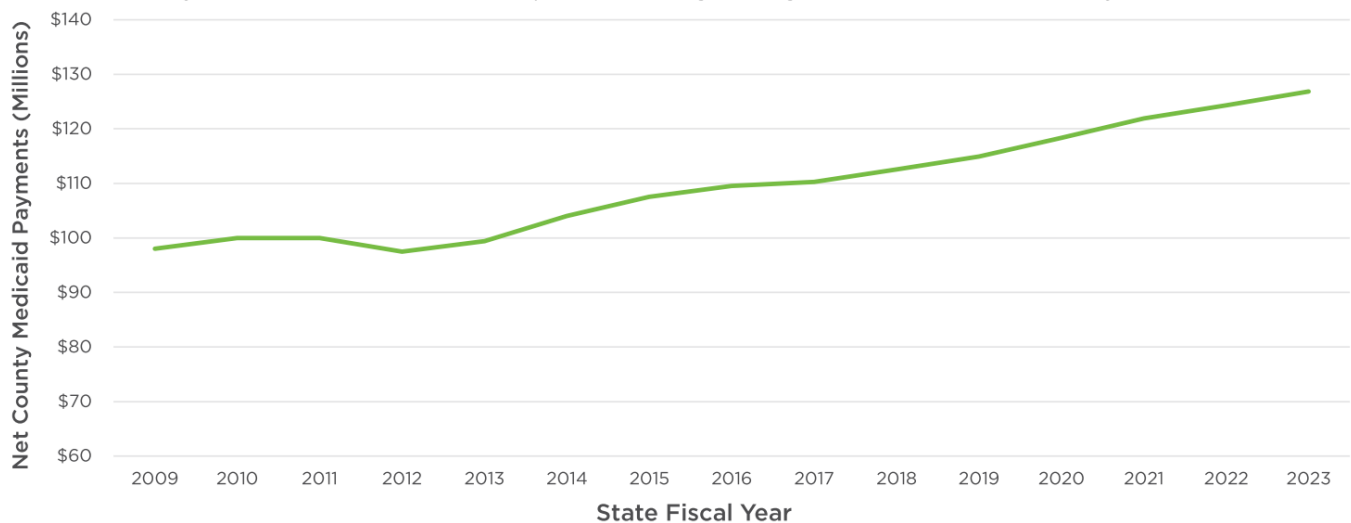
REVENUE FROM NURSING FACILITIES AND COUNTIES

The State taxes health care providers to fund certain Medicaid costs. Hospitals pay the Medicaid Enhancement Tax, and nursing homes pay the Nursing Facility Quality Assessment (NFQA).⁶¹ The NFQA funds the non-federal share of the MQIP funding that flows back to nursing facilities, effectively meaning nursing facilities in aggregate receive half of the revenue formally allocated to them through MQIP, although MQIP funds relative to NFQA taxed amounts may vary across facilities.⁶²

Counties are also required to contribute to LTSS costs in New Hampshire. For county residents in nursing facilities, the county government is responsible for most of the non-federal share of those LTSS Medicaid costs, regardless of if they are receiving services from the county nursing facility or from private nursing facilities within or outside of the county. Similarly, for county residents receiving CFI waiver services, the county is responsible for most of the non-federal share of the CFI Medicaid costs. Counties are not responsible for other Medicaid costs for residents, and the State typically pays a small portion of the non-federal cost with State General Fund contributions. The State caps the amount counties are required to pay in the State Budget each year, although that amount has increased every year since SFY 2012. Counties are also required to pay a portion of the funding for ProShare1 payments to public county nursing facilities.⁶³

MEDICAID PAYMENTS FROM COUNTIES FOR LONG-TERM CARE SERVICES

*Payments to the State of New Hampshire, Including Nursing Home, CFI, and ProShare Payments**



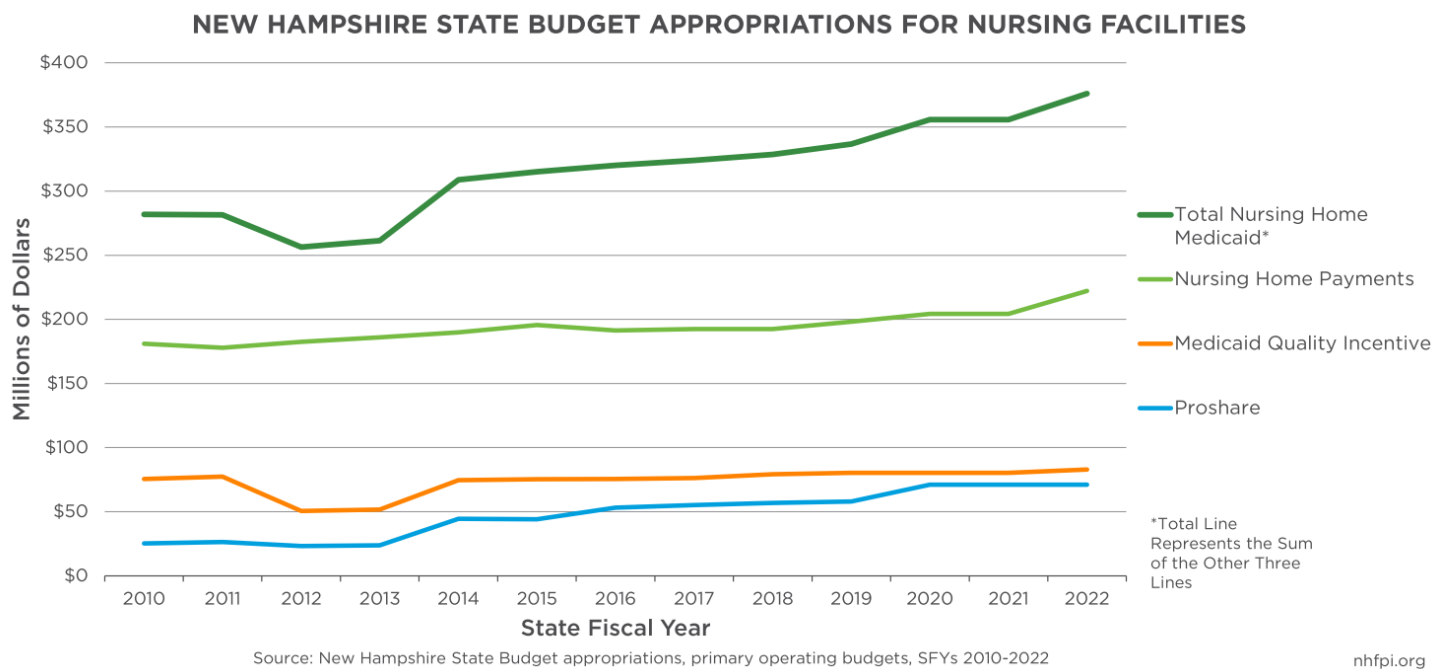
*Note: MQIP payments not included.

Sources: New Hampshire Department of Health and Human Services; New Hampshire State Budgets and Trailer Bills

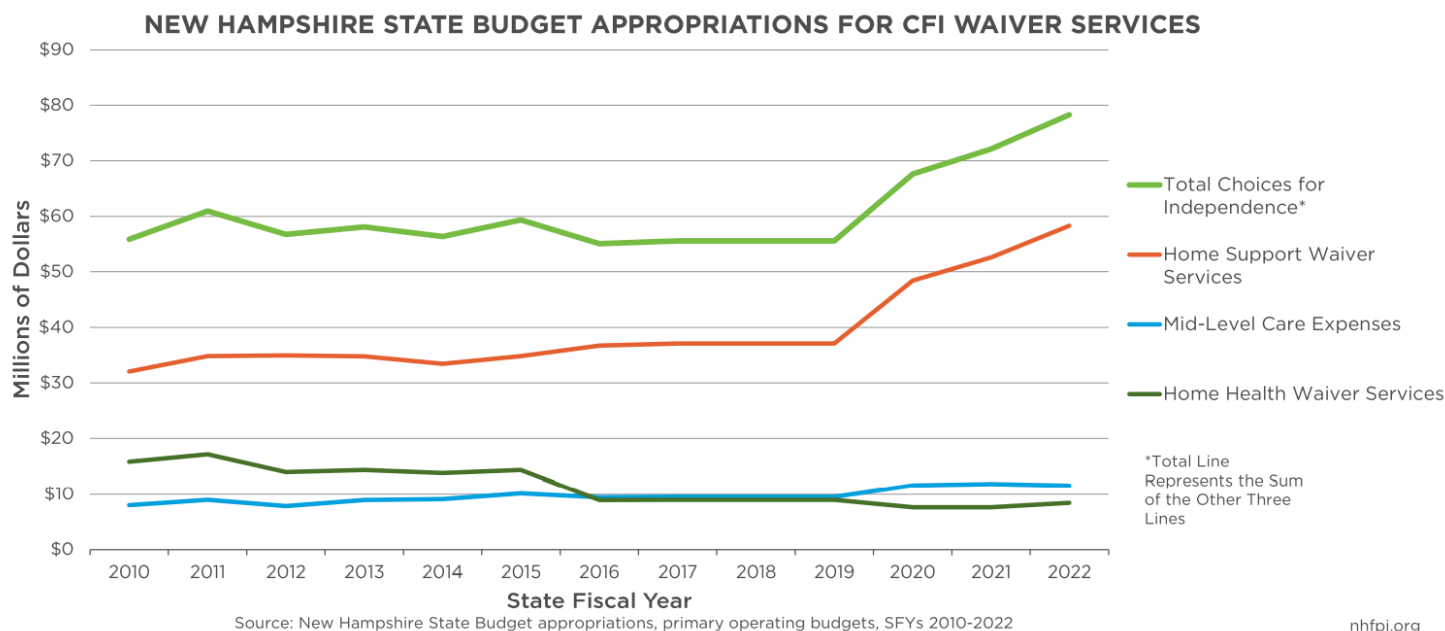
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STATE BUDGET FUNDING LEVELS

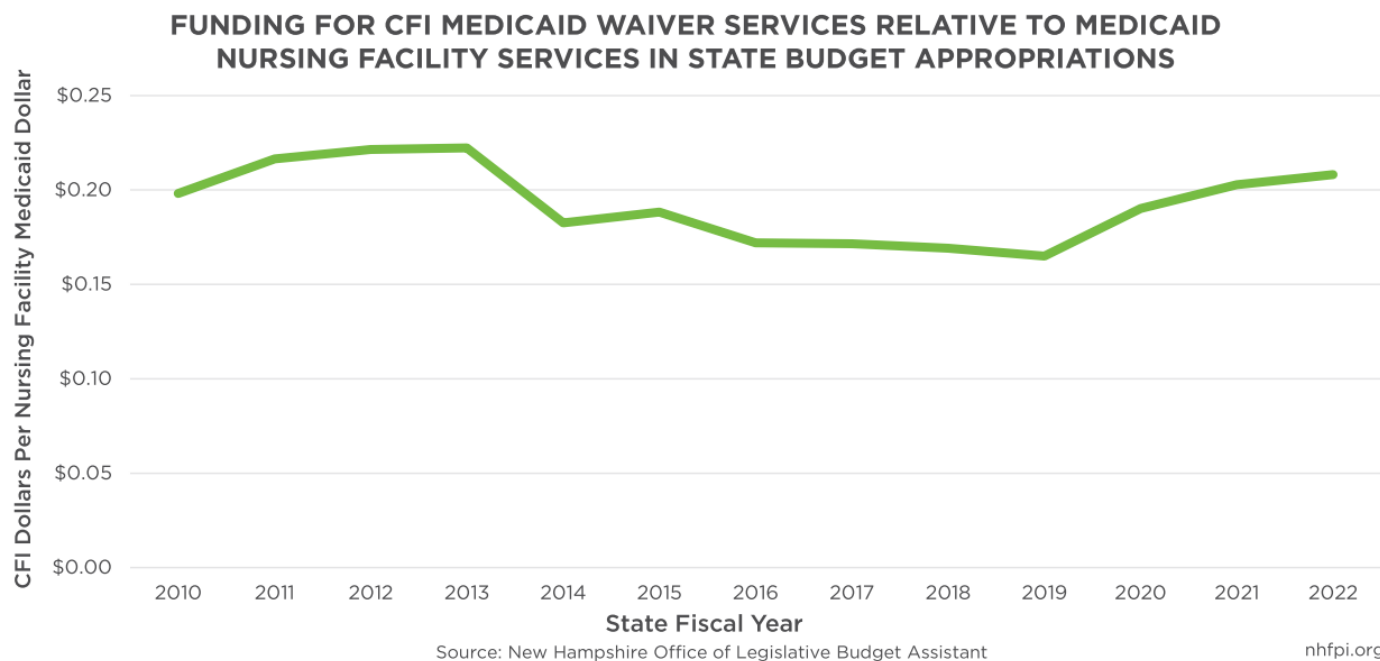
Total aggregate State Budget funding for nursing facility Medicaid payments over time has increased since SFY 2014. Between SFY 2011 and SFY 2012, the combined budget lines for nursing facility payments through regular payments, MQIP, and ProShare declined by about \$25.2 million, falling to \$256.3 million, primarily because of a reduction in budgeted MQIP payments. The appropriations rebounded to a total of \$308.8 million in SFY 2014, and have climbed to \$376.1 million in SFY 2022. Between SFY 2014 and SFY 2022, without inflation adjustments, funding for regular nursing facility payments increased by 17.0 percent, while MQIP payments increased by 11.2 percent and ProShare payments flowing to county facilities increased by 59.9 percent.



