NH DHHS Operations Assessment

January 2021 Phase IB

ALVAREZ & MARSAL

Executive Summary

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Executive Summary | Project Overview

Background: The New Hampshire Department of Health and Human Services (DHHS) engaged Alvarez & Marsal (A&M) to conduct a strategic assessment of DHHS operations to (1) quantify the impact of the COVID-19 pandemic, (2) identify programmatic improvements to increase operational efficiency, and (3) improve the delivery of services during and after the public health emergency (PHE).

A&M executed its assessment in two distinct phases:

- Phase IA (August 24 – October 30, 2020)
- Phase IB (November 2 – December 31, 2020)

In Phase IA, A&M focused on Department programs and services with the largest amounts of allocated funding. With each focus area or "workstream", A&M assessed the financial and operational impact of the pandemic for vulnerabilities that may impede recovery, acknowledging that while devastating, the pandemic presents a unique opportunity to emerge stronger and more prepared for future public health emergencies.

In Phase IB, A&M continued to assess the impact of the COVID-19 pandemic and explored additional opportunities to improve services and outcomes for the citizens of New Hampshire. A&M also supported the implementation of two short-term, high-impact opportunities developed in Phase IA.

This report presents A&M's Phase IB analysis and recommendations.

Executive Summary | Approach | Overview

A&M applied the same approach to recommendation development in Phase IB as we did in Phase IA.

Approach: A&M's assessment breaks down into three key phases: (1) perform initial interviews and data collection, (2) identify opportunities and conduct analysis, and (3) vet opportunities and recommendations. A&M identified discrete areas of focus into which we organized our analyses and recommendations in this report. A&M conducted a range of analyses touching on both specific divisions, such as the Division of Long-Term Supports and Services or the Division of Behavioral Health, as well as on broader areas that affect multiple functions within DHHS, such as information technology or care management.

Recommendations: In Phase IB, after performing analysis and vetting the various opportunities with DHHS stakeholders, A&M produced seven recommendations for efficiency in addition to those issued during Phase IA. A full list of short-term and long-term recommendations can be found in the following slides.

Additionally, A&M provided advisory and support to DHHS stakeholders with the implementation of two recommendations issued in Phase IA.

Executive Summary | Approach | Presentation Key

This Phase IB report presents each recommendation with the following key information, as done in Phase IA. The report also details the implementation support provided to DHHS for two recommendations developed in Phase IA.

Recommendation: This section provides a headline for the recommendation that A&M concluded DHHS should pursue.

Findings: This section defines the supporting analysis that led to A&M's recommendation. In some sections, additional analysis is provided in supplementary slides. These findings included a problem statement, observations, and the impact related to COVID.

Benefits: This section highlights the benefit to DHHS if a recommendation were to be pursued.

Financial Impact:

- *In some recommendations where savings ranges are inappropriate to present in summary, this portion lists "variable" or will otherwise navigate to a table with a more complete view*

	Estimate range provided	
	Low	**High**
Savings	Either revenue enhancements and/or cost reductions realized	
Costs[1]	Total incremental costs incurred in implementation	
Net Benefit	Net **NH General Fund impact [Savings less costs]**	

Timeframe: Recommendations that can be completed in under 18 months can be considered "short-term" while recommendations between 18 months and 5 years are "long-term." Note that one recommendation (MMIS) is a 10-year projection, and the information provided will reflect that timeframe.

Complexity: This section provides A&M's assessment of the relative complexity of implementing a recommendation.

Implementation Requirements: This section provides the resources needed to complete the recommendation, including people, process, technology, preparation work, and any statutory limitations, changes, or deadlines (if applicable). Any requirement listed "N/A" means that there are no additional requirements in that area.

Timeline: This section provides a projected time to implement the recommendation.

Risks: This section provides potential risks in implementing the recommendation.

A&M organized analyses and recommendations for Phase IB into the following six focus areas or "workstreams." For focus areas 5 and 6, A&M provided implementation guidance as a continuation of the recommendations developed in Phase IA.

Focus Area	Description of Analysis Conducted
1. Behavioral Health	Analyzed (1) the potential impact of implementing Critical Time Intervention (CTI); (2) the possibility of bundling Assertive Community Treatment (ACT) payments; and (3) CMHC grant funding.
2. Sununu Youth Services Center	Assessed service options for youth at SYSC.
3. Grants Administration	Performed a process assessment and reviewed cost allocation data in order to understand the process issues in the current cost allocation system and prescribed corresponding process improvements.
4. Long-Term Supports and Services: CFC 1915(k)	Conducted an analysis of Personal Attendant Services (PAS) expenditures for waiver participants to estimate potential savings of implementing a 1915(k) program for people who meet institutional Level of Care (LOC) and are seeking to maximize their independence.
5. IV-E Funding	Provided support to DCYF and Fiscal Specialist Unit in the implementation of recommendations to increase the federal IV-E penetration rate.
6. Medicaid Disenrollment	Provided guidance regarding disenrollment planning post-PHE.

Executive Summary | Recommendations (Short-Term)

A&M identified the following short-term recommendations (i.e., with the potential to implement within 18 months). All figures are General Fund; costs reflect both one-time and recurring; savings figures shown are annual only.

				Est. Costs ($M)		Est. Savings ($M)	
#	**Slide Ref.**	**Recommendation**	**Description**	**Low**	**High**	**Low**	**High**
A.1	12	Implement Critical Time Intervention (CTI)	Critical Time Intervention, an evidence and community-based practice, may better address the needs of community members; lower hospital readmission rates; and lower hospital readmission costs.	$0.7M	$1.3M	$1.7M	$1.7M
A.2	23	Rationalize CMHC funding	Bundling payments of specific State-funded services, such as ACT, and activating currently dormant Medicaid codes may generate savings for the State.	$0.0M	<$0.2M	$0.8M	$1.7M
B.1.a	34	SYSC System of Care and Long-Term Plan	Continue to build out the System of Care for DCYF to inform a feasible timeline and long-term plan for right-sizing the SYSC facility.	*Proper cost and savings estimates require further review and depend on future actions of the State.*			
B.1.b	32	Establish Concurrent Uses for SYSC	Identify concurrent uses for the SYSC facility to offset costs.				
C.1	47	Restructure Grants Selection Process	Restructure the discretionary grant application and selection process to increase the potential to draw more administrative dollars from federal grants by building more indirect cost allocation into grant applications. DHHS should also mandate and enforce Finance final approval on both new discretionary grants and discretionary grant renewals.	*Retroactive projections have been provided, but forward-looking savings are dependent on grants pursued.*			
			TOTAL	**$.7M**	**$1.5M**	**$2.5M**	**$3.4M**

See each section for further cost and savings detail

Executive Summary | Recommendations (Long-Term)

A&M identified the following long-term recommendations (i.e., with the potential to implement in 18 months to five years). All figures are General Fund; costs reflect both one-time and recurring; savings figures shown are annual only.