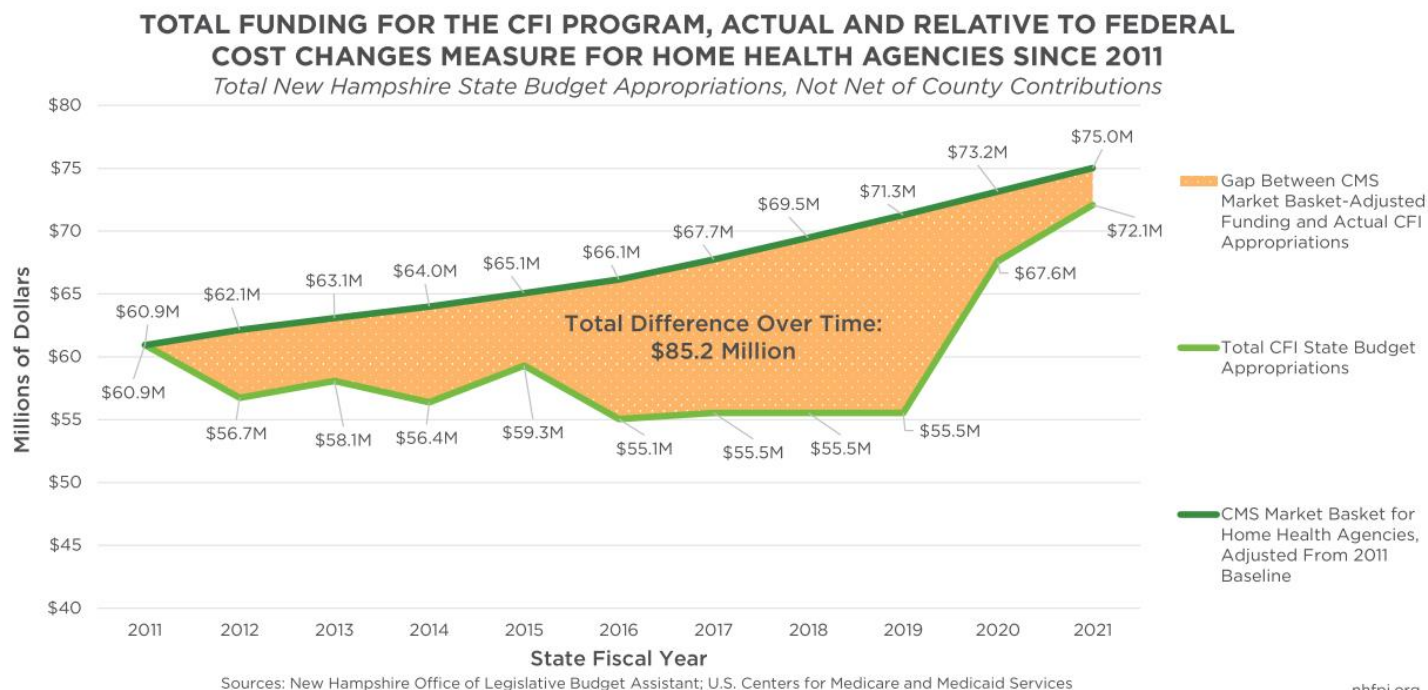
Funding for CFI services were not as negatively impacted by the SFY 2012-2013 State Budget appropriations as funding for nursing homes, but CFI services funding experienced an aggregate decline, unadjusted for inflation, between the end of the Great Recession and SFY 2019. Total CFI services funding was \$60.9 million in SFY 2011, but did not reach or exceed that level again until SFY 2020; funding in SFY 2016 had dropped to approximately \$55.1 million, and was held constant at \$55.5 million for the next three years. Between SFY 2014 and SFY 2019, aggregate funding for CFI mid-level services increased 4.6 percent, while the combined home health and home support waiver services budget lines decreased by 2.6 percent, unadjusted for inflation, across this five-year period. Starting in SFY 2020, CFI services saw a significant increase in funding following nearly a decade of stagnant funding levels even while enrollment began increasing. Total funding rose from \$55.5 million in SFY 2019 to \$78.3 million in SFY 2022. The funding for CFI mid-level services increased 27.2 percent between SFY 2014 and SFY 2022, while home health and home support waiver services combined appropriations increased 41.1 percent.



While the recent rise in CFI services appropriations in the State Budget has substantially boosted funding for CFI services after a long period of stagnation, nursing facilities have also seen their Medicaid appropriations boosted in the State Budget relative to SFY 2019. As a result, the ratio between the funding of the two types of services has stayed relatively similar between SFY 2010 and SFY 2022. The balancing of the appropriations between the two was most in favor of CFI services in the immediate aftermath of the Great Recession, as appropriations rose to 22.2 cents for CFI services for every dollar appropriated to nursing facilities in SFY 2013. By SFY 2019, CFI waiver services were appropriated 16.5 cents for every dollar appropriated to nursing facilities through regular payments, MQIP, and ProShare. The increase in CFI services appropriations since SFY 2019 has boosted the ratio to 20.8 cents for CFI services for every dollar appropriated to nursing facility Medicaid costs.



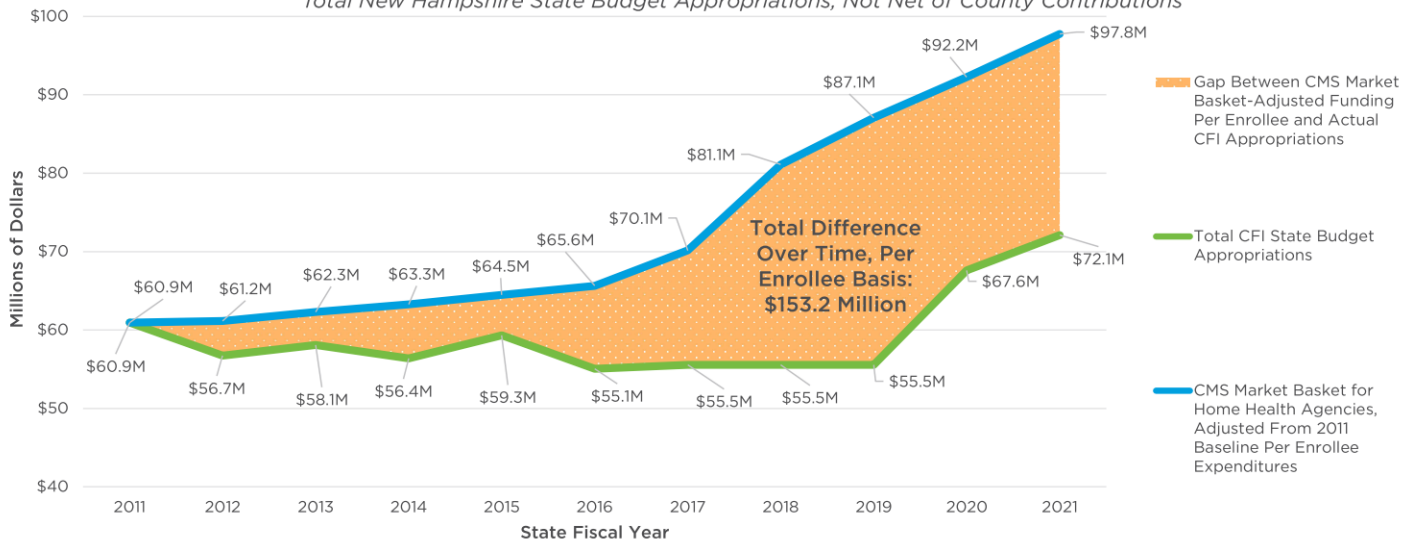
The preceding analysis of nominal appropriations provides perspective regarding funding levels for services over time, but does not reflect either changes in cost or in levels of enrollment. The CMS Market Basket for Home Health Agency costs informs the DHHS budget process and provides regular insight into cost inflation faced by HCBS agencies. Relative to SFY 2011, the second year of the State Budget crafted during the Great Recession of 2007-2009, CFI services funding has fallen behind inflation every year. If total CFI services funding had kept pace with the CMS Market Basket, there would have been an additional approximately \$85.2 million invested in the CFI waiver budget lines from SFY 2012 to SFY 2021. The gap was largest during the SFYs 2016-2019 period. While SFY 2011 is used as a starting point for this analysis, this comparison to SFY 2011 is not intended to suggest that SFY 2011 funding was sufficient for successful service delivery at that time; SFY 2011 is used only as a comparison benchmark in this analysis.



While adjusting for inflation provides a more complete picture than only examining nominal costs, the number of enrollees has also varied across the examined timespan, with CFI enrollment rising faster than the number of Medicaid nursing home residents both before and during the pandemic. In SFY 2011, the number of dollars appropriated in the State Budget per actual enrollee during the fiscal year was \$20,928. Adjusting this figure for inflation with the relevant CMS Market Basket and multiplying by the actual number of enrollees each year provides a comparison, benchmarked to SFY 2011, of funding for CFI services that reflects increases in costs of services and the number of actual enrollees served through CFI State Budget appropriations. Using this measure and adjusting for inflation and enrollment from SFY 2011 to SFY 2021 suggests that CFI waiver services have been underfunded in the State Budget by approximately \$153.2 million in aggregate. As noted above, using SFY 2011 as a benchmark year for comparison is not intended to suggest that funding was sufficient in that year.

TOTAL FUNDING FOR CHOICES FOR INDEPENDENCE RELATIVE TO FEDERAL INFLATION MEASURE ON A PER ENROLLEE EXPENDITURE BASIS SINCE 2011

Total New Hampshire State Budget Appropriations, Not Net of County Contributions

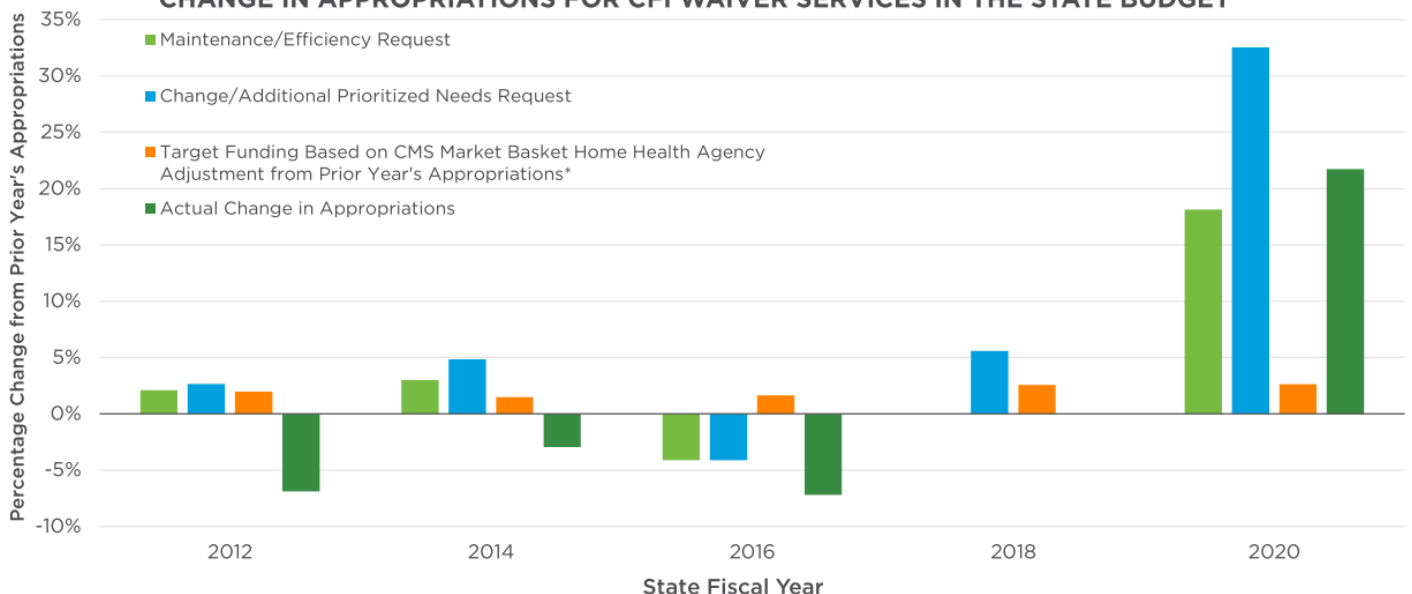


Sources: New Hampshire Office of Legislative Budget Assistant; U.S. Centers for Medicare and Medicaid Services

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These funding levels reflect the final appropriations in the State Budget. Early in the State Budget process, the DHHS submits budget requests to the Governor's office prior to the publication of the Governor's proposed budget.⁶⁴ Analysis of the DHHS's budget requests for CFI services indicate the proposed increases in CFI services have been closer to the relevant CMS Market Basket measure increases on a year-over-year basis than the final budgeted amounts, with variation above or below the CMS Market Basket measure across budget request years. The DHHS requested CFI funding increases relative to the prior years for SFYs 2012, 2014, and 2016, but the final budget passed by the Legislature decreased State Budget funding relative to the prior year in each of those years. In SFY 2018, final funding levels approved by the Legislature matched the DHHS's lower "Efficiency" budget request, but not the higher levels included in the "Additional Prioritized Needs" budget request. In SFY 2020, the actual final appropriations passed by the Legislature exceeded the "Efficiency" budget request, which grew substantially from SFY 2019, but did not exceed the "Additional Prioritized Needs" request.

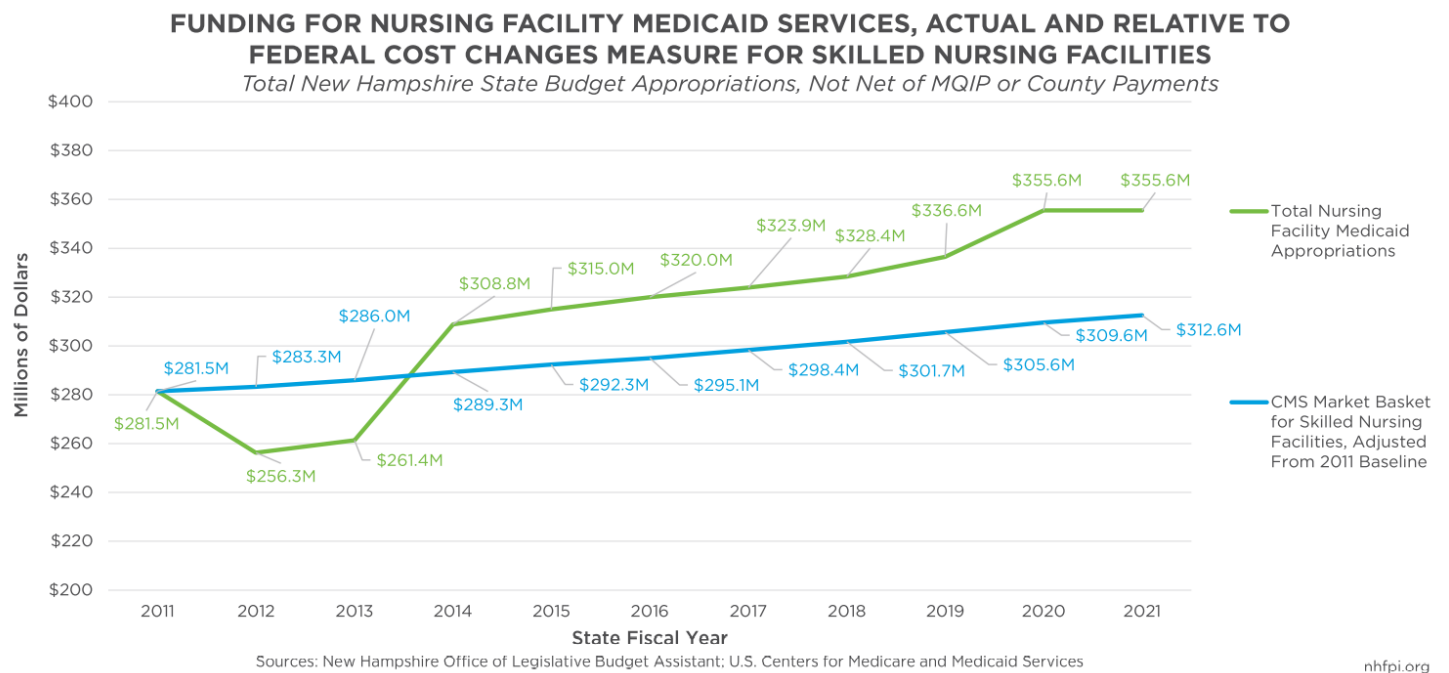
STATE AGENCY BUDGET REQUESTS, COST INFLATION ADJUSTMENT, AND ACTUAL CHANGE IN APPROPRIATIONS FOR CFI WAIVER SERVICES IN THE STATE BUDGET



Sources: New Hampshire Department of Administrative Services; New Hampshire Office of Legislative Budget Assistant; U.S. Centers for Medicare and Medicaid Services

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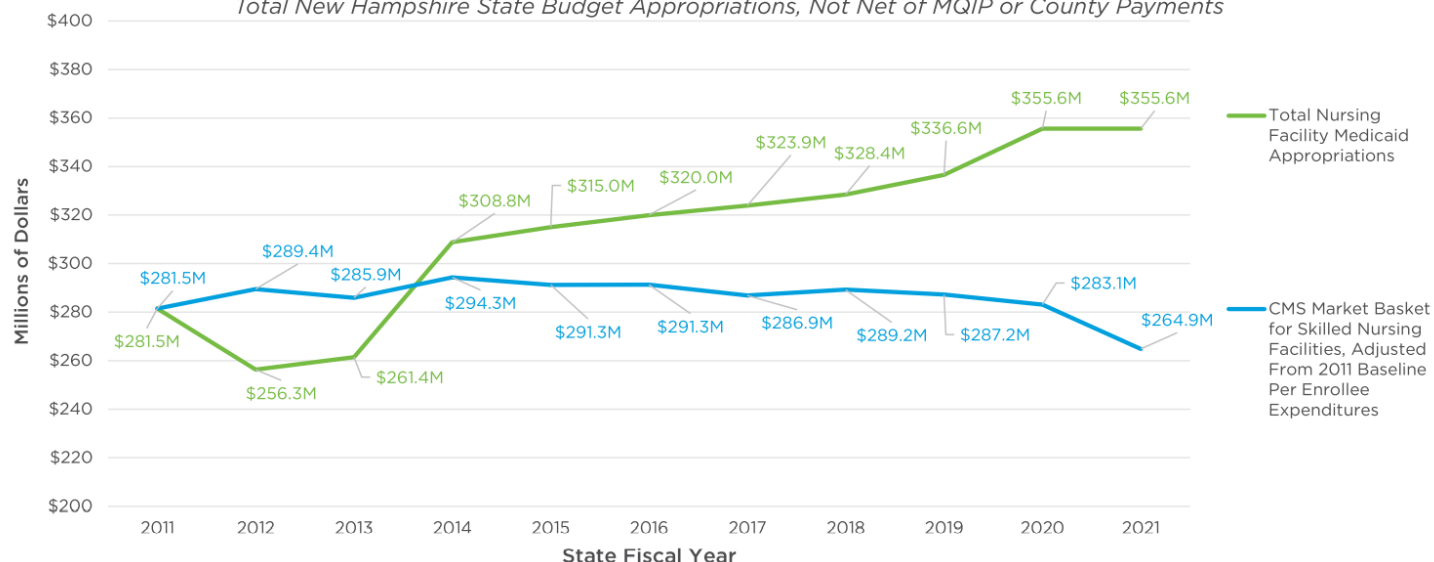
Relative to CFI waiver service funding, support for nursing facilities in the State Budget has kept pace with the relevant CMS Market Basket inflation measure in a more favorable manner for service provision. Relative to SFY 2011, aggregate State Budget funding for nursing facility Medicaid services fell below CMS Market Basket cost increase estimates for skilled nursing facilities in SFYs 2012 and 2013, but increased in SFY 2014 and grew in line with, or slightly faster than, the relevant CMS Market Basket index calculations would suggest since that time. The largest deviation has been a budget increase in SFY 2020, but there was no budget increase in SFY 2021 relative to SFY 2020. As with the analysis of CFI waiver services funding, using SFY 2011 as a benchmark year is not designed to indicate funding was sufficient for service delivery in that year relative to other years.



Medicaid nursing facility enrollment has declined in recent years, with a faster decline in SFY 2021, likely due to the impacts of the pandemic. In SFY 2011, the original State Budget appropriations per actual Medicaid enrollee that received nursing facility services in SFY 2011 was \$65,812. Adjusting this SFY 2011 per enrollee appropriation to future years by the CMS Market Basket costs and the number of Medicaid nursing facility enrollees shows that nursing facility funding has exceeded the SFY 2011 costs per enrollee. As with the analyses above, using SFY 2011 as a benchmark year does not indicate that funding levels in that year were optimal for successful service delivery. Nursing facilities may have experienced increased costs on a per enrollee basis during this period due to other factors, such as changes in average Medicaid resident acuity. Nursing facilities also likely faced increased costs per resident due to the pandemic.

FUNDING FOR NURSING FACILITY MEDICAID SERVICES, ACTUAL AND RELATIVE TO FEDERAL INFLATION MEASURE ON A PER ENROLLEE EXPENDITURE BASIS

Total New Hampshire State Budget Appropriations, Not Net of MQIP or County Payments



Sources: New Hampshire Office of Legislative Budget Assistant; New Hampshire Department of Health and Human Services; U.S. Centers for Medicare and Medicaid Services

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Funding trends relative to inflation and enrollment for both CFI waiver services and for nursing facility services suggest that the cost reporting infrastructure used to inform nursing facility Medicaid reimbursement rates reduces the risk of underfunding for services relative to the process for CFI waiver services. The CMS Market Basket cost indices and the comparisons of individual CFI Medicaid reimbursement rates to various measures of inflation suggest funding has tracked service cost delivery changes over time more poorly for CFI services than the aggregate levels of funding for nursing facility services. Nursing facilities will continue to face growing costs and provide critical services to Medicaid patients over time, particularly as more older adults are in need of nursing-level care in the state; the cost reporting requirements for nursing facilities may have been helpful in keeping State Medicaid reimbursement levels closer to meeting those costs than the methodology for funding adjustments to CFI services.

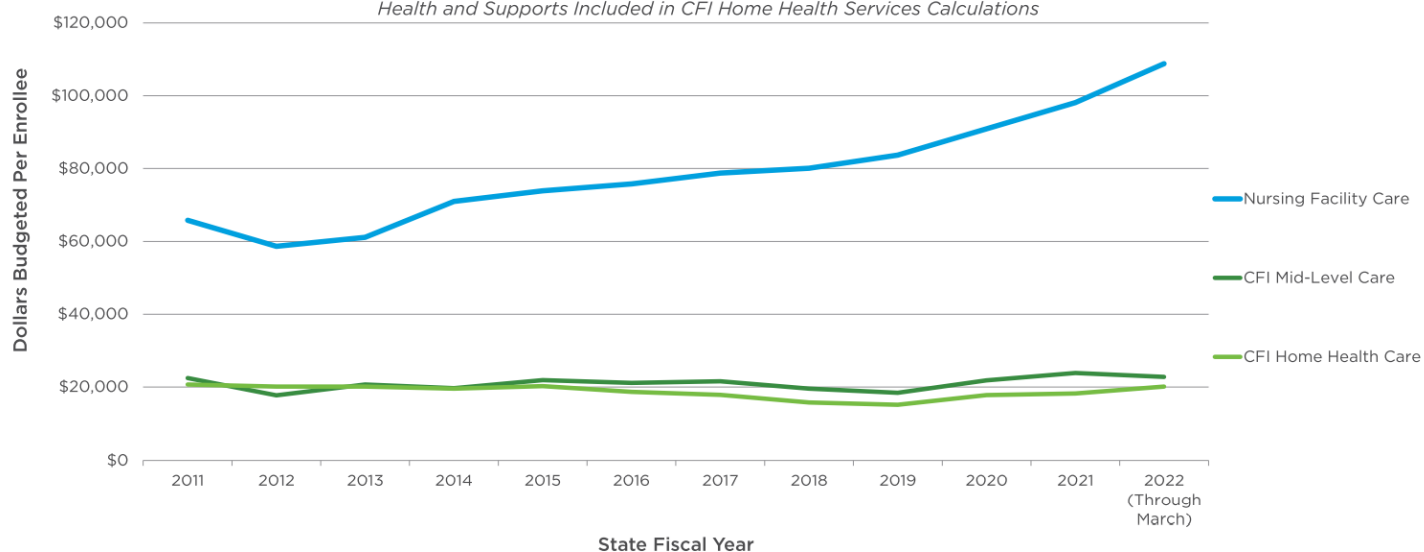
RELATIVE COSTS OF NURSING FACILITY AND CFI WAIVER SERVICES

Medicaid-funded nursing facility services cost more, on a per enrollee basis, than CFI waiver services. The SFY 2021 State Budget appropriations for nursing facility services, including MQIP and ProShare, totaled approximately \$98,111 for each enrollee, based on the actual average number of enrolled Medicaid individuals in nursing home beds over the course of that year. Costs per resident appeared to rise in SFY 2022, as enrollment dropped and nursing facilities likely faced ongoing higher expenses associated with the pandemic. Medicaid nursing facility services funding had also been rising on a per enrollee basis in the years before the pandemic as well, unadjusted for inflation.

CFI waiver services appropriations, however, have remained fairly steady on a per enrollee basis from SFY 2011 to SFY 2022. Even without adjusting for inflation, per enrollee costs for home health services and for mid-level services, focused on those residents in assisted living facilities, have remained within a relatively narrow band. CFI mid-level services lowest per enrollee appropriations were in SFY 2012, at \$17,755 per enrollee, while the highest per enrollee allocation was \$23,896 in SFY 2021. For CFI home health services, appropriations dropped as low as \$15,137 per enrollee in SFY 2019, and had their highest level during this period at the beginning of the time window analyzed, at \$20,686 in SFY 2011. State Budget appropriations per actual enrollee across all CFI services in SFY 2021 totaled \$18,997, an increase from a total across all CFI services of \$15,616 in SFY 2019. While actual expenditures varied from appropriations amounts, these levels show the costs of CFI waiver services for each person served were substantially lower than the nursing facility services paid for by Medicaid.

NEW HAMPSHIRE BUDGETED APPROPRIATIONS FOR MEDICAID SERVICE TYPES PER CAPITA, BASED ON ACTUAL AVERAGE FISCAL YEAR ENROLLMENT

Nursing Facility Payments Include Nursing Home, Medicaid Quality Incentive, and ProShare Payments, Home Health and Supports Included in CFI Home Health Services Calculations



Note: "Other Nursing Services" excluded. The annual average enrollment in "Other Nursing Services" in SFY 2021 was 22 people.
Sources: New Hampshire Department of Health and Human Services Operating Statistics Dashboard; Office of Legislative Budget Assistant

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The federal government requires that HCBS waivers be no more costly than the average costs of providing institutional care through non-waiver Medicaid services.⁶⁵ While more recent analyses were not available publicly, reports from the State of New Hampshire to the federal government identified substantial differences in Medicaid costs through the waiver services in SFYs 2016, 2017, and 2018 relative to estimated costs if the same individuals would have otherwise received if the CFI waiver had been unavailable. The State reported to the federal government that, in SFY 2018, per capita waiver and other associated Medicaid costs would total \$28,070, while if those same enrollees had received care in an institutional setting, the annual per capita Medicaid cost would have been \$51,751.⁶⁶

Individuals and families may choose to enroll in Medicaid HCBS or in a nursing facility for the services they need, and those services may be better provided in a nursing facility or through HCBS, depending on the individual situations. As enrollees receiving services through CFI must meet the same clinical eligibility criteria as those who are receiving services in nursing facilities, helping ensure awareness of, and access to, CFI services may result in reduced costs for New Hampshire Medicaid overall.

NATIONAL TRENDS IN MEDICAID LTSS EXPENDITURES

The percentage of total nationwide Medicaid expenditures that are Medicaid LTSS expenditures has decreased from 47 percent in Federal Fiscal Year (FFY) 1988 to 34 percent in FFY 2019. This decrease primarily reflects two key trends. First, Medicaid generally has increased spending for populations that typically do not use LTSS, as the composition of Medicaid-eligible populations has shifted to include more children and younger adults. Second, states have undertaken efforts to rebalance expenditures toward more cost-effective HCBS and away from typically more expensive institutional settings.⁶⁷

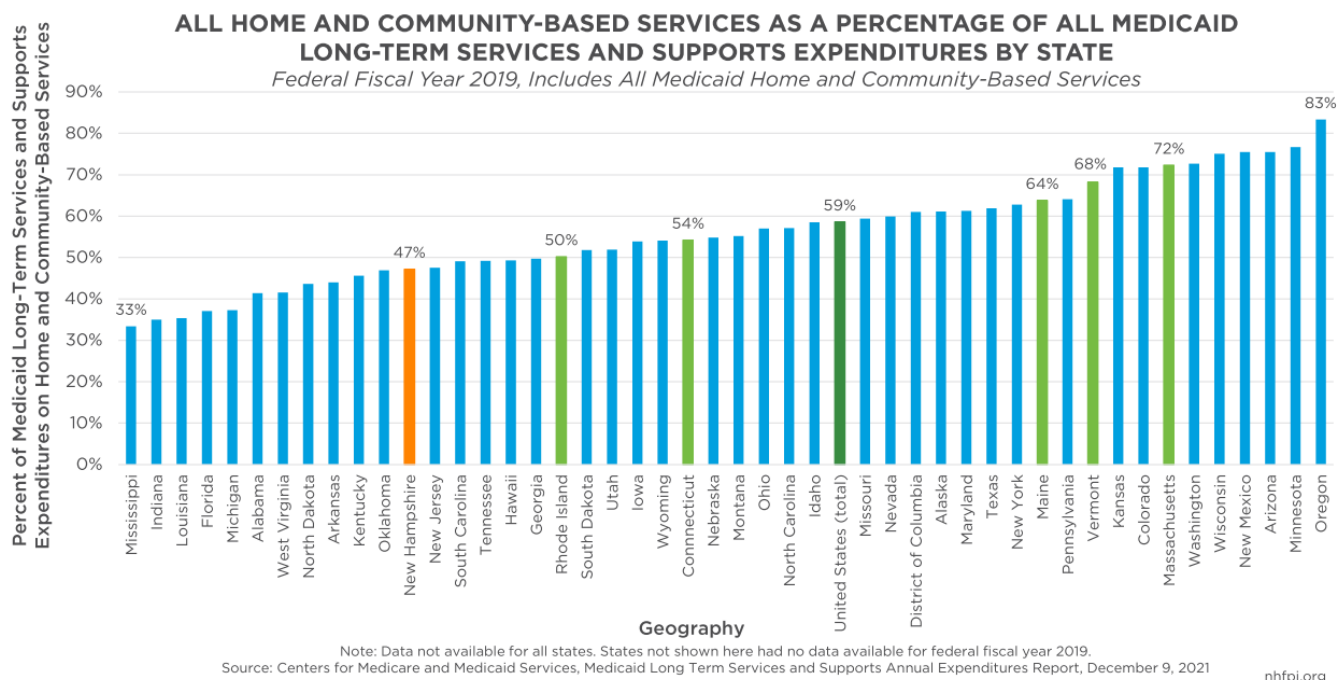
Even as LTSS expenditures as a share of all Medicaid expenses have fallen, Medicaid HCBS expenditures have risen as a percentage of all Medicaid LTSS expenditures. About 88 percent of Medicaid LTSS expenditures were for institutional LTSS care in FFY 1989, but that figure had dropped to about 41 percent in FFY 2019.⁶⁸

Nationally, in FFY 2019, nursing facilities accounted for 80 percent of Medicaid LTSS institutional care settings, with the remainder almost entirely for intermediate care facilities for individuals with developmental disabilities or for mental health facilities and hospitals caring for Medicaid mental health patients.⁶⁹

The national figures for HCBS expenditures were less concentrated within a few service types. Medicaid 1915(c) waivers fund HCBS through Medicaid waivers directly, while 1915(k) waivers provide a mechanism for incorporating HCBS services into the State Plan for traditional Medicaid.⁷⁰ About 51 percent of Medicaid HCBS expenditures were through a Section 1915(c) Medicaid waiver program of some form (which is the form of the four key New Hampshire Medicaid waivers), 22 percent in personal care, 7 percent in HCBS programs authorized under Section 1915(k) waivers, 5 percent in home health, 3 percent in rehabilitative services, and the remainder in other managed care LTSS HCBS or other services.⁷¹ In February 2020, all states offered services through at least one HCBS waiver, and all states offered home health state Medicaid plan services.⁷²

In FFY 2019, the percentage of LTSS expenditures that were on HCBS, rather than institutional care, varied widely among the states. In FFY 2019, with 59 percent of all Medicaid LTSS nationally on HCBS, Mississippi had only 33.4 percent of LTSS expenditures on HCBS, the lowest percentage of any state. Oregon had the highest percentage of Medicaid LTSS dollars spent on HCBS, totaling 83.3 percent in FFY 2019.⁷³

New Hampshire was below the national average for HCBS expenditures, with 47.2 percent of the total Medicaid LTSS on non-institutional, HCBS forms of care. New Hampshire was the lowest percentage among its immediate neighbors in FFY 2019, with Maine at 63.8 percent, Vermont at 68.2 percent, and Massachusetts at 72.3 percent. New Hampshire had the twelfth-lowest percentage among the 46 states measured by the U.S. Center for Medicare and Medicaid Services in FFY 2019.⁷⁴ This relatively low percentage indicates a smaller percentage of the public dollars going to LTSS through Medicaid were funding services for people directly in their homes or communities in New Hampshire than in the majority of other states.