					Est. Costs ($M)		Est. Savings ($M)	
#	Slide Ref.	Recommendation	Timeframe	Description	Low	High	Low	High
D.1.a	67	Shift 1915(c) waiver services to 1915(k) Community First Choice (CFC)	2 years	Shift PAS and related services from the CFI waiver to CFC; services must also be available to developmental waiver participants as an alternative, and not in addition to comparable waiver services.	$.07M $.15M	$.11M $.25M	$3.9M	$3.9M
D.1.b	67	Shift Medicaid State Plan Personal Care Assistant (PCA) services to 1915(k) Community First Choice (CFC)	2 years	Shift Medicaid State Plan Personal Care Assistant (PCA) services for waiver participants to 1915(k) Community First Choice (CFC).	--	--	$.37M	$.37M
D.1.c	67	Improve coordination of HCBS	2 years	With the implementation of CFC, create utilization management protocols to ensure Personal Assistant Services (PAS) benefits for waiver participants are coordinated and are not duplicative.	--	--	$0.0M	$3.1M

See each section for further cost and savings detail

Behavioral Health

Behavioral Health | Critical Time Intervention | Executive Summary | Overview

Scope: New Hampshire's 10-Year Mental Health Plan calls for supporting people at risk of hospitalization and reducing avoidable psychiatric hospital readmissions. The State employs a variety of programs to achieve this goal, including Assertive Community Treatment (ACT)**.** Many individuals with severe mental illness (SMI) or severe and persistent mental illness (SPMI) may not qualify for ACT, however, and may instead benefit from an alternative program that is proven to reduce hospital admissions. A&M thus examined:

1) Cost-effective and impactful complements to ACT
2) Health outcomes and financial impacts of implementing a new "step-down" program

Approach: A&M, working with DBH and Program Quality staff, gathered and reviewed documents and data related to 10-Year Mental Health Plan, ACT, readmissions at New Hampshire Hospital (NHH), and the State's IDNs, among other areas. A&M also partnered with third-party authorities, such as the Center for the Advancement of Critical Time Intervention (CACTI) and Arnold Ventures, to review literature and conduct analysis. A&M engaged in multiple conversations with DBH staff, as well as with the staff of CACTI and Arnold Ventures.

Results: Several key findings emerged from A&M's discussions with stakeholders, document review, and data analysis:

1) Fewer than 1% of individuals screened for ACT receive ACT services, largely due to ACT's strict eligibility requirements.
2) New Hampshire Hospital admits over 1,200 people annually, of which an average of 21% are readmitted each year.
3) Critical Time Intervention (CTI) is a cost-effective and flexible model with positive clinical and financial outcomes and may function as a complement to ACT.

Based on these findings, A&M recommends that the State implement a statewide Critical Time Intervention program to (1) better address the needs of community members; (2) lower hospital readmission rates; and (3) decrease hospital readmission costs to the State.

Behavioral Health | Critical Time Intervention | Executive Summary | Recommendations (Short-Term)

A&M has identified the following recommendation for Critical Time Intervention. All figures are General Fund; costs and savings reflect average annual figures.

			Est. Costs ($M)*		Est. Savings ($M)	
#	Recommendation	Description	Low	High	Low	High
A.1	Implement Critical Time Intervention (CTI)	Critical Time Intervention, an evidence and community-based practice, may better address the needs of community members; lower hospital readmission rates; and lower hospital readmission costs.	$0.7M	$1.3M	$1.7M	$1.7M

** Costs represent statewide aggregate; actual implementation will be regionalized and require further assessment.*

Behavioral Health | Critical Time Intervention | Executive Summary | Approach

Stakeholder Engagement

Key Personnel Interviewed

DHHS Division for Behavioral Health

- Katja Fox, Division Director
- Julianne Carbin, Director, Bureau of Mental Health Services
- Kelley Capuchino, Senior Policy Analyst

DHHS Bureau of Program Quality

- Andrew Chalsma, Director, Data Analytics and Reporting

Center for Advancement of Critical Time Intervention (CACTI)

- Daniel Herman, PhD
- Kimberly Livingstone, PhD
- Bebe Smith, MSW, LCSW

Arnold Ventures

- Kim Cassel, Director, Evidence-Based Policy

Data Request

Key Data Reviewed

- New Hampshire Hospital readmission data, FY18-20
- CMHA Progress Reports
- New Hampshire CMHA
- New Hampshire CMHA Quarterly Progress Reports
- New Hampshire CMHC 2018 financial reports
- New Hampshire DSRIP IDN Semi-Annual Reports
- 20+ studies (RCTs, literature reviews, etc.) of CTI effectiveness
- CACTI CTI literature (i.e., model overview, history, etc.)
- ACT academic literature

Behavioral Health | Critical Time Intervention | Summary (1 of 2)

Recommendation

Implement a statewide Critical Time Intervention program to (1) better address the needs of community members; (2) lower hospital readmission rates; and (3) decrease hospital readmission costs to the State.

Findings

The State's 10-Year Mental Health Plan includes supportive programming aimed at helping people at risk of hospitalization reduce readmissions. While the State's "toolkit" for assisting individuals includes services like ACT, there are many people who may benefit from a less rigid step-down program.

Observations:

- Fewer than 1% of individuals screened for ACT receive ACT services.
- New Hampshire Hospital, the only State-operated inpatient psychiatric hospital, admits over 1,200 people annually, of which an average of 21 percent are likely to be readmitted. Many of these individuals may not qualify for ACT but would benefit from a less rigid program.
- Step-down treatment is a core part of the State's 10-Year Mental Health Plan. CTI, a step-down practice, is a cost-effective and flexible model that complements a service like ACT.

COVID Impact:

CTI, because of the intimate involvement of the CTI team in each client's daily routine, may enable faster identification of COVID-19 symptoms in clients and thus more timely treatment, if required.

Benefits

- Numerous studies demonstrate CTI drives positive results, including reduced hospital readmission rates and improved clinical outcomes.
- Reduced hospital readmissions translate to savings for the State and the Federal Government, which share the cost of inpatient care.
- CTI will help many more people in need because of its more open eligibility requirements and because there is a need for its application.
- CTI complements a variety of care management and coordination efforts already underway (as part of the State's 10-Year Mental Health Plan) by strengthening an individual's connections to family and community.
- CTI may lead to a more efficient care model at New Hampshire Hospital.

	Low*	High*
Net Savings	$1.7M	$1.7M
Impl. Costs	$1.3M	$.7M
Net Benefit	**$.4M**	**$1.0M**
Timeframe	12-24 Months	
Complexity	Moderate	

** Savings and costs reflect annual averages*

Behavioral Health | Critical Time Intervention | Summary (2 of 2)

Recommendation

Implement a statewide Critical Time Intervention program to (1) better address the needs of community members; (2) lower hospital readmission rates; and (3) decrease hospital readmission costs to the State.