In FFY 2019, Medicaid Section 1915(c) waivers accounted for approximately 27 percent of all Medicaid LTSS expenditures nationally.⁷⁵ Of these 1915(c) waiver expenditures, about 75 percent were on services for autism spectrum disorder, developmental disabilities, or intellectual disabilities. About 20 percent of these expenditures were on services for older adults and people with physical or other disabilities. Just under 4 percent of expenditures were for people receiving services from programs that can service multiple groups, while just over 1 percent were

for brain injury treatment. The remainder of Section 1915(c) expenditures were for services for those who were medically fragile, in need of mental health services, or related services.⁷⁶

An analysis of Section 1915(c) waivers nationwide showed growth in expenditures overall between FFY 2013 and FFY 2016, but New Hampshire's Choices for Independence Medicaid Waiver saw its expenditures decrease over that time period in this analysis.⁷⁷ Nationally, 1915(c) Medicaid waiver expenditures had an annual compound growth rate of 5.9 percent, while the corresponding annual growth rate for New Hampshire in this time period was 5.1 percent. The annual compound growth rate for waivers serving older adults and people with physical disabilities was 5.5 percent nationally during this period; in New Hampshire, the analysis showed the equivalent rate was negative 0.5 percent, declining half a percent each year on average, for the Choices for Independence Medicaid Waiver.⁷⁸

A Kaiser Family Foundation analysis of Section 1915(c) waiver expenditures per enrollee by state in FY 2018 estimated that New Hampshire spent \$12,700 per enrollee on the 1915(c) waiver services for "Seniors & Adults with Physical Disabilities." In this same category of waiver, 37 states had a spending per enrollee of \$15,200. Two other categories of target populations for 1915(c) waivers, "Seniors" and "Adults with Physical Disabilities," also had measures for overall costs per enrollee and potentially cover some of the same populations as the broader category of "Seniors & Adults with Physical Disabilities" with 37 states, which included New Hampshire. The "Seniors" category, which included eight states, had a total cost per enrollee of \$9,800, while the "Adults with Physical Disabilities" category had an expenditure per enrollee of \$28,300 across 16 states. These data, and the individual state-by-state estimates, suggest substantially different costs for enrollees and populations served by the combined waivers in the 37 states reporting them.⁷⁹

In 2018, an analysis from the AARP Public Policy Institute showed that New Hampshire had the lowest percentage of Medicaid HCBS spending as a percentage of LTSS expenditures for older people and adults with physical disabilities of any state and the District of Columbia except Kentucky, based on 2016 data. New Hampshire ranked 42nd among the 51 entities in a comparable analysis of expenditure data from 2011.⁸⁰ Updated analyses comparing state expenditures have likely been limited by data reporting changes, based on assessments of data quality, from the federal government.⁸¹

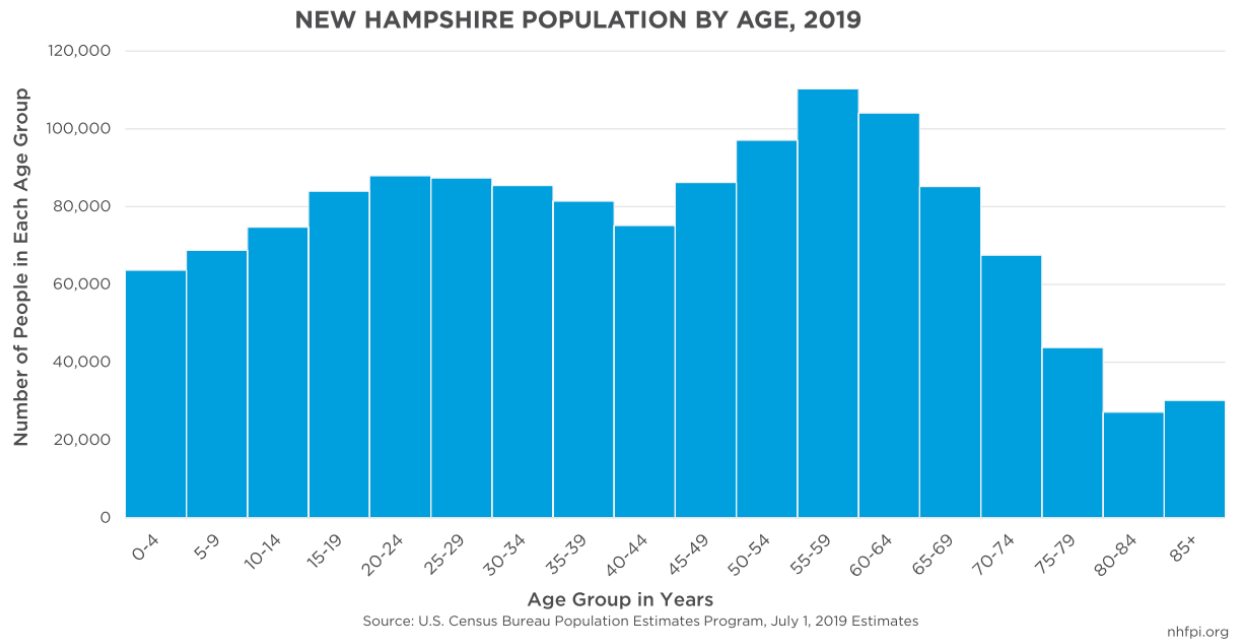
EVALUATING LTSS SUPPLY AND DEMAND IN NEW HAMPSHIRE

To better understand trends in Medicaid LTSS expenditures designed to serve older adults and adults with physical disabilities in New Hampshire, contextual information can provide insights into the supply of, and demand for, these services. The supply of Medicaid LTSS includes both budgeted appropriations and provider capacity. The demand for these services stems from the need in the Granite State population and the extent to which residents in need are aware of these services, can seek them out, and access them successfully.

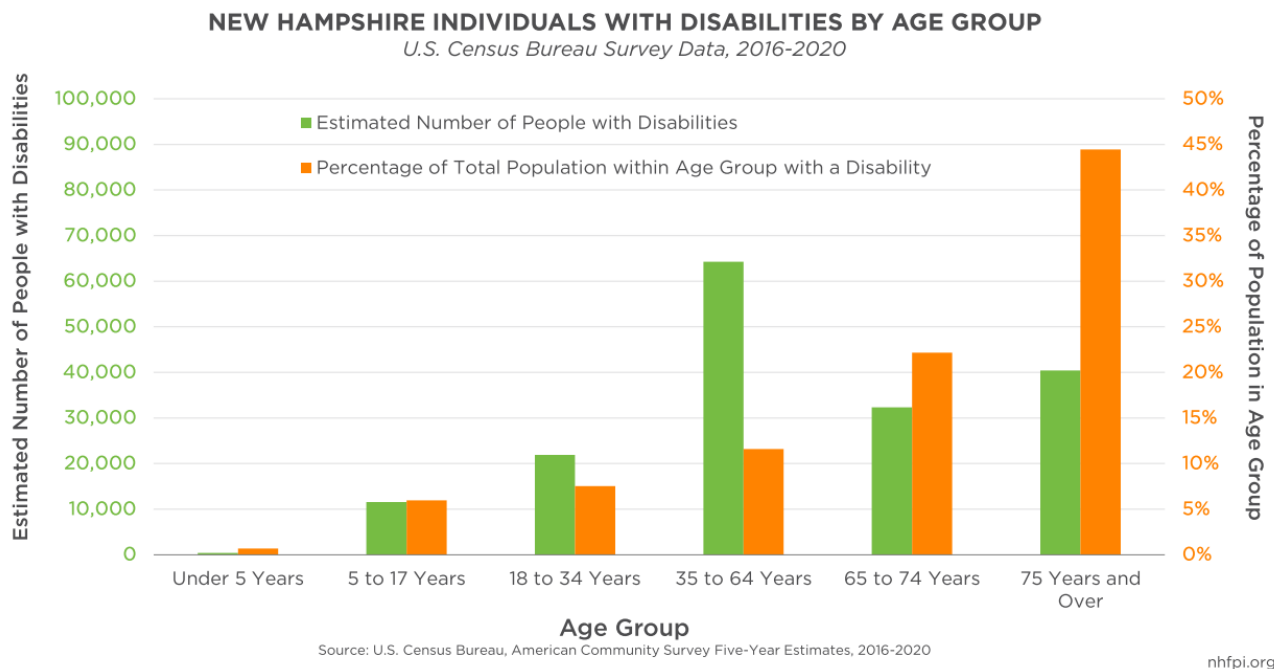
DEMOGRAPHIC TRENDS SHOW INCREASED NEED AND FEWER WORKERS

New Hampshire is demographically older than most states. In 2019, the median age of New Hampshire's population was 43.0 years, and statistically indistinguishable from both Vermont (42.8 years) and West Virginia (42.9 years). All three states were effectively tied for being the second-oldest state by this measure, surpassed only by Maine (45.1 years) and followed by Florida (42.4 years). For the United States as a whole, the median age was 38.5 years in 2019.⁸² Certain areas of New Hampshire, particularly rural areas and popular destinations for retirees, have higher populations of older adults. Based on data collected from 2016 to 2020, the estimated median age in Carroll County was 53.4 years old, while it was 48.7 years in Coos County and 47.9 years in Belknap County.⁸³ In September 2016, the New Hampshire Office of Energy and Planning estimated that a third of the state's population would be age 60 years or older by 2030, and more than one out of every ten Granite Staters would be over age 80 years by 2040.⁸⁴ In 2019, an estimated 34 percent of New Hampshire's population was age 55 years or older, and nearly 19 percent were age 65 years or older. More than 200,000 residents, or about 16 percent of the state's population, were

estimated to be between the ages of 55 and 64 in 2019, which was the largest ten-year age group in the state in these estimates.⁸⁵



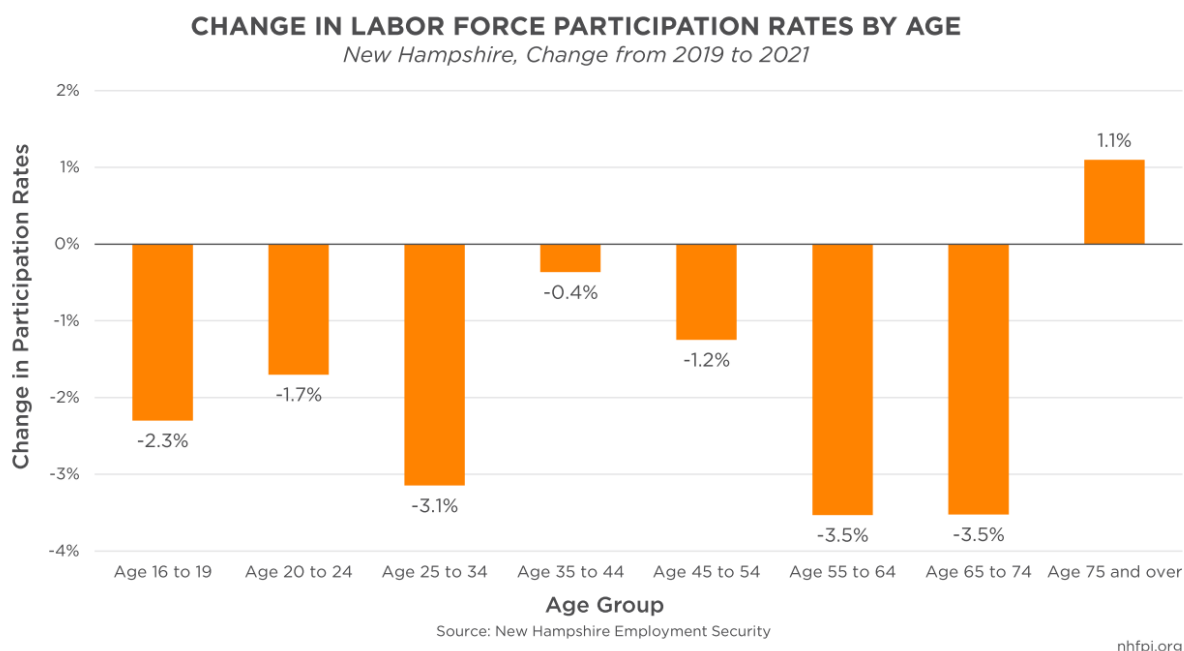
Data suggest older adults are more likely to be experiencing a disability, and an older population will likely have higher aggregate care needs. Survey data of New Hampshire residents collected from 2016 to 2020 indicate that about 12.8 percent of the total noninstitutionalized population in New Hampshire has a disability identified in the U.S. Census Bureau’s survey questions, and the percentage rises with age. In the population age 65 to 74 years, 22.2 percent reported some form of disability, and the percentage rose to 44.4 percent for the population age 75 years and older. About 10.4 percent of the population age 65 years and older reported an independent living difficulty, including 18.5 percent of the population age 75 years and older. About 9.2 percent of adults age 75 years and older reported a self-care difficulty, and 26.2 percent reported an ambulatory difficulty. About 10.2 percent of the population age 75 years and older were estimated to have a cognitive difficulty.⁸⁶



The aging of New Hampshire's population has both short-term and long-term workforce implications. In 2019, the labor force participation rate for New Hampshire residents age 55 to 64 was about 76 percent, dropping to about 72 percent in 2021, likely due in part to the impacts of the pandemic. The labor force participation for residents age 65 to 74 years was 33 percent in 2019, and just under 30 percent in 2021.⁸⁷ As a significant number of New Hampshire residents age out of the labor force, New Hampshire will be relying increasingly on a smaller number of younger workers. Between the 2010 Census and the 2020 Census, the size of New Hampshire's population under age 18 years dropped by 10.6 percent, the largest decline of any state. Nationwide, the population of children dropped 1.4 percent between the 2010 and 2020 Census counts.⁸⁸ The declining number of children in New Hampshire has long-term implications for the state's workforce and the corresponding ability to care for older adults.

WORKFORCE CONSTRAINTS LIMITING SERVICES

Long-term demographic changes and the short-term impacts of the pandemic have created acute workforce constraints in New Hampshire. Estimates from the U.S. Bureau of Labor Statistics showed about 61,000 job openings in New Hampshire in February 2022, while only about 20,500 residents in the state were unemployed and looking for work that month.⁸⁹ The state's unemployment rate fell to a seasonally-adjusted 2.3 percent in April 2022, the lowest comparable monthly estimated unemployment rate since May 1988.⁹⁰ The size of New Hampshire's workforce in April 2022, or the total number of state residents who were working or looking for work, was estimated to be about 23,700 people (4.1 percent) below its pre-pandemic peak of July 2019, and about 14,000 people (1.8 percent) smaller than in April 2019.⁹¹ A decline in the size of the workforce following the onset of the pandemic is primarily due to declines in workforce participation among younger adults, age 25 to 34 years, and older adults, age 55 to 74 years. The younger adults are at an age at which they may have young children and may have experienced difficulty finding child care during the pandemic, while older adults may have either taken themselves out of the workforce temporarily during the pandemic or permanently retired from the labor force.⁹²



With a workforce constraint and an ongoing pandemic, the health care industry has struggled to attract a sufficient number of workers in New Hampshire. Health care providers had difficulty attracting enough workers prior to the pandemic to meet needs as well; job openings in HCBS, skilled nursing facilities, continuing care, and retirement facilities have increased at a faster rate than overall job openings in New Hampshire since at least early 2019, and have approximately doubled in the last six years.⁹³

In a survey of the seven active CFI case management agencies in New Hampshire in January 2019, all seven (100 percent) indicated an individual might not receive CFI services because there are not enough available workers to meet the overall need for services or available workers at the times when services are needed. In that survey, five agencies (71.4 percent) noted that pay for staffing or Medicaid reimbursement rates should be increased, while a sixth noted providers are unable to hire or retain workers. Six agencies (85.7 percent) indicated that authorized CFI services were not received in full due to unfilled positions or a shortage of workforce availability “Very Often,” with the seventh indicating the frequency was “Often.” The seven case management agencies were also asked to characterize how the availability of workers to meet CFI service delivery needs had changed since December 2015, when New Hampshire’s estimated unemployment rate dropped below 3.0 percent. When given five options ranging from “Increased Significantly” to “Decreased Significantly” for their responses, all seven agencies (100 percent) indicated the availability of workers had “Decreased Significantly.” Survey respondents indicated in short-answer responses that often CFI services could offer few, if any, choices when only one provider was available. The CFI case management agencies also all noted that providers could rarely or very rarely fulfill requests for services on nights and weekends, and six indicated coverage of services on nights and weekends were more difficult to meet than they were three years before.⁹⁴ New Hampshire providers and health care professionals interviewed during late 2021 and early 2022 all indicated that the availability of workforce for their operations had declined since the pandemic began in early 2020.

The decline in labor force participation among all workers, but particularly among older workers, is likely contributing to the workforce shortage. In 2004, a total of about 24,300 workers were employed in New Hampshire in nursing and residential care facilities as well as social assistance jobs, which could be considered jobs caring for older adults and directly adjacent positions in the same field. Of those workers, about 13.7 percent were aged 55 to 64 years, and 4.2 percent were aged 65 years and older. In 2021, those percentages had shifted to 19.9 percent of workers falling into the age 55-to-64-year age bracket, and 9.0 percent of workers aged 65 years or older, more than double the percentage 65 and older of seventeen years earlier. The total number of people working in those industries in New Hampshire rose from the 2004 levels to more than 33,900 workers in 2019, before sliding below 31,700 workers on average in 2021.⁹⁵ Considering only employment in home health care services and in nursing care facilities, the percentage of workers age 55 to 64 years old rose from 15.8 percent in 2004 to 22.3 percent in 2021, and workers aged 65 years and older rose from 4.3 percent to 8.6 percent, also doubling as a percentage of all workers relative to 2004.⁹⁶ This reliance on older workers means the long-term care workforce is at risk of losing significant numbers of current employees to retirement in the next ten years.

HCBS WORKER COMPENSATION LOWER THAN IN NEIGHBORING STATES

While the overall labor force remains smaller than it was prior to the pandemic, New Hampshire’s health care workforce has been particularly constrained. The estimated number of Granite Staters employed in health care and social assistance in May 2022 was 2,300 people (2.4 percent) lower than in May 2019, and 3,600 below the seasonally-adjusted peak of 95,500 in February 2020.⁹⁷ This reduction has reportedly impacted capacity across all long-term care settings, including shortages of nurses, nursing assistants, and HCBS workers, and could contribute to more workers leaving health care or shifting positions within the sector at a faster pace.⁹⁸ While wages in key sectors, including sectors outside of health services, have increased in response to the reduced supply of workers in New Hampshire, compensation for providing HCBS for Granite Staters have lagged behind wages for the same positions in neighboring states.

In May 2021, the median hourly wage paid to home health and personal care aides in New Hampshire was \$14.12, which was lower than the median hourly wages for these positions in Maine (\$14.28), Vermont (\$14.44), and Massachusetts (\$17.45). In May 2021, for the lowest wage workers in these positions, or those workers for whom only 10 percent of other workers in these positions were earning less, the gap between pay in New Hampshire and in other states was wider.⁹⁹

Home health and personal care aide workers at the tenth percentile of earners in New Hampshire earned \$11.56 per hour, well below the tenth percentile wage in Vermont (\$13.32), Maine (\$13.65), and Massachusetts (\$14.28). For

example, if a full-time worker making the tenth percentile home health and personal care aide wage in New Hampshire decides to take a job making the equivalent relative wage in Massachusetts, their annual income would increase \$5,670 (23.6 percent).¹⁰⁰

ESTIMATED HOURLY WAGES FOR HOME HEALTH AND PERSONAL CARE AIDES BY STATE AND RELATIVE WAGE LEVEL, MAY 2021				
Relative Wage Level	Maine	Massachusetts	New Hampshire	Vermont
10th Percentile	\$13.65	\$14.28	\$11.56	\$13.32
25th Percentile	\$13.94	\$14.81	\$13.52	\$14.07
50th Percentile (Median)	\$14.28	\$17.45	\$14.12	\$14.44
75th Percentile	\$17.23	\$17.68	\$16.40	\$17.98
90th Percentile	\$18.03	\$18.08	\$18.14	\$22.57

Source: U.S. Bureau of Labor Statistics, Occupational Employment and Wage Statistics, May 2021.

NHFPI's analysis of wages for home health aides and personal care aides among New Hampshire and its neighbors in the 2013 to 2017 time period also showed New Hampshire's wages for the lowest paid workers in these jobs were growing more slowly than in neighboring states. Public policies have likely impacted these wages and their growth rates over time. Medicaid reimbursement rate policies may be more likely to impact lower-paid workers, as Medicaid reimbursement rates for services are typically lower than reimbursement rates from Medicare or private-sector insurance companies, and may provide coverage for different types of services. Providers primarily serving Medicaid patients may be more likely to pay their workers lower amounts than providers that rely on a mix of payers through non-Medicaid clients, as the typically lower Medicaid reimbursements would only support more limited wages.¹⁰¹ Additionally, New Hampshire's minimum wage was at least \$5 per hour lower than all other New England states at the beginning of 2022, and Massachusetts had a minimum wage of \$14.25 per hour, the highest in the region, relative to New Hampshire's \$7.25 per hour.¹⁰²

Nursing assistants had wages in New Hampshire that were closer to those in neighboring states than wages for home health aides in May 2021, and New Hampshire's hourly pay generally only trailed wages in Massachusetts. Nursing assistants work under the director of licensed nursing staff in a health or nursing facility.¹⁰³ At the tenth percentile, hourly wages were nearly identical across Maine (\$13.99), New Hampshire (\$14.01), and Vermont (\$14.01), and were slightly higher in Massachusetts (\$14.38). New Hampshire had the second highest median wage (\$17.68) after Massachusetts (\$17.97), higher than Vermont (\$17.59) and Maine (\$17.33).¹⁰⁴ As with home health care, a variety of occupations are employed in the delivery of skilled nursing facility services beyond the nursing assistants job description used in this analysis.

ESTIMATED HOURLY WAGES FOR NURSING ASSISTANTS BY STATE AND RELATIVE WAGE LEVEL, MAY 2021				
Relative Wage Level	Maine	Massachusetts	New Hampshire	Vermont
10th Percentile	\$13.99	\$14.38	\$14.01	\$14.01
25th Percentile	\$14.24	\$15.06	\$14.50	\$14.21
50th Percentile (Median)	\$17.33	\$17.97	\$17.68	\$17.59
75th Percentile	\$17.86	\$18.29	\$18.15	\$17.92
90th Percentile	\$18.63	\$22.73	\$22.04	\$20.39

Source: U.S. Bureau of Labor Statistics, Occupational Employment and Wage Statistics, May 2021.

The relatively detailed cost reporting for nursing facilities that informs reimbursement rates may help wages for nursing assistants and other employees at nursing facilities match wages in neighboring states more closely than the reimbursements for CFI waiver services, which do not have such detailed cost reporting and may become less competitive with those in other states without more detailed forms of monitoring.

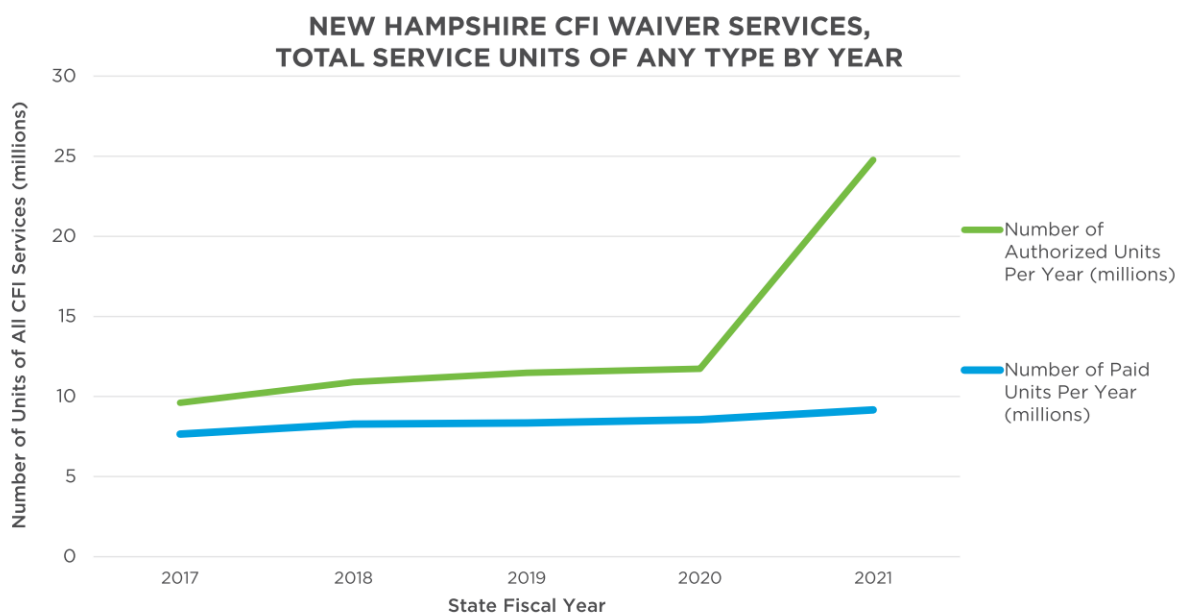
CFI WAIVER SERVICE AUTHORIZATIONS AND DELIVERY SUGGEST LIMITED SUPPLY, UNMET DEMAND

CFI services are authorized for enrollees based on their service needs, after being requested by case management agencies. If approved, those services are authorized through the State's Medicaid program. However, not all of those authorized services are fulfilled, indicating some authorized services were not delivered or paid for by Medicaid.¹⁰⁵

Unfulfilled Medicaid authorized services may be the result of many factors, ranging from temporary changes in needs to inclement weather.¹⁰⁶ Limited workforce availability to deliver these services has likely been a key factor in unfilled authorized units of approved CFI services in recent years.¹⁰⁷ As noted above, in a 2019 NHFPI survey of the seven CFI case management agencies operating at that time, six agencies (85.7 percent) indicated that authorized CFI services were not received in full due to unfilled positions or a shortage of workforce availability "Very Often," with the seventh indicating the frequency of reduced delivery was "Often."¹⁰⁸

The workforce shortage and other challenges have led to a significant number of Medicaid service units authorized to be unfulfilled in recent years. The percentage of authorized units of service of any kind that were actually paid declined from 79.7 percent in SFY 2017 to 72.7 percent in SFY 2019, according to data provided by the DHHS. The percentage of the total dollar value of authorized units that were actually paid was 81.4 percent in SFY 2017, falling to 76.1 percent in SFY 2019. SFY 2020, which included the first three and a half months of the pandemic's impacts, yielded a slight increase in actual reimbursement for both units (72.9 percent) and dollars (77.1 percent) authorized through the CFI waiver.

However, SFY 2021 saw a dramatic increase in CFI units authorized, and a similar rise in the amount of dollars permitted to be spent through Medicaid. The number of CFI service units of any type authorized rose from about 11.7 million to nearly 24.8 million, or an increase of 111.3 percent from SFY 2020. The number of dollars authorized rose from about \$85.2 million in SFY 2020 to approximately \$190.8 million in SFY 2021, which was an increase of 124.0 percent and well above the SFY 2021 CFI waiver services State Budget appropriations of nearly \$72.1 million.¹⁰⁹



Source: New Hampshire Department of Health and Human Services, Data Through December 28, 2021

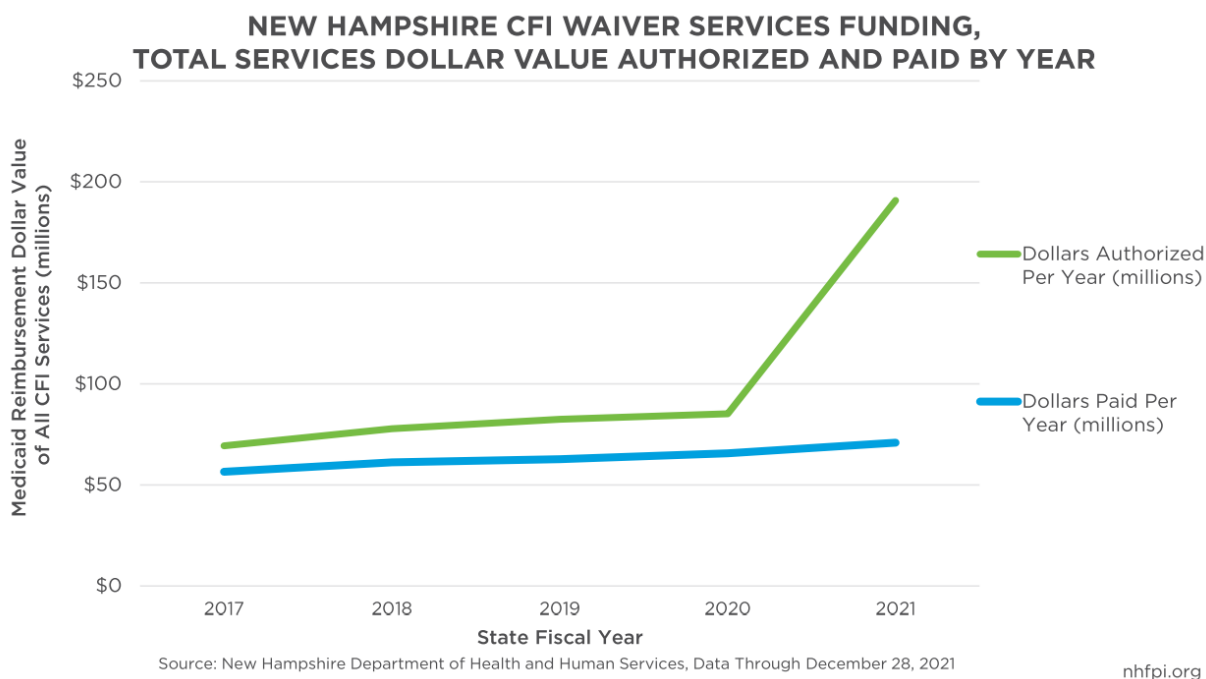
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The DHHS identified several key reasons for the significant increase in authorized services during SFY 2021.¹¹⁰ The federal Public Health Emergency associated with the COVID-19 pandemic is a key factor, as people may have become more interested in HCBS, rather than nursing facilities, and the State has generally not disenrolled people from Medicaid while the provisions of the federal Public Health Emergency are in effect.¹¹¹ The ability to provide key services through telehealth could have also increased the number of services sought and authorized.¹¹² The pandemic's economic and health impacts and other population-based factors may have also contributed to the number of people financially and medically eligible for CFI services under Medicaid.¹¹³

The DHHS also indicated that lifting prior limitations on environmental modifications, which support making homes and living spaces more accessible or conducive to treatments, may have helped boost authorized services. DHHS data show "Environmental Accessibility Adaptations" units authorized increased 337.4 percent from SFY 2020 to SFY 2021, but the total number and cost of these units do not explain most of the CFI authorized services increase; the total authorized cost increase from the boost in Environmental Accessibility Adaptations was approximately \$2.7 million.