Implementation Requirements

People	• Centralized CTI management team within DBH • Regionalized supervisors and case teams (based on population) • Third party authorities (e.g., CACTI, academic leaders) to assist with implementation and ongoing education
Process	• Identify core areas for CTI rollout (e.g., areas with larger SMI/SPMI population, like Concord, Manchester, etc.) • Recruit CTI teams and partner with relevant organizations (e.g., CMHCs, hospitals, ServiceLink) – likely the most time-consuming • Initial training on CTI model; development of learning collaboratives
Technology	• Leverage existing provider systems, EHR in particular • Regular reporting and analysis of CTI data is crucial – EHR makes this possible; centralized collection and analysis recommended
Prep. Work	• Secure funding for two years of CTI: sufficient for one year of rollout and a second year of statewide results • Identify initial CTI regions for rollout • Engage third party authorities for education and potential funding (e.g., Arnold Ventures)
Statute	• N/A – no statutory obstacles or requirements.

Timeline Outline

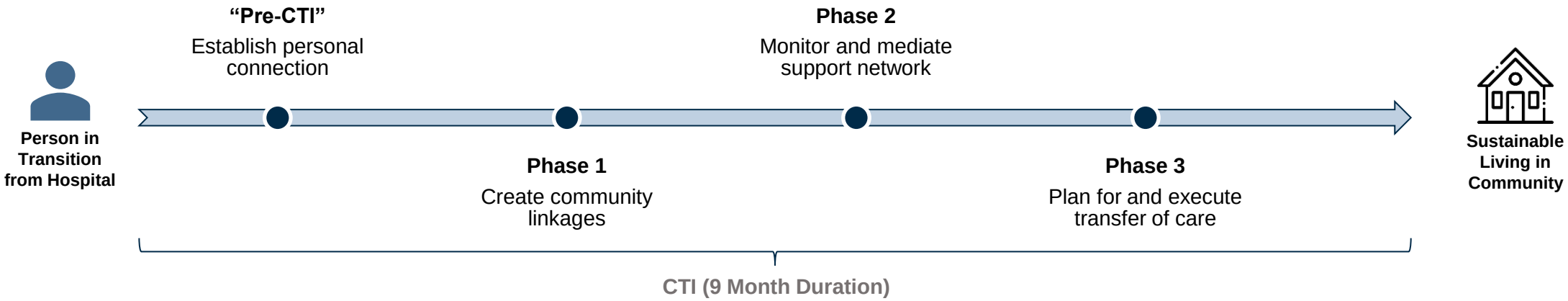
Target Start Time: ~July 2021

Time Range	Basic Tasks
Months <0	Identify and secure sufficient funding for two years of CTI implementation
Months 1-2	Create central CTI management team; develop statewide rollout strategy
Months 2-6	Recruit and train regional CTI teams and partners; integrate with local hospitals and providers (including IT)
Months 6-12	Begin initial CTI engagements; develop learning collaborative to share best practices, ongoing education initiatives, etc.
Months 12-24	CTI operational in targeted areas; data centralized and analyzed for impact. Expansion to more rural areas of the State.

Risks

- Insufficient funding will likely limit fidelity and thus CTI's effectiveness.
- Hospital partners (i.e., staff) may require ongoing engagement on the benefits of CTI to ensure they see value in the program and cooperate with CTI teams.
- A lack of, or poorly defined, eligibility criteria will increase the difficulty in identifying the right individuals for CTI, resulting in decreased program effectiveness.
- Lack of alignment with the 10-Year Mental Health Plan may lead to confusion about CTI's place in the broader continuum of care.

CTI is a time-limited, evidence- and community-based practice that mobilizes support for individuals with severe mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital)