Another potential factor is the removal of the relative cap on CFI waiver services cost relative to nursing facility costs. This statutory cap limited the average costs of CFI mid-level and home-based care to 60 percent and 50 percent, respectively, of the cost service provision in nursing facilities. That two-part cap on costs was removed January 1, 2021.¹¹⁴

Although the number of units authorized and their dollar value increased dramatically in SFY 2021 relative to SFY 2020, the number of units paid did not. Between SFY 2020 and SFY 2021, while the number of units authorized increased 111.3 percent, the number of units actually paid increased 7.2 percent, which was smaller than the 8.2 percent increase between SFYs 2017 and 2018, according to data provided by the DHHS. The percentage of all authorized units actually paid in SFY 2021 was 37.0 percent, and the percentage of the total number of authorized dollars that were actually paid was 37.2 percent.



While this shortfall is an underutilization of available services, the gap between services authorized and those actually delivered was likely substantially limited by provider capacity, rather than a lack of need on the part of Medicaid enrollees. Authorization through Medicaid is a critical step, but actual service delivery requires the available provider agencies and workforce to provide those services. The increase in authorized service units likely helped enable a rise

in the number and volume of services delivered, but the total increase in authorizations may have substantially outpaced the ability of providers to supply services with available workforce and existing reimbursement rates.

The increases in authorizations for SFY 2021 also suggest that the need for CFI waiver services, and potentially previously unrecognized needs, could support a substantially larger number of CFI services delivered. While a portion of these additional authorizations for SFY 2021 may be associated with the pandemic and temporary, the magnitude of the increase suggests prior underutilization was likely not due to a lack of demand from those in need of services, but rather from other factors, such as a lack of available and accessible workforce for service providers.

KEY AREAS OF CONCERN

This analysis of the Medicaid-funded LTSS systems designed to support older adults and people with physical disabilities in New Hampshire has identified two key areas of concern. The first area is the timely accessibility of Medicaid LTSS services through the existing Medicaid application processes. The second area of concern is regarding the interaction of relatively low reimbursement rates and limited workforce availability, which restricts provider capacity to provide these key services to Granite Staters in need.

MEDICAID APPLICATION DIFFICULTIES AND DELAYS IN SERVICES

In the interviews conducted with officials and stakeholders engaged in the long-term care system in New Hampshire, almost all reported that they were aware of issues of delays in processing applications. Although there were some issues relating to clinical or medical eligibility, the primary reasons for these delays appeared to be relative to financial eligibility, according to these interviewees. At least eight people with firsthand knowledge of the system indicated there were delays in applications and enrollment that were largely related to the processing of financial eligibility. Publications from two independent entities also reflected these concerns.

THE GUIDEHOUSE REPORT

The firm Guidehouse, Inc., under contract with the DHHS, conducted a DHHS-published 2021 report titled “New Hampshire Long Term Supports and Services for Seniors & Individuals with Physical Disabilities, Findings and Recommendations” (Guidehouse Report).¹¹⁵ The Guidehouse Report’s findings and recommendations include comments from DHHS staff, as well as providers, consumers, and others familiar with the LTSS System in New Hampshire relative to care for older adults and adults with physical disabilities.

The Guidehouse Report stated that CMS requires Medicaid LTSS eligibility determinations to be made within 90 days of application; however, there are exceptions to this rule if applicant documentation is not provided in a timely manner. According to the Guidehouse Report:

- Based on Medicaid eligibility determination data for applications completed from July 2019 to April 2020, the Guidehouse Report’s authors estimated that the median number of days used to process applications was 65.
- A DHHS team sampled 82 applications that were above 90 days in application processing time and found that 77 percent of these applications were delayed because the applicant, bank or insurance company, or nursing facility failed to provide financial or medical documentation in a timely manner. The report noted that the interviewed key informants identified long delays, primarily due to the financial eligibility process for Medicaid, can lead to institutionalization and increases risks related to health and wellness.
- There were “several external factors that may negatively impact determination timeframes: ...It takes some banks or life insurance companies 30-45 days to provide requested information. Family members filling out applications are not aware of all of the applicant’s financial information, which requires additional time.”

- In a survey conducted as a component of the research for the Guidehouse Report, 41 percent of the 47 key informant respondents strongly disagreed with the statement “The Medicaid eligibility process is clear and timely,” and another 30 percent disagreed with the statement; only 2 percent agreed and 2 percent strongly agreed with the statement.¹¹⁶
- Given the number of available documents and websites, the Guidehouse Report’s authors found it was unclear where consumers and providers should go to better understand financial documentation requirements for Medicaid LTSS coverage.
- The survey responses published in the Guidehouse Report reinforced the confusion regarding explanatory documents, as 41 percent of respondents disagreed with the statement “It is easy for participants to access and learn about available LTSS,” and another 20 percent strongly disagreed, while only 14 percent agreed and no respondents strongly agreed.
- Some of the Medicaid LTSS eligibility materials online were outdated, and the Guidehouse Report recommended these materials be removed.
- Certain DHHS financial documentation standards were inconsistent across public-facing materials. Appendix D of the Guidehouse Report provides a comparison of Medicaid LTSS financial eligibility requirements across DHHS documentation.¹¹⁷

In interviews with stakeholders, including State staff and other informants, the Guidehouse Report’s authors noted they consistently heard “the current LTSS system lacks sufficient staff, IT systems, workforce capacity, and processes to run effectively.”¹¹⁸

The full Guidehouse Report is available online on the DHHS website.¹¹⁹

NEW HAMPSHIRE FOUNDATION FOR HEALTHY COMMUNITIES DATA COLLECTION

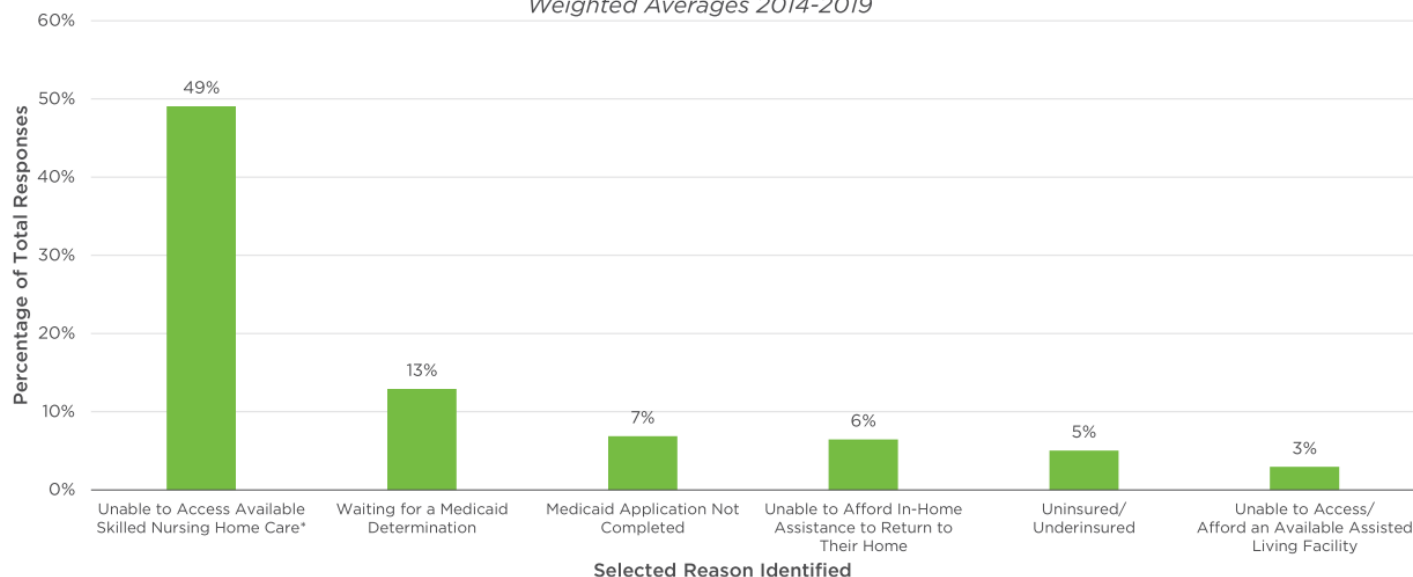
Survey data from the New Hampshire Foundation for Healthy Communities also provided separately-collected insight into concerns with regard to both Medicaid application processing and access to services. In reports from 2015, 2016, 2017, and 2020, the Foundation for Healthy Communities published survey results from hospitals throughout the state. The 2016, 2017, and 2020 reports were all titled “Barriers to People Receiving the Right Care,” with the most recent of these published on December 29, 2020.¹²⁰

The survey of hospitals from around the state published in 2020, which was conducted during three months in 2019, showed that, of the 643 individuals who were delayed in being discharged from the hospital, 26 percent had difficulty with Medicaid application process or were under-insured. Within the detailed reasons identified within those 26 percent, the most common was insurance authorization delay or denial, and the second-most common was waiting on Medicaid determination. The third leading reason was the Medicaid application was not complete. Among all detailed reasons identified in the report, across all respondents, insurance authorization delay or denial was the second-most common barrier to hospital discharge (115 patients, 17.9 percent of the total), while waiting on Medicaid determination was the fourth most common reason (73 patients, 11.4 percent).¹²¹

Aggregated survey data across the reports from 2015 to 2020, which included survey data from 2014 to 2019, show that being unable to access available skilled nursing home care, short-term rehabilitation services, or geropsychology care was a barrier to hospital discharge for nearly half of undischarged residents who were medically cleared to leave. Waiting for Medicaid determination was an identified reason for delaying discharge for about one of out every eight patients unable to leave, and Medicaid application completion delays had kept about one out of every fourteen who were unable to leave in the hospital. About 6 percent of undischarged individuals had a barrier to discharge stemming from being unable to afford the in-home assistance necessary to return to their home safely, while 5 percent were uninsured or underinsured and 3 percent were unable to access or afford an available assisted living facility.¹²²

SELECTED BARRIERS TO CARE IDENTIFIED IN SURVEY DATA OF HOSPITAL PATIENTS CLEARED FOR DISCHARGE BUT UNABLE TO LEAVE

Weighted Averages 2014-2019



*Note: Included LTC/Gerospsych/28 Day Rehab in 2019 data.

Sources: Foundation for Healthy Communities publications: Barriers to People Receiving the Right Care at the Right Time, June 11, 2015; Barriers to People Receiving the Right Care, July 20, 2016; Barriers to People Receiving the Right Care, July 19, 2017; Barriers to People Receiving the Right Care, December 29, 2020

nhfpi.org

Additional research was conducted by the New Hampshire Hospital Association, the New Hampshire Health Care Association, and the Home Care, Hospice and Palliative Care Alliance of New Hampshire based on a point-in-time collection of data from membership on November 4, 2021. The results were published in a December 20, 2021 report “Barriers to Health Care Transitions in New Hampshire: A Snapshot Review” and used a different methodology than the prior reports. The November 4, 2021 snapshot found that 102 patients in 15 hospitals had spent a combined total of 3,977 days in a hospital due to not having a place to be discharged to that met the appropriate level of care. Nearly half of patients delayed, and nearly three-quarters of the additional days spent waiting, were for patients seeking to access long-term care, and another 28 percent of patients and 13 percent of total days delayed were due to postponed access to skilled nursing facilities for rehabilitation. For undischarged patients referred to nursing homes, staffing challenges reported by nursing homes contributed to 66 percent of referrals not made, and undischarged patients referred to home care agencies had a reported 93 percent of all delayed referrals affected by staffing challenges at home health and assistance agencies. Medicaid eligibility challenges were also identified as a causal factor, and the report recommended both a faster approval process for Medicaid eligibility and higher Medicaid reimbursement rates for providers.¹²³

STAKEHOLDER INTERVIEWS AND ELIGIBILITY CHALLENGES

NHFPI’s interviews with 25 stakeholders during late 2021 and early 2022, ranging from various association representatives to nursing home administrators and CFI case management agency personnel to state officials, also identified concerns with the eligibility process.

Multiple sources indicated a systemic need to streamline the eligibility process, particularly for the financial eligibility portion of the eligibility evaluation. Familiarity with the ServiceLink network, which is in place to help connect people to services, is not universal; limited knowledge of available assistance may contribute to problems potential enrollees face while attempting to complete the application process. ServiceLink personnel can provide help to potential enrollees by indicating which materials and information are necessary for the applications and by helping people with the application process generally.

Several respondents indicated that DHHS requests for additional medical or financial information can be an issue because those requests can “stop the clock” with regard to the State’s required processing timeline, and slow the

process overall. As a result, the State's processing times for a particular application may be within federal limits, but the applicant may wait months to become eligible. Several respondents indicated that, when performing intakes of patients newly approved for CFI, it is not unusual for the patient to have passed away or be in the hospital while they had been waiting. In contrast to all other interviewees who directly addressed the topic, one person did indicate that timing of CFI eligibility has improved and the delays were not of as much concern as they had previously been.

One interviewee who worked with the application process on a regular basis as part of this person's job duties found that the system was difficult to navigate, saying that the NH Easy system, designed to facilitate enrolling in assistance programs, was actually more similar in user experience to "NH Difficult." This person indicated that they had participated in a training in 2016 and had not been offered any training offered for NH Easy since that time. This interviewee indicated that requests from the DHHS sometimes could not be responded to before an application would be closed. This interviewee also indicated there was no consistent person that could be accessed to help with questions and problems with applications, and that sometimes technical difficulties related to file sizes made uploading necessary documents problematic, requiring multiple attempts or workarounds and slowing the application process.

Another interviewee indicated that completing the CFI eligibility evaluation while already on Social Security Disability Insurance may slow down the process of obtaining benefits. This interviewee also indicated that the process for obtaining bids for equipment needed can take 30 days to 45 days; this delay is significant when a person with a disability needs this equipment for mobility, accessing certain parts of their home, or other critical functions. This individual questioned the need to have two bids on a piece of equipment when there are a limited number of providers, such as in a case when a lift broke and this person needed it fixed quickly. This interviewee also noted that the number of providers has declined, as providers do not want to deal with the State, because the process is cumbersome. The individual expressed that the State needs to have a faster process, because people with disabilities need help and need to get necessary tools and supports fixed quickly.