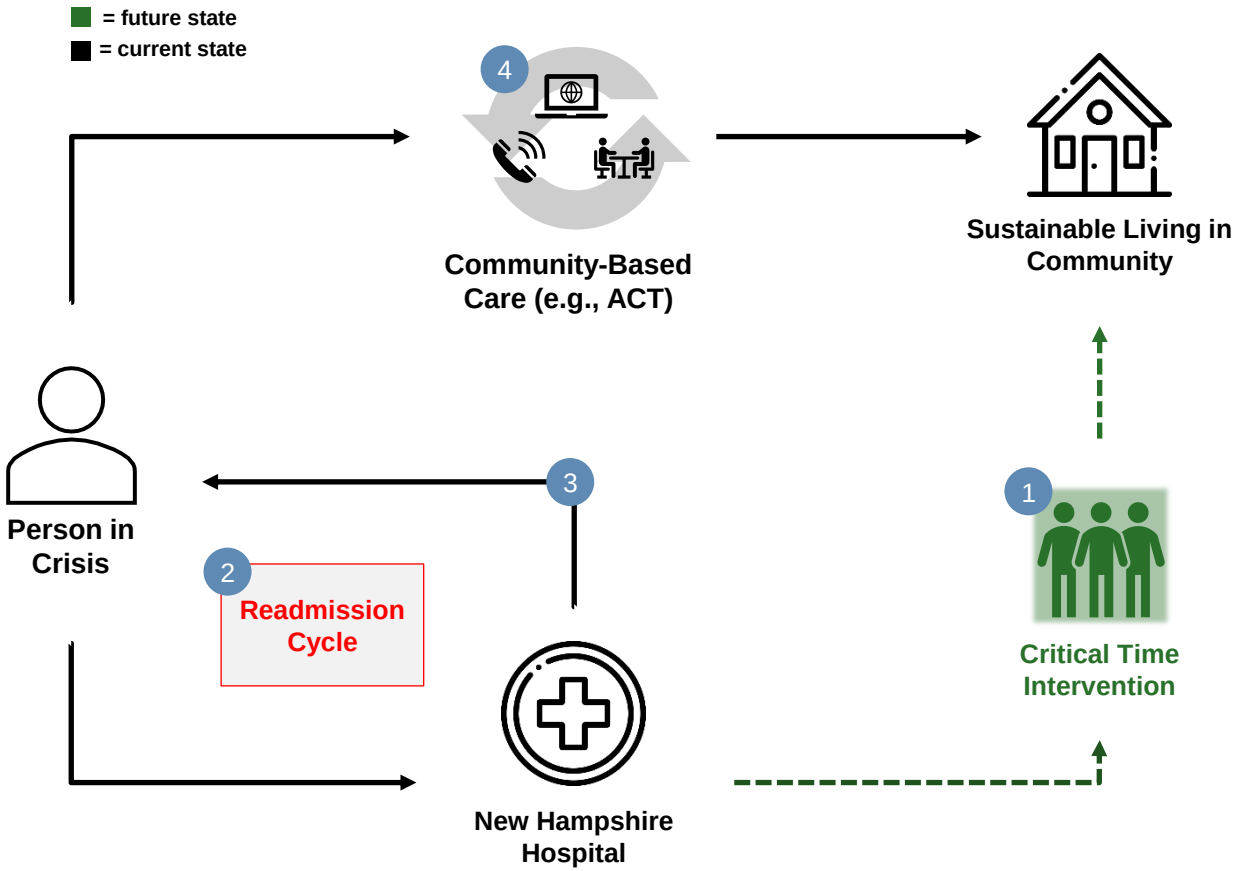


Phase Summary	Eligibility and Fidelity[1]	History and Efficacy*
Pre-CTI: CTI team meets with client and establishes personal relationships (prior to hospital discharge). **Phase 1:** CTI team connects client to people and agencies ("linkages") that will assume the primary roles of support (e.g., food, housing, healthcare, employment, family, etc.). **Phase 2:** CTI team observes operation of client's new support network; mediates any conflict between client and caregivers; and encourages client to take increasing responsibility. **Phase 3:** CTI team and client develop plan for long-term goals; plan for and execute final transfer of care to linkages. CTI team ensures client can function independently of CTI.	Eligible individuals include those with severe mental illness (SMI) and severe and persistent mental illness (SPMI) undergoing a vulnerable moment of transition – e.g., discharge from a psychiatric hospital. Key fidelity requirements include: 1. Focused on fixed period of transition 2. Time-limited (9 months) 3. Phased approach (beginning, middle, end) • Unique activities in each stage • Decreasing intensity over time 4. "Bridge" to long-term provision of supports and services – CTI team itself is not the provider	CTI was developed originally in New York City by clinicians, researchers, and advocates working with mentally ill and homeless individuals. They observed that transitions from homeless shelters or hospitals back to the community represented one of their patients' greatest challenges. CTI was thus designed as a short-term intervention for people undergoing a "critical time" of transition in their lives.[2] Multiple studies have demonstrated that CTI: 1. Decreases hospital readmission[3] 2. Improves housing stability and clinical outcomes (e.g., decreased alcohol and drug use)[4] 3. Improves continuity of care after inpatient discharge[5]

See "Sources" slide below for full list of source materials

** Two RCTs are being conducted by **Arnold Ventures** to further quantify the impact of CTI, demonstrating significant interest in the model and its benefits*

CTI specifically addresses the unique needs of individuals transitioning out of inpatient care. It can serve as a targeted complement to more intensive mental health care treatments, such as ACT.



Key Considerations

1. CTI targets individuals in transition and thus at risk of hospital readmission in the future. Patients typically receive little support after discharge other than basic case management, increasing odds of readmission.

2. CTI aims to break this "readmission cycle" by giving a patient hands-on guidance to return to the community and create linkages that will enable them to live sustainably.

3. In New Hampshire in FY18, **26% of all NHH discharges were readmitted within 180 days**; in FY19 and FY20, **19% and 20% of all discharges were readmitted within 180 days**, respectively.[6]
   - 342 people in FY18
   - 220 people in FY19
   - 240 people in FY20

4. CTI is not **mutually exclusive with or divorced from other community-based care models**; it is a targeted, time-limited intervention that can **complement** more involved models like ACT.

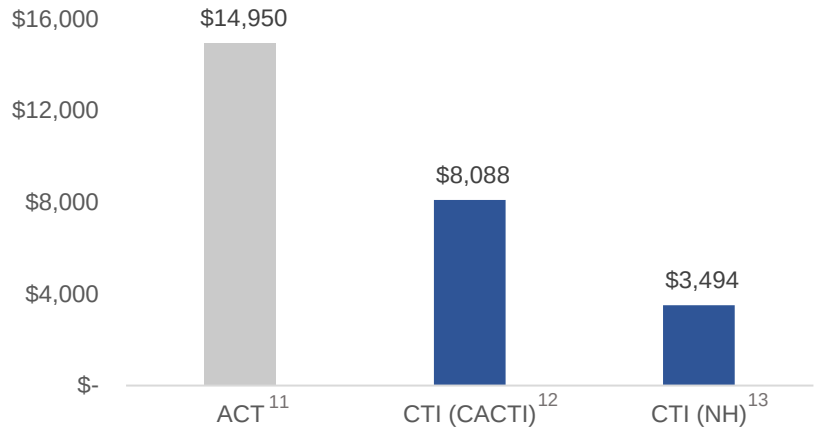
See "Sources" slide below for full list of source materials

ACT is a well-regarded and effective practice that serves a discrete population in need. CTI, with its broader applicability, represents a cost-effective, flexible, and scalable complement to ACT.

Criteria	ACT	CTI
Staffing (per team)	7-10 individuals, including psychiatrist, nurse, peer specialist, Masters-level clinician, functional support worker; staff must be trained in substance abuse, housing assistance, and supported employment[7]	3-5 individuals including one supervisor (Masters preferred but not required) and field workers[8]
Caseload (per team)	10 clients	40-80 clients (~20 per field worker)[9]
Timeframe	Indefinite	9 months
Fidelity Requirements	Extensive*, including: • Large, skilled staffing requirement (as above) • 24/7 team availability • Wide-ranging clinical and social support, from psychiatry to substance abuse support • Rigid engagement requirements with client (e.g., team meetings 4x / week)[10]	Minimal: • Focused on fixed period of transition (9 months) • Phased approach with decreasing intensity • "Bridge" to long-term provision of supports and services
Cost per Client	*See chart at right*	*See chart at right*

** The Dartmouth Assertive Community Treatment Scale (DACTS), an authority on ACT, includes 28 discrete fidelity requirements.*

ACT and CTI: Average Cost per Client

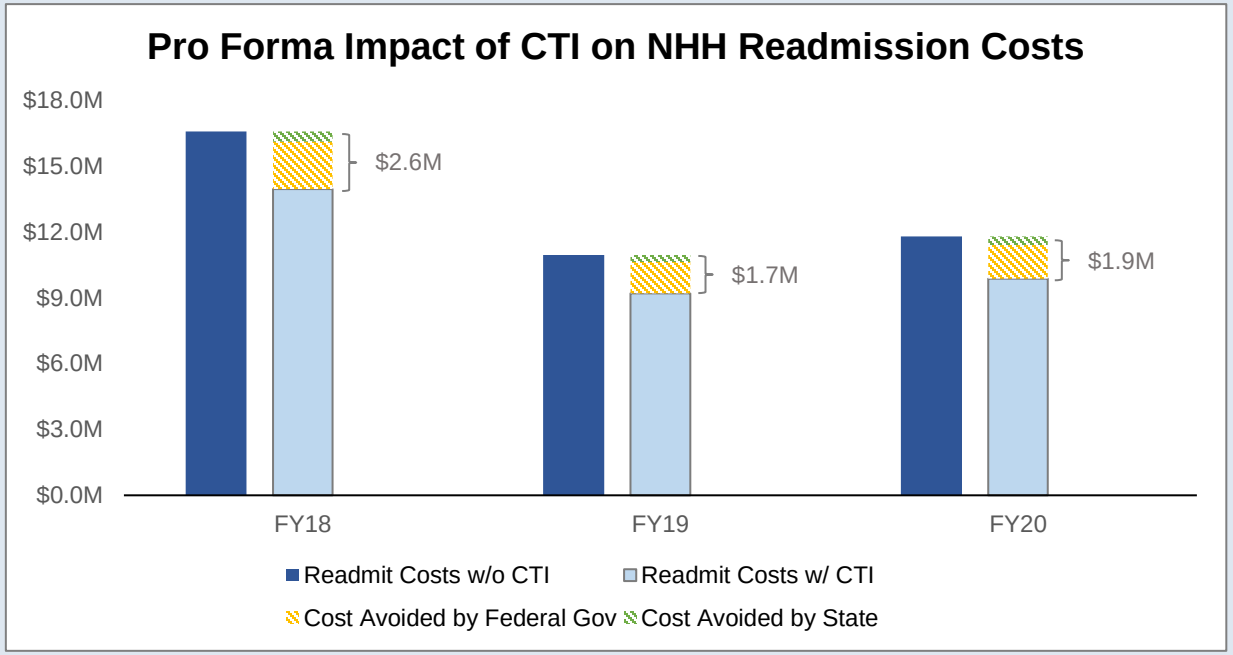


NB – ACT and CTI (CACTI) costs trended to 2019

- Less than 1% of those screened for ACT receive ACT services, and the State is not currently meeting ACT caseload and capacity targets.[14]
- CTI's lower cost, flexible design, and track record suggest it may be a valuable complement to ACT. Introducing CTI to DHHS' step-down toolkit may demonstrate the State's commitment to supporting people exiting institutional settings.