A nursing facility administrator indicated that the application process can be lengthy at times and that anything unusual in a person's finances can slow the process.

Corresponding with findings provided in the Guidehouse Report, interviewees indicated that there was no simple way to access materials to help navigate the eligibility system. The interview process included questions regarding application process documentation for most interviewees, and responses did not provide readily available documents that explained and detailed the application process, or would do so for potential applicants or people assisting applicants.

The stakeholder interviews reinforced concerns regarding the eligibility process identified in other research and accounts. These interviews were conducted primarily with professionals engaged in the field. The difficulty and lack of consistency in the process expressed through these interviews suggest individuals and families in need of services may experience greater challenges, as they do not go through these complex processes on a regular basis. These difficulties may be compounded by a relative lack of frequently-used explainer documentation for enrollees and those assisting applicants in the process, as well as a potential lack of awareness of, and access to, navigation resources such as ServiceLink.

FUNDING CONSTRAINTS EXACERBATE WORKFORCE SHORTAGE, LIMIT ACCESS TO SERVICES

Workforce constraints are a key challenge to service delivery. Evidence collected prior to the pandemic suggested limited workforce availability was particularly constraining for CFI service delivery.¹²⁴ Interviewed professionals in the field, available research, and analysis of available New Hampshire workforce data all indicate that workforce-related challenges have all become more severe since the start of the pandemic and are a significant contributor to people not receiving care, or the most optimal forms of care, in a timely manner.

Medicaid-funded workforce constraints may be exacerbated by reimbursement rates that have not kept up with inflation in service delivery costs, particularly for CFI waiver services. Long-term underfunding may have implications for the workforce pipeline, as lower pay may make it more difficult for providers to attract and retain workers, including when payments for similar work may be higher in neighboring states.

Medicaid providers may also be less able to respond quickly to changes in the labor market, such as the decline in available workers associated with the relatively rapid economic rebound and changes in the economy resulting from the pandemic-induced recession; Medicaid reimbursement rates are not adjusted as quickly as private sector pricing for goods and services, for example, and wages offered by Medicaid providers relying on fixed reimbursement rates may not be able to continue attracting workers in a dynamic labor market with rising wages in key sectors, particularly when other costs are increasing.

Information collected from providers indicates Medicaid reimbursement rates are low relative to the costs of service delivery. In response to a survey conducted as part of the Guidehouse Report's research, 66 percent of the 47 key informants who responded to the survey strongly disagreed with the statement "HCBS reimbursement rates are adequate," while another 18 percent indicated they disagreed; 2 percent strongly agreed with the statement while none agreed and 2 percent neither agreed nor disagreed.¹²⁵

Reimbursement rates that are low relative to costs have other significant implications for provider agencies. For example, provider agencies may have to raise money for these services from other sources, or may close their operations, which could reduce service availability for both Medicaid and non-Medicaid patients.¹²⁶ Provider closures could have a significant impact on the likelihood of key services being successfully delivered, as other providers may not be available. In the Guidehouse Report survey, 57 percent of respondents strongly disagreed with the statement "There are sufficient direct service providers to deliver all covered HCBS," and another 18 percent indicated they disagreed, while only 7 percent agreed and none strongly agreed.¹²⁷ Although nursing facilities or their employees do receive payment for certain licensed nursing assistant training expenses, HCBS agencies do not, leading organizations to rely on covering additional costs, particularly those associated with turnover, with existing reimbursement rates for other services.¹²⁸ Increased travel costs associated with rising motor fuel prices, including for HCBS aides traveling to in-home appointments, may also be dependent on funding drawn through fixed reimbursement rates for services delivered that may not adjust based on fuel prices and other factors.

The lack of workforce and providers for these services, and the resulting decrease in available capacity for services, increases the need for efficient allocation of resources. However, determining available provider capacity can reportedly be a cumbersome process, especially when provider capacity is very limited. Interviewees managing cases reported to NHFPI that they would often have to make many phone calls to successfully identify placement options and available services for Medicaid patients in need of LTSS. Survey respondents for the Guidehouse Report also indicated that information may not flow efficiently through the service delivery system. Of key informant survey respondents, 34 percent disagreed and 32 percent strongly disagreed with the statement "Information and data is seamlessly shared across ServiceLink, HCBS case managers, [the State Bureau of Elderly and Adults Services], institutional care providers, and HCBS direct service providers," while 8 percent agreed and none strongly agreed.¹²⁹

Relatively low reimbursement rates appear to be key constraints in the ability of Medicaid service providers to timely deliver the supports needed by enrollees, particularly due to a very competitive employment environment and workers having many potential job opportunities. These conditions existed in part before the pandemic, but have been exacerbated by its impacts.

POLICY DISCUSSIONS AND RECOMMENDATIONS

Several policies may help increase availability and access to LTSS in New Hampshire. These policy options range from those that could help address short-term issues with system efficiency to long-term investments that will help support more residents as a larger number reach ages in which they may need additional supports. Particularly, added investments in HCBS may be a cost-effective way to help more Granite Staters access these services while remaining in their homes and communities. Certain investments related to the workforce could also help across the LTSS industry.

The ten recommendations below address two broad categories of concern. The first set of recommendations seeks to address the Medicaid application and eligibility process. The second set of recommendations focuses on funding mechanisms for services and the workforce challenges associated with prior and current funding levels.

MEDICAID ELIGIBILITY PROCESS

The Medicaid eligibility system would benefit from being streamlined, which would enhance the potential for people to obtain timely eligibility determinations to receive services when they are needed and prevent unnecessary institutionalization or underutilization. The eligibility process is reportedly difficult to understand and navigate, even for professionals working in this field. Several policies may help connect people with services more quickly.

1. **Use flexible federal funds provided through the American Rescue Plan Act (ARPA) to hire public benefit navigators to help people applying for Medicaid services.** Coronavirus State Fiscal Recovery Funds (CSFRF) allocated to the State could be used to hire public benefit navigators to help access LTSS. For example, these flexible funds, which are one-time funds but can be used through the end of 2026, could be appropriated to ServiceLink to bolster its ability to help people with the application process. ServiceLink workers already help people get information about Medicaid services, and additional funds could be used by ServiceLink to hire navigators without the creation of new or additional institutions.¹³⁰
2. **Consider additional, systemic help for people accessing services beyond the existing frameworks for LTSS in New Hampshire.** One possibility is consideration of a system, or components of a system, like the model used in Vermont known as the Support Services at Home Program (SASH).¹³¹ SASH coordinates the resources of social-service agencies, community health providers, and nonprofit housing organizations to support people who choose to live independently at home. Individualized, on-site support is provided by a Wellness Nurse and a SASH Care Coordinator through that person's housing location. This program is currently operating in Vermont. A federally-contracted evaluation of SASH, covering 2010 to 2016, described SASH as "a promising approach to providing support services and care coordination to older adults and individuals with disabilities, using affordable housing properties as a platform for service delivery."¹³² A key component of SASH is the connection between services and housing, as people can receive supports before they are in crisis and can receive the support to come back home after staying at a hospital or rehabilitation facility. This program, or some of its components, could be piloted in one or more regions to determine its effectiveness in New Hampshire.
3. **Support home care providers with a form of payment, or commitment of future payment, prior to the formal establishment of Medicaid eligibility, or implement a form of presumptive eligibility.** The timely provision of HCBS health care may be enhanced by supporting HCBS providers with some form of compensation or assurance of known future supporting revenue prior to patient CFI eligibility being fully established. Nursing facilities already have retroactive eligibility reimbursement dating back to the time of initiating services once approval of an applicant is completed, which is a requirement under the federal Medicaid rules.¹³³ Retroactive reimbursement may also help providers start services in a timelier manner in the context of HCBS, as enrollees would not have to wait for formal eligibility. There are several ways to achieve this form of reimbursement or payment for providers, including presumptive eligibility. The DHHS identified the potential benefits for HCBS service delivery timeliness of presumptive eligibility in a proposal to spend Medicaid funding enhancements supplied through ARPA on a presumptive eligibility pilot program.¹³⁴ A 2019 analysis from the AARP Public Policy Institute, drawing on data from states that have

implemented forms of presumptive eligibility, estimated that less than 2 percent of applications presumed to be eligible are eventually denied, and that the cost to Medicaid of those payments when an eventually-denied individual is presumed eligible are substantially lower than the costs to Medicaid of funding an individual's services in a nursing facility, rather than through HCBS.¹³⁵ Payments could also come in the form of retroactive eligibility, matching the structure for nursing facilities, or some other guaranteed payment. Depending on the structure, ARPA CSFRF could be used to support non-Medicaid grants, a revolving loan fund to support presumptive or retroactive eligibility, or test pilot programs.

4. **Reduce wait times for providing certain services by designating approved service providers with a pre-approved range of costs for service provision.** The State could potentially reduce the amount of time individuals are waiting for key services, while maintaining assurance of cost containment, by formally identifying approved providers for these services with a range of costs that have been previously approved by the State. Obtaining home modifications or purchasing major medical devices, such as wheelchairs, can reportedly involve significant time delays. One of the reported contributors to these delays is the requirement that individuals have multiple bids from providers for these services or products. A streamlined process with designated or pre-approved providers may decrease wait times for services while also making providers more willing to participate.
5. **Consider updates to the NH Easy system for applying for services and provide additional trainings for professionals who frequently assist people applying for services.** Interviewees reported some difficulty using NH Easy, the State's primary web portal for accessing key services, including Medicaid. Potential enrollees may benefit from updates to this web portal.
6. **Establish a centralized information portal or dashboard for providers, case managers, and navigators to quickly understand which services are available to help connect people to services faster.** Once an individual is eligible for Medicaid services, access to services is reportedly commonly delayed by a lack of available workforce capacity for service delivery. Finding an option or options for an individual being discharged from a hospital or in need of a change in LTSS care can be difficult, and interviewees reported it could require many phone calls to individual providers to find capacity to care for an individual. Reportedly, no central information hub for understanding quickly which providers have capacity to meet an individual's needs exists. A single information hub could facilitate rapid access to services for individuals in need and help optimize the use of existing provider capacity.

FUNDING REIMBURSEMENTS AND SUPPORTING THE WORKFORCE

Limited reimbursements for services relative to costs, particularly for HCBS, likely constrains available services and reduces the ability of providers to retain and attract staff to deliver services. With workforce constraints affecting employers in New Hampshire across industries, and key age demographic changes combined with a limited housing supply making rapid solutions to workforce limitations unlikely, policymakers should consider steps to help support critical Medicaid-reimbursed LTSS in New Hampshire.¹³⁶

7. **Consider a long-term program to provide a stipend or other additional funding for workforce supports to Medicaid providers, potentially funded with flexible federal funds that can be used through the end of 2026.** Available evidence from interviewees suggests pay increases and stipends have been effective at retaining workers. Using federal funds in 2020, the State established the Long Term Care Stabilization Program.¹³⁷ This program provided stipends to Medicaid LTSS front line workers of \$300 per week for full time workers and \$150 per week for part time workers, defined as those working less than 30 hours per week. Providers and other knowledgeable interviewees were nearly universal in reporting that this program helped keep LTSS employees in the workforce, and several reported that in the case of home care workers the stipend increased the number of hours that employees worked. Providers reported that the program did not help them attract new workers or increase the size of the workforce, but that the program was key to stabilizing the existing workforce. Interstate, pre-pandemic research on Medicaid payments targeted by states at direct care workers suggests those programs do effectively boost wages.¹³⁸ A longer-term program operated by the State and funded with CSFRF ARPA dollars through 2026 could provide a similar stipend for Medicaid providers. This new program's design could be informed by the shortcomings of the Long Term

Care Stabilization Program, and could involve a higher degree of complexity or targeting with the longer program timeline. A longer-term program may be more effective at attracting workers, as they would have more certainty of pay going forward, and the LTSS field may have become more attractive to potential employees as the pandemic has subsided relative to 2020. This longer-term program could also permit evaluations of the workforce and service delivery impacts, providing more information for future policy decisions.

8. **Include flexibility in public wage enhancement programs for Medicaid providers to reflect related costs.** Policymakers considering wage enhancement policies may also consider the associated costs for providers, who may disproportionately benefit from more flexibility or broader scopes of use for funds designed to enhance wages. Alongside other shortcomings of prior wage-enhancing programs for LTSS workers, providers reported that increased expenses related to wages, such as worker compensation costs and employer taxes, were not necessarily considered in prior programs. Added flexibility for these workforce-enhancing payments could be especially helpful for smaller providers, including many HCBS providers.
9. **Establish a set and more sophisticated methodology for estimating CFI waiver service delivery costs that will help inform decisions regarding reimbursement rates and help to better align future investment levels with cost changes.** Nursing facility reimbursement rates are established based on a sophisticated system of cost reporting and adjustments, including per diem rates calculated specifically for each facility and updated on a regular schedule, with set methodologies for adjusting costs. HCBS delivered through the CFI waiver do not include any comparable documentation of costs as a basis for establishing rates. Funding for CFI waiver service providers has fallen behind indices reflecting increasing costs, while funding for nursing facilities appears to have kept pace with key indices. An established, sophisticated, and transparent methodology for informing funding levels based on CFI waiver service delivery costs could reduce the likelihood of future underfunding relative to inflation. The State would benefit from collecting relevant data regarding costs to deliver HCBS as a baseline understanding of the costs of providing these key health services. Policymakers could establish an automatic cost adjustment for each budget cycle, potentially based on a combination of relevant CMS Market Basket measures and other indicators of inflation in provider costs. Other factors measuring the availability of workforce in New Hampshire generally, such as the unemployment rate or wage changes across the broader economy, could also be considered as part of the adjustment calculations. The calculated projected expenditure changes, and the basis for those adjustments relative to prior periods, could be communicated to policymakers clearly and in detail as part of the State Budget process.
10. **Use flexible federal funds and other resources to establish and support initiatives to grow and develop the workforce for nursing facilities and home and community-based services.** Providers reported in interviews that reimbursement rates and payments to employees are not the only factors to maintain and expand available workforce. Educational opportunities, employee recognition, and career ladders are other means to support and grow the LTSS workforce. Specialized training for LTSS may also be beneficial for enhancing the skills of existing and new LTSS provider employees. Research into potential policies and initiatives from the Endowment for Health and the New Hampshire Health Care Workforce Coalition to understand specific opportunities for supporting New Hampshire's Medicaid LTSS workforce may inform policy solutions.¹³⁹

These policy options could offer potential LTSS improvements at a time when these services in New Hampshire face both significant challenges and the potential for new strategic direction. As the State has pivoted away from deploying a managed care model for LTSS and is emerging from the worst periods of the pandemic, New Hampshire has an opportunity to assess existing LTSS assets and make thoughtful and coordinated policy decisions to help ensure investments in this critical infrastructure build toward a vision for improved LTSS care for Granite Staters.¹⁴⁰

CONCLUSION

New Hampshire's systems for providing LTSS already deliver important care to Granite Staters in need, and these systems will only become more important over the next several decades as the state's population ages. Key ongoing challenges within the current infrastructure should be addressed to help effectively meet current and future needs.

The majority of successful formal LTSS provision, including for Granite Staters with limited financial resources, relies on Medicaid funding. Medicaid LTSS for older adults and adults with physical disabilities is delivered through two foundational systems: institutional care through public and private nursing facilities, and home and community-based care through the CFI waiver program. Both serve important roles in LTSS care. Nursing facilities provide key rehabilitation and 24-hour care services, and CFI waiver services provide cost-effective alternatives that enable people to remain in their own homes or communities when needed treatments and care can be delivered in those settings.

Both nursing homes and CFI providers face workforce shortages in New Hampshire. These shortages were likely limiting service delivery, particularly by reducing the capacity of CFI providers, before the pandemic reached the state. The pandemic brought substantial new workforce constraints and challenges related to keeping residents and clients safe. In many cases, Medicaid LTSS systems already were under some stress before the pandemic. Particularly relative to CFI, this stress had been exacerbated by relatively low reimbursement rates, which fell behind key cost inflation indices for most of the prior decade. Lower reimbursement rates can limit the ability of providers to pay staff higher wages or provide benefits, potentially making employment in agencies providing Medicaid services to people in need less attractive, or feasible, than other employment options. Home health and personal care aides earning lower incomes in New Hampshire may also find substantially similar work in neighboring states and gain significant wage increases. Differences between reimbursement rates among separate parts of the Medicaid program may also lead to disparities between providers or segments within the LTSS workforce. Policymakers can help address these workforce shortages with both funding increases, including those targeted at supporting staff, and other support and training infrastructure for current and potential workers in the LTSS field.

The cost reporting system for nursing facilities, which is used to inform the State Budget process, appears to have helped funding for nursing homes keep better pace with cost inflation than the budgeted funds for CFI service provision. A more comprehensive system for understanding changes in CFI provider costs, such as using relevant inflation indices, could help alleviate future workforce challenges and reduce the likelihood of underfunding services over time.

Additional investments in CFI services and related or supporting HCBS present a key opportunity to strategically address challenges in New Hampshire's Medicaid-funded LTSS. National survey data suggest older adults are interested in staying in their homes or communities for as long as they can, and HCBS funded through CFI help enable people who prefer these settings to remain in them. HCBS care is also typically less expensive than care at nursing facilities, both in New Hampshire and nationwide.

The process for determining Medicaid eligibility delays LTSS delivery for older adults and adults with physical disabilities, particularly for CFI services, which do not have retroactive payments once eligibility is determined. These delays in the provision of care can present considerable risk to individuals in need of services. While determining both medical and financial eligibility are critical steps, simplifying the Medicaid application process and enabling an enhanced form of retroactive or presumptive eligibility across both nursing facilities and CFI services could help ensure services are delivered in a timely manner and the medical risks to patients are reduced. Policymakers could also facilitate timely service delivery by supporting a single information hub, which could help providers and case managers quickly and efficiently understand capacity within the LTSS systems, and through additional funding for public benefit navigators. Bolstered guidance and navigation services could help more patients be aware of their options, including potentially cost-saving home-based care, as well as ease and speed the Medicaid application process.

Investments in the provision of Medicaid-funded LTSS, and changes in the Medicaid application process, will be key as the state continues to face a substantial workforce shortage and the population ages. Helping ensure that care is



available for a growing population of individuals likely in need will only increase in importance in the future, particularly over the next two decades. More than 200,000 adults were estimated to be between age 55 and 64 years in 2019, the largest group of any other ten-year age demographic in the state. Survey data from New Hampshire indicate that more than one in five adults aged 65 to 74 years experience a disability, and more than two in five who are age 75 years or older do as well. The State of New Hampshire currently has resources, including flexible federal funds, to make needed investments and implement pilot programs that may be helpful and cost-effective for delivering LTSS to a greater number of people. These Medicaid-funded services are essential to the ongoing livelihoods and well-being of thousands of Granite Staters, and will be crucial to the lives of many thousands more in the next two decades.

New Hampshire has an opportunity, with resources currently available, to make strategic, long-term investments in LTSS for older adults and adults with physical disabilities that efficiently and effectively provide support to the state's residents. Policy decisions in the near-term can help address present challenges and create a stronger foundation for a Medicaid-funded LTSS system that will support many more Granite Staters in the future.

APPENDIX A – RELEVANT REPORTS AND RESOURCES

New Hampshire Publications

Medicaid Home- and Community-Based Care Service Delivery Limited by Workforce Challenges, New Hampshire Fiscal Policy Institute, March 15, 2019

<https://nhfpi.org/resource/medicaid-home-and-community-based-care-service-delivery-limited-by-workforce-challenges/>

County Medicaid Funding Obligations for Long-Term Care, New Hampshire Fiscal Policy Institute, August 1, 2019

<https://nhfpi.org/resource/county-medicaid-funding-obligations-for-long-term-care/>

New Hampshire Long Term Supports and Services (LTSS) for Seniors & Individuals with Physical Disabilities, Findings and Recommendations, Guidehouse Inc., March 12, 2021

<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-12/guidehouse-report-03122021.pdf>

Barriers to Health Care Transitions in New Hampshire: A Snapshot Review, New Hampshire Hospital Association, New Hampshire Health Care Association, and Home Care, Hospice and Palliative Care Alliance of New Hampshire, December 20, 2021

https://www.nhha.org/images/Barriers_to_Healthcare_Transitions_12.20.21.pdf

Bureau of Elderly and Adult Services and Choices for Independence Legislative Performance Audit and Oversight Committee Item, New Hampshire Office of Legislative Budget Assistant, April 30, 2021

http://www.gencourt.state.nh.us/LBA/audit/LPAOC_AgendasMinutes/Items/LPAOC-Items-April%2030,%202021.pdf#page=2

Giving Care: A Strategic Plan to Expand and Support New Hampshire's Health Care Workforce, Endowment for Health, March 2022

<https://endowment-assets.nyc3.digitaloceanspaces.com/images/Giving-Care-A-Strategic-Plan-to-Expand-and-Support-NH-Health-Care-Workforce.pdf>

New Hampshire State Plan on Aging 2019-2023, State Committee on Aging, June 2019

<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/beas-nh-state-plan-on-aging.pdf>

New Hampshire Medicaid Long Term Care Quick Facts, University of New Hampshire School of Law and Institute for Health Policy and Practice, June 21, 2018

<https://chhs.unh.edu/sites/default/files/nh-long-term-care-quick-facts-062118.pdf>

National and Other Publications

Medicaid Long Term Services and Supports Annual Expenditures Report, Federal Fiscal Year 2019, Centers for Medicare and Medicaid Services, December 9, 2021

<https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>

Key State Policy Choices About Medicaid Home and Community-Based Services, Kaiser Family Foundation, February 4, 2020

<https://www.kff.org/report-section/key-state-policy-choices-about-medicaid-home-and-community-based-services-issue-brief/>

Medicaid Home and Community-Based Services Enrollment and Spending, Kaiser Family Foundation, February 4, 2020

<https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/>

Who Pays for Long-Term Services and Supports, U.S. Congressional Research Service, June 15, 2022

<https://crsreports.congress.gov/product/pdf/IF/IF10343>

Across the States 2018: Profiles of Long-Term Services and Supports, AARP Public Policy Institute, August 27, 2018

<https://www.aarp.org/ppi/info-2018/state-long-term-services-supports.html>

Home and Community-Based Services for Older Adults, AARP Public Policy Institute, November 2021

<https://www.aarp.org/content/dam/aarp/ppi/2021/11/home-and-community-based-services-for-older-adults.doi.10.26419-2Fppi.00153.001.pdf>

Presumptive Eligibility for Medicaid Home and Community-Based Services Can Expand Consumer Options, AARP Public Policy Institute, April 2021

<https://www.aarp.org/content/dam/aarp/ppi/2021/04/presumptive-eligibility-for-medicaid-home-community-based-services.doi.10.26419-2Fppi.00138.001.pdf>

All States Must Set Higher Wage Benchmarks for Home Health Care Workers, Economic Policy Institute, June 2, 2022

<https://www.epi.org/publication/state-home-health-care-wages/>

Support And Services at Home (SASH) Evaluation: SASH Evaluation Findings 2010-2016, U.S. Department of Health and Human Services, July 9, 2019

<https://aspe.hhs.gov/reports/support-services-home-sash-evaluation-sash-evaluation-findings-2010-2016>

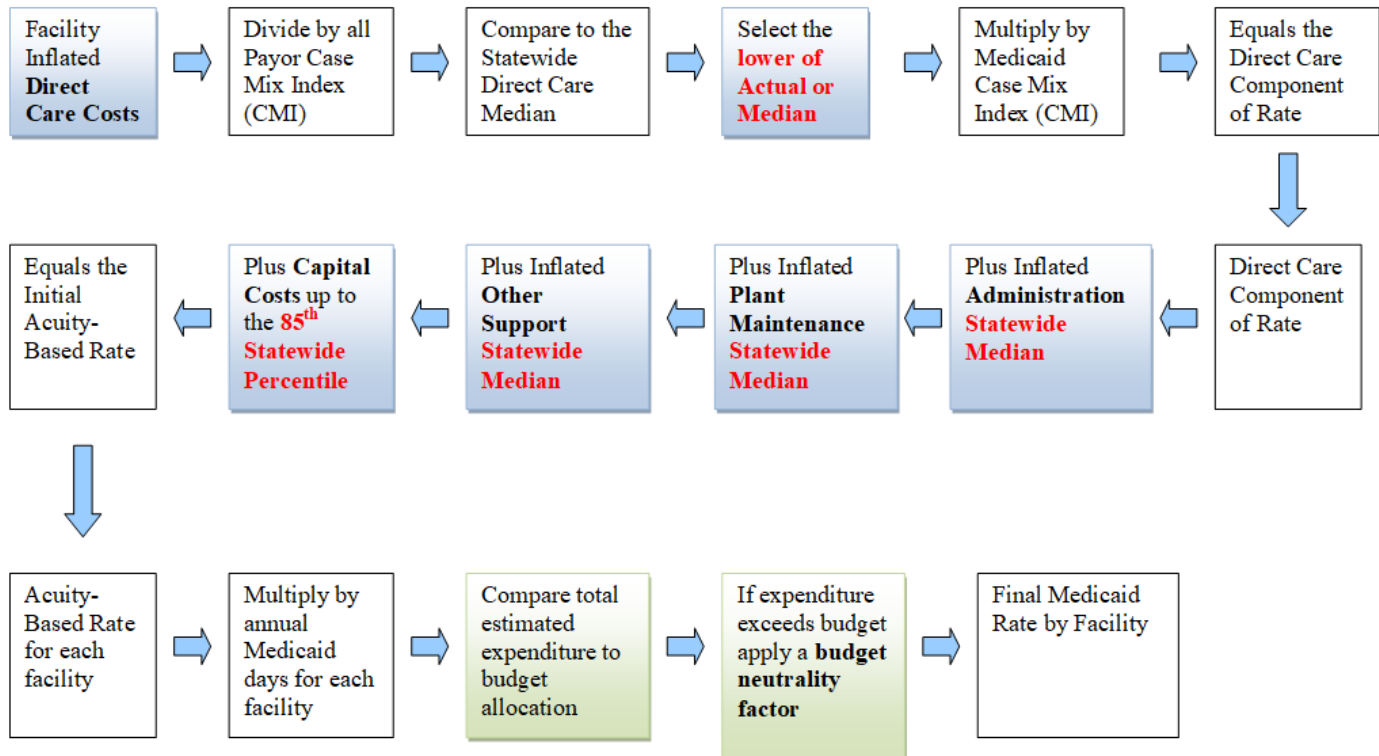
APPENDIX B – NH DHHS ACUTIY-BASED RATE CALCULATIONS FLOW CHART

State of NH, DHHS

Acuity Rate Setting Flow

Prepared By: Medicaid Rate Setting

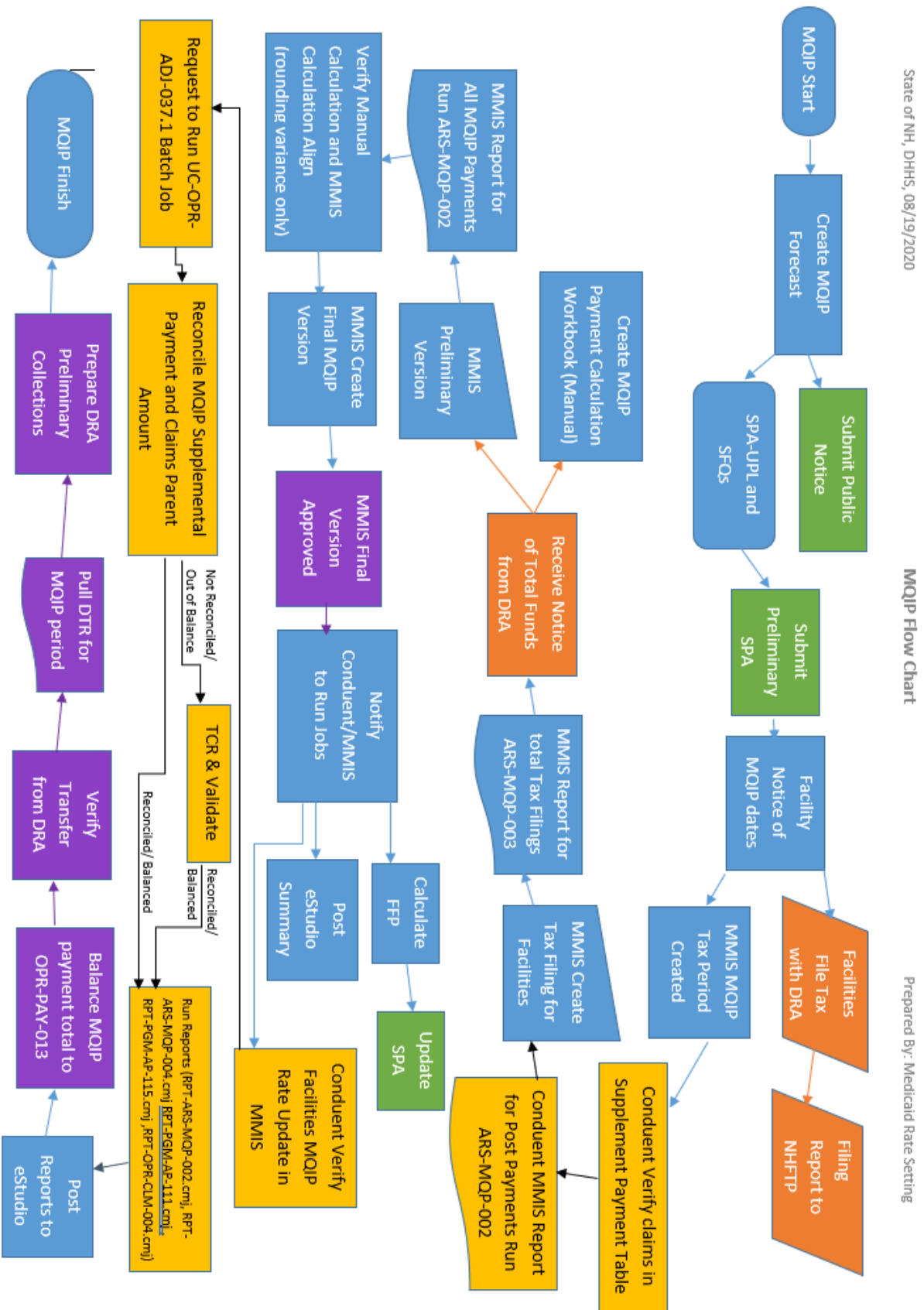
Acuity-based Rate Calculations



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APPENDIX C - NH DHHS MQIP PROCESS FLOW CHART



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