See "Sources" slide below for full list of source materials

Implementation of CTI at New Hampshire Hospital could have avoided up to $1.2M in hospitalization costs to the State and prevented 209 hospital readmissions between FY18-20.



Costs / Savings	FY218	FY19	FY20
Readmit Costs w/o CTI	$16.6M	$11.0M	$11.8M
Readmit Costs w/ CTI	$14.0M	$9.3M	$9.9M
Cost Avoided by Federal Gov	*$2.1M*	*$1.4M*	*$1.5M*
Cost Avoided by State	*$0.5M*	*$0.3M*	*$0.4M*

NB - net savings shown; "Readmit Costs w/ CTI" include cost of CTI

- Analysis of New Hampshire Hospital readmission data from FY18-20 shows patient readmission rates between 19% and 26% annually.[15]
- CTI studies suggest CTI can reduce hospital readmission rates by 26% if eligible individuals receive CTI treatment post-discharge.[16]
- A&M model suggests that CTI's impact for FY18-20 could have **led to 209 fewer readmissions to NHH** and avoided $6.3M in hospitalization costs**, of which $1.2M would have accrued to the State**.
  - $2.6M total in FY18 - $0.5M to NH
  - $1.7M total in FY19 - $0.3M to NH
  - $1.9M total in FY20 - $0.4M to NH
- Under this baseline scenario, the savings from avoided readmissions are split evenly between the State and the Federal Government, with the State absorbing the cost of CTI. It is possible, however, that the Federal Government could shoulder some of CTI's costs if the State billed the program through Medicaid.

See "Sources" slide below for full list of source materials

The State should evaluate several funding options for CTI with the goal of long-term, reliable financing. Billing CTI via Medicaid has advantages: it could have avoided $3.1M in hospitalization costs over FY18-20.

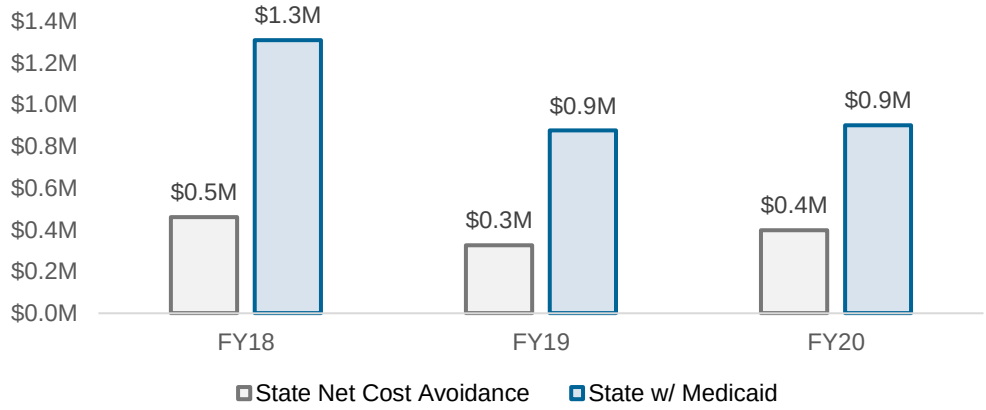
Funding	Advantages	Disadvantages
Government Grants / Contracts	• State contracts or federal grants ensure funds dedicated strictly for CTI capacity creation; SAMSHA has awarded CTI-specific grants in the past (e.g., the Idaho Department of Health and Welfare)[17]	• Grants and contracts require reauthorization and are delivered in discrete amounts. • Federal grants are unlikely to prove sustainable over the long term.
Nonprofit / Foundation Grants	• Nonprofit grants can cover some or all program start-up costs, as well as studies of program effectiveness (e.g., RCTs). • Grants can come with organizational expertise in CTI or similar interventions.	• Grants are delivered in discrete amounts that may not always cover costs and may prove time-limited.
Medicaid (FFS)*	• Billing as a fee-for-service via Medicaid allows for FMAP, reducing cost to the State. • Payment is tied to provision of CTI services. • More data created as a result of Medicaid inclusion, making more analysis possible across patients and populations.	• Potential lack of service codes that match all CTI activities.[18] • Won't cover those who don't have or won't qualify for Medicaid.
Bundled or "Case" Rate*	• Bundled rate allows for easy, predictable payments to providers. • Payment covers all services a qualifying patient receives, at a set monthly or daily rate. • Covers the full scope of CTI activities.	• Bundled rate development necessary as a precursor; will need to win buy-in of providers.
MCOs*	• Payors may be incentivized to promote CTI to reduce hospital readmission costs. • Payment for CTI services can be bundled into existing admin or PMPM rates.	• MCOs are inherently conservative with new programs and typically cost-averse (even for programs with long-run ROI in the form of cost avoidance).

**** Medicaid options***

See "Sources" slide below for full list of source materials

1. Multiple stakeholders will need to be involved to stand up and expand a statewide CTI program, including providers, CMHCs, CTI experts and trainers (e.g., CACTI staff), and the State's DHHS and political leadership.
2. An extensive "learning infrastructure" is also important for a CTI roll-out – i.e., a collaborative community of practitioners.
3. New Hampshire has experimented with five CTI pilot projects at several Integrated Delivery Networks. These CTI pilots have shown promise and demonstrate a foundation for the model already exists.
4. Several states and municipalities have already adopted CTI or CTI-informed programs. North Carolina developed a CTI program with extensive support from CACTI and a billing rate run through Medicaid.
5. CTI should be viewed as a complementary addition to the various care management and coordination supports under the State's 10-Year Mental Health Plan. It is not duplicative of any other existing services.

Potential Medicaid Impact on State Savings



Behavioral Health | Critical Time Intervention | Sources

1. Interview with Daniel Herman, Ph.D, member of CACTI, conducted November 23, 2020
2. Center for the Advancement of Critical Time Intervention (CACTI), https://www.criticaltime.org/
3. Tomita, Andrew and Herman, Daniel. “Impact of Critical Time Intervention in Reducing Psychiatric Rehospitalization After Hospital Discharge.” Psychiatric Services, September 2012
4. Kasprow, Wesley and Rosenheck, Robert. “Outcomes of Critical Time Intervention Case Management of Homeless Veterans After Psychiatric Hospitalization.” Psychiatric Services, July 2007
5. Dixon, Lisa et al. “Use of a Critical Time Intervention to Promote Continuity of Care After Psychiatric Inpatient Hospitalization.” Psychiatric Services, April 2009
6. New Hampshire Hospital Admission Data, FY18-20, provided by Andrew Chalsma
7. New Hampshire Community Mental Health Agreement
8. Center for the Advancement of Critical Time Intervention (CACTI), https://www.criticaltime.org/
9. Interview with Daniel Herman, Ph.D, member of CACTI, conducted December 7, 2020
10. Dartmouth Assertive Community Treatment Scale, Revised 2017
11. New Hampshire CMHC 2018 Financial Reports
12. “Evidence Summary for the Critical Time Intervention.” *Social Programs That Work*, The Arnold Foundation, August 2018
13. June 2020 New Hampshire DSRIP Integrated Delivery Network Semi-Annual Reports
14. New Hampshire Community Mental Health Agreement Quarterly Data Report: April – June 2020, published October 14, 2020
15. New Hampshire Hospital Admission Data, FY18-20, provided by Andrew Chalsma
16. “Evidence Summary for the Critical Time Intervention.” *Social Programs That Work*, The Arnold Foundation, August 2018
17. Center for the Advancement of Critical Time Intervention (CACTI), “CMHS funds three new CTI programs through Transformation grant program,” https://www.criticaltime.org/2011/02/01/cmhs-to-fund-three-new-cti-programs-through-transformation-grant-program/
18. Interview with Daniel Herman, Ph.D, member of CACTI, conducted November 23, 2020

Behavioral Health | CMHC Funding Rationalization | Executive Summary | Overview

Scope: New Hampshire provides regular contract funding to the 10 Community Mental Health Centers (CMHCs) that operate across the State. These CMHCs play a vital role in the broader continuum of care, offering a range of mental health services to predominantly lower-income populations. At the State's request, A&M explored how funding for the CMHCs may be rationalized in order to:

1) Tie funding more closely to the provision of services
2) Potentially generate savings for the State

Approach: A&M worked with the staff of DBH to gather and review documents and data related to the CMHCs' finances and State-funded programs. A&M conducted research on bundling rates via Medicaid, and on how other states have approached creating bundled rates for select services. This research included interviews with current and former Medicaid staff from other states. A&M also engaged in multiple conversations and correspondence with DBH staff.

Results: Several key findings emerged from A&M's discussions with stakeholders, document review, and data analysis:

1) Assertive Community Treatment (ACT) constitutes 41% of all State contract funding to CMHCs between FY18-21
2) Payments for services such as ACT are often bundled in other states and run through Medicaid
3) There are inactive Medicaid codes that could be activated and may cover the cost of some of the State's contracts

Based on these findings, A&M recommends that the State rationalize CMHC funding by (1) adopting a bundled rate for specific services (e.g., ACT); and (2) shifting State-funded programs to Medicaid reimbursement.

Behavioral Health | CMHC Funding Rationalization | Executive Summary | Recommendations (Short-Term)

A&M has identified the following recommendation for CMHC funding. All figures are General Fund; savings reflect average annual figures while costs reflect one-time costs.

			Est. Costs ($M)*		Est. Savings ($M)	
#	Recommendation	Description	Low	High	Low	High
A.2	Rationalize CMHC funding	Bundling payments of specific State-funded services, such as ACT, and activating currently dormant Medicaid codes may generate savings for the State.	$0	<$.2M	$.8M	$1.7M

** Non-zero cost assumes some minimal spend on accounting firm to validate proposed ACT bundled rate*

Behavioral Health | CMHC Funding Rationalization | Executive Summary | Approach

Stakeholder Engagement

Key Personnel Interviewed

DHHS Division for Behavioral Health

- Katja Fox, Division Director
- Julianne Carbin, Director, Bureau of Mental Health Services
- Jayne Jackson, Finance Director
- Kelley Capuchino, Senior Policy Analyst
- Tanja Godtfredsen, Business Administrator
- Kyra Leonard, Business Administrator

New York State Office of Mental Health

- Nicole Haggerty, Director, Bureau of Rehabilitation Services and Care Coordination

Steele Policy Strategies

- Jennifer Steele, former Louisiana State Medicaid Director

Data Request

Key Data Reviewed

- CMHA Progress Reports
- New Hampshire CMHA
- New Hampshire CMHA Quarterly Progress Reports
- New Hampshire CMHC 2018 financial reports
- ACT Quality Reports
- ACT data and payment rates for MA, RI, NY, IA
- Medicaid codes and descriptions
- ACT academic literature
- CMS guidance on bundled rate development

Behavioral Health | CMHC Funding Rationalization | Summary (1 of 2)

Recommendation

Rationalize CMHC funding by (1) adopting a bundled rate for specific services (e.g., ACT); and (2) shifting State-funded programs to Medicaid reimbursement.

Findings

The State spends $6.9M per year, on average, on CMHC contracts. Starting in the next fiscal year, this figure may rise to as much as $9M per year as the State's DSHP payment expires. These State contracts are "block grants" and are not directly tied to the provision of services.

Observations:

- The State funded 21 CMHC programs from FY18-21, totaling $28M.
- Assertive Community Treatment (ACT) constitutes 41% of all State contract funding to CMHCs between FY18-21. Any effort to rationalize CMHC funding should logically start with ACT.
- Payments for services such as ACT are often bundled in other states and reimbursed through Medicaid on a monthly or daily basis.
- There are at least 21 inactive Medicaid codes that could be activated and may cover the cost of some of the State's contracts.

COVID Impact:

A bundled ACT rate, and the possible activation of more Medicaid codes, could result in more data collected by CMS, allowing for better tracking and analysis of individuals with COVID symptoms.

Benefits

- Creating a bundled rate allows for effective reimbursement of providers, based on actual service delivery, while still allowing the State to control costs.
- Depending on the rate, a bundled ACT rate can generate savings or be cost-neutral to the State while removing the overhead of contract management.
- Bundled rates are ideal for multidisciplinary services, like ACT, that involve diverse activities that may not all be individually billable under Medicaid. A bundled rate streamlines the billing for those activities into a single payment.
- Shifting State-funded CMHC programs to Medicaid reimbursement, if possible, would allow for the State to take advantage of FMAP for those services billed to Medicaid.

	Low*	High*
Net Savings	$.8M	$1.7M
Impl. Costs	<$.2M	$0
Net Benefit	**$.6M**	**$1.7M**
Timeframe	9-12 months for ACT rate development and CMS approval. 3-4 weeks for Medicaid code review.	
Complexity	Low	

** Savings and costs tied to bundling ACT; analysis of Medicaid code activation is still required*

Behavioral Health | CMHC Funding Rationalization | Summary (2 of 2)

Recommendation

Rationalize CMHC funding by (1) adopting a bundled rate for specific services (e.g., ACT); and (2) shifting State-funded programs to Medicaid reimbursement.

Implementation Requirements

People	• Analysts to develop new ACT bundled rate and review Medicaid codes for possible activation • State's Medicaid policy team (for drafting SPA) • Third party firm to verify proposed ACT rate (e.g., accounting firm)
Process	• Develop and vet new ACT bundled rate • Engage CMS in ongoing dialogue around proposed ACT rate; complete required CMS documentation • Draft State Plan Amendment (SPA) to authorize new rate • Review inactive Medicaid codes
Technology	• Ensure that State has a system for tracking ACT outcomes; presenting this data to CMS will be a core part of the SPA. • CMHCs should already have the capacity to bill for Medicaid claims, using standard FFS billing procedure or bundled rate
Prep. Work	• Connect with CMHCs to discuss bundled rate and obtain data • Collect evidence of ACT effectiveness for CMS; frame value of rate and emphasize it allows State management of delivery and costs • Research into allowable application of dormant Medicaid codes
Statute	• N/A – no statutory obstacles or requirements

Timeline Outline

Target Start Time: ~January 2021

Time Range	Basic Tasks
Months 1-3	Discuss ACT bundled rate with CMHCs and collect data; conduct rate setting analysis; review Medicaid codes to activate
Months 3-9	Draft SPA for submission to CMS; engage in ongoing dialogue with CMS; vet proposed ACT rate with third party, if needed
Months 9-12	Finalize SPA and rate with CMS; roll out to CMHCs

DHHS should move to set a bundled ACT rate before new CMHC contracts are in place, especially due to loss of DSHP. Other states report this timeline may be elongated because of the ongoing PHE and transition to a new Federal Administration.

Risks

- Shifting programs to Medicaid may not cover those ineligible for Medicaid – the State may consider continuing contracts, in some form, to cover that portion of the population.
- Utilization management is critical – the State will need to define what level of service qualifies for the monthly rate, and what level of service may require a reduced (e.g., half-monthly) rate, to promote cost containment.[1]
- CMS approval process is rigorous – the State will need to demonstrate strong evidence of the positive outcomes of ACT and the benefits of shifting to a bundled rate.

The State funded 21 CMHC programs with contracts from FY18-21, totaling $28M.[2] The annual expenditure on contracts is expected to increase by $2M annually as a result of the State's DSHP payment expiring.

CMHC FY18-21 Budgeted State Contracts, by Program

#	CMHC Program	FY18	FY19	FY20	FY21	FY18-21	% Total
1	ACT - Adults	2,730,000	2,730,000	2,955,000	2,955,000	11,370,000	41%
2	Emergency Services	1,507,708	1,507,708	1,507,708	1,507,708	6,030,832	22%
3	Cypress Center Funding	675,000	675,000	675,000	675,000	2,700,000	10%
4	BCBH	280,000	285,000	400,000	400,000	1,365,000	5%
5	Deaf Services Funding	326,500	326,500	326,500	326,500	1,306,000	5%
6	REAP Funding	245,000	245,000	245,000	245,000	980,000	4%
7	Specialty Residential Services Funding	201,444	201,444	246,444	246,444	895,776	3%
8	PATH Provider (BHS Funding)	208,171	208,171	235,628	235,628	887,598	3%
9	System Upgrade Funding	-	300,000	-	-	300,000	1%
10	IRB Funding	63,000	63,000	63,000	63,000	252,000	1%
11	ACT Enhancement Payment - Adults	-	250,000	-	-	250,000	1%
12	Housing Bridge Start Up Funding	-	250,000	-	-	250,000	1%
13	BHSIS	50,000	50,000	50,000	50,000	200,000	1%
14	RENEW	40,873	40,873	48,000	48,000	177,746	1%
15	Glencliff Home In-Reach-Services	-	-	132,122	15,963	148,085	1%
16	First Episode Psychosis Program	-	21,500	61,162	61,162	143,824	1%
17	MATCH	16,000	20,000	50,000	50,000	136,000	0%
18	General Training Funding	-	100,000	-	-	100,000	0%
19	Refugee Interpreter Services	24,000	24,000	24,000	24,000	96,000	0%
20	DCYF Consultation	23,010	23,010	23,010	23,010	92,040	0%
21	Alternative and Crisis Housing Subsidy	22,000	22,000	22,000	22,000	88,000	0%
	Totals	6,412,706	7,343,206	7,064,574	6,948,415	27,768,901	

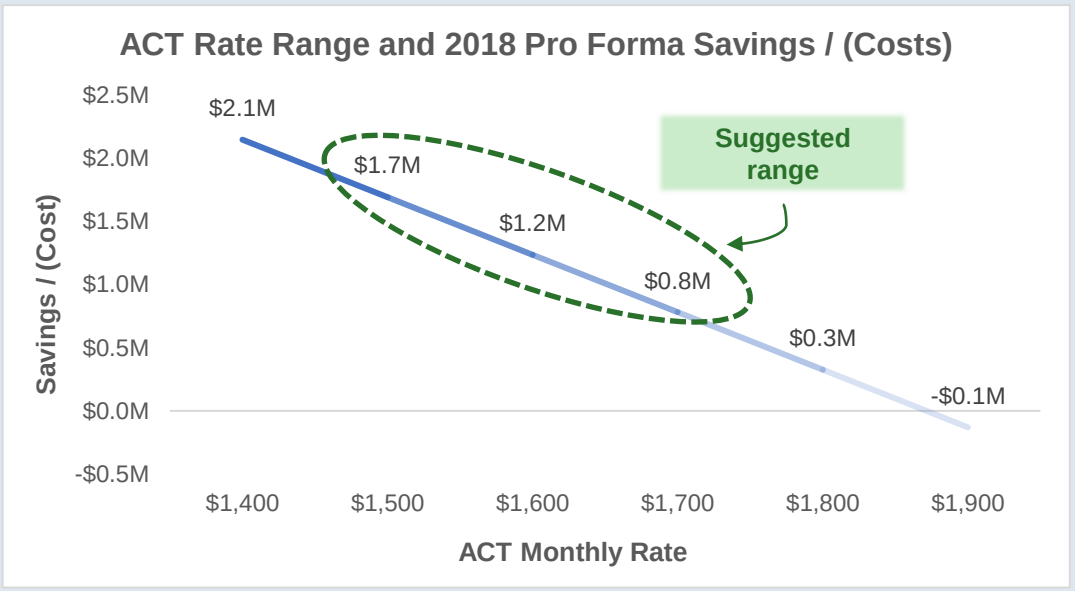
1. The State's annual CMHC contracts are intended to cover the costs of CMHC services that are unqualified for, or uneconomical to bill through, Medicaid. There are also some recipients who receive these services who do not meet the Medicaid eligibility criteria.
    - These contracts address a real funding need and ensure CMHCs (and the State) can provide a full continuum of BH services.

2. These contracts **average $6.9M annually between FY18-21 and are poised to increase by $2M annually** with the expiry of the State's DSHP payment (with most of the increased cost coming from ACT and Emergency Services).[3]

3. A&M was unable to obtain documentation of the Medicaid codes billed for each program; it is unclear if such an inventory exists. A&M did obtain a partial list of inactive Medicaid codes that could potentially be used to bill for some or all contract-funded services.[4]
    - It is unclear from conversations with State stakeholders and from document review why these codes are inactive.

See "Sources" slide below for full list of source materials

The State should consider alternative funding sources for these CMHC programs. Creating a bundled rate for ACT, for example, could generate savings for the State with minimal impact on CMHC finances.



State	Monthly Rate	
New York	$	1,719
Iowa	$	2,025
Massachusetts	$	1,446
Rhode Island	$	1,250
Average	$	1,610

*Bundled ACT rates are common among states. New York sets a monthly rate[6]; Massachusetts[7], Iowa[8], and Rhode Island[9] operate under daily rates (shown as monthly at left).**

* Other states with bundled ACT rates include North Carolina, Delaware, Oregon, Ohio, Washington, and Nebraska

- **ACT constitutes 41% of CMHC contract payments between FY18-21**, and thus represents the biggest opportunity for savings.
- A&M modeled the impact of a bundled ACT rate by developing a range of rates (benchmarked against other states), applying those rates to 2018 CMHC financials (the most recent data made available to A&M), and backing out that year's contract payments.[5]
- The model compares the net savings or cost to the State if a particular rate had been in effect during 2018. Bundling ACT in this manner allows the State to obtain a federal match for all ACT spending.
- **The effect of implementing a bundled ACT rate on CMHC revenue is minimal**: a rate of $1,500 causes an average revenue decline of 0.7%; a rate of $1,700 causes an average revenue increase of 0.2%.

- DHHS stakeholders also identified 21+ Medicaid codes that are currently "inactive" – that is, not being billed by the CMHCs. It is possible that these codes may be applicable to some or all the existing contract-funded CMHC programs.
- The State should consider creating a complete inventory of the codes used by each program; as of today, it is not clear that such an inventory exists. This will allow for deeper analysis of program costs and potential savings from activating currently inactive Medicaid codes.

Requires further research and analysis

See "Sources" slide below for full list of source materials

Behavioral Health | CMHC Funding Rationalization | Sources

1. “Utilization Management Guidelines for New York State Medicaid Managed Care Organizations (MMCO) and Health and Recovery Plans (HARP) regarding Assertive Community Treatment (ACT)”, New York Office for Mental Health, April 2019
2. New Hampshire CMHC Mental Health Contracts and Amendments
3. Interview with Julianne Carbin, Tanja Godtfredsen, Jayne Jackson, and Kyra Leonard, November 23, 2020
4. Email correspondence with Kelley Capuchino, November 12, 2020
5. New Hampshire CMHC 2018 financial reports
6. New York State Office of Mental Health, Regional ACT Rates, Effective 4/1/2020
7. Commonwealth of Massachusetts Regulations, Section 430.03, https://www.mass.gov/regulations/101-CMR-43000-rates-for-program-of-assertive-community-treatment-services
8. Iowa Department of Human Services, “Assertive Community Treatment Reimbursement Rates Report.” December 215, 2018
9. “Behavioral Health Comparison Rate Report”. Prepared for State of Rhode Island Executive Office of Health and Human Services, Milliman Client Report, February 13, 2020

Sununu Youth Services Center (SYSC)

SYSC | Executive Summary | Overview

Background: The youth population at Sununu Youth Services Center (SYSC), consistent with national trends in juvenile justice, declined in recent years for several reasons. Among the most prominent is the decline in the use of secure facilities to incarcerate juvenile offenders, as research and experience demonstrated that incarceration is inappropriate for most juveniles. Nonetheless, all states maintain secure care and treatment options for the subset of juvenile delinquents who have committed violent crimes and who pose a significant threat to their communities. The Department should anticipate that a secure detention/correctional facility will continue to be necessary.

Scope: A&M was tasked with reviewing the current operations of the Sununu Youth Services Center (SYSC). A&M focused on observing the current Juvenile Justice Services (JJS) System of Care, utilization of the current SYSC facility, understanding the historical and present context that affects the daily census, and the impact of recent legislation on providing critical juvenile justice services. A&M also analyzed and benchmarked metrics of facilities and compared them to the current operations of SYSC.

Approach: A&M began by developing an understanding of major services provided by JJS/DCYF, focusing on critical pain points outlined by stakeholders. In partnerships with SYSC and DCYF staff, A&M interviewed stakeholders, reviewed past reports and audits, and reviewed current operations. Working with leadership in DHHS and DCYF, A&M was able to identify key recommendations for the SYSC facility moving forward.

Results: A&M identified two high-level recommendations as a result of its review of SYSC:

1a) Continue to build out the System of Care for DCYF and SYSC to establish a feasible timeline and long-term plan to right-size the SYSC facility

1b) Identify concurrent uses for the SYSC facility

SYSC | Executive Summary | Recommendations (Short-Term)

A&M identified the following short-term recommendations for SYSC.

			Est. Costs ($M)		Est. Savings ($M)*	
#	Recommendation	Description	Low	High	Low	High
B.1.a	SYSC System of Care and Long-Term Plan	Continue to build out the System of Care for DCYF to inform a feasible timeline and long-term plan to right-size the SYSC facility.	*Proper cost and savings estimates require further review and depend on future actions of the State.*			
B.1.b	Establish Concurrent Uses for SYSC	Identify concurrent uses for the SYSC facility to offset costs.				

** There are potential cost aversion opportunities associated with implementing a concurrent use for the SYSC facility.*

SYSC | Executive Summary | Approach

Stakeholder Engagement

Key Personnel Interviewed

DHHS Division of Children, Youth and Families

- Joe Ribsam, Director, Division for Children, Youth and Families
- Rhonda Chasse, Director of Operations for Sununu Youth Services Center

Other DHHS Stakeholders

- Lori Weaver, Deputy Commissioner
- Kerrin Rounds, CFO

Data Request

Key Data Reviewed

- DCYF 2020 Databook
- DCYF 2019 Databook
- DCYF Service Array
- SYSC Recidivism Data FY16 – FY19
- Legislative Updates HB397, HB517
- SYSC Historical Census Data
- Report to Fiscal Committee of the General Court as to Most Appropriate, Cost Effective, Long and Short-Term Uses of SYSC (11/2014)
- Cost Reduction Plan for Sununu Youth Services Center (11/2015)
- NH DCYF Adequacy and Enhancement Assessment (7/2018**)**
- Committee to Study Alternatives to the Continued Use of SYSC Facility (11/2018)

SYSC | Summary (1 of 2)

Recommendation

Continue to build out the System of Care for DCYF to inform a feasible timeline and long-term plan to right-size the SYSC facility, while simultaneously identifying concurrent uses for the SYSC facility.

Findings

Problem Statement: The youth population at SYSC has continued to decline in recent years, consistent with national trends in juvenile justice, but return rates have increased. Additionally, due to the low utilization, a portion of the current facility is unused, while fixed costs of maintaining SYSC remained almost the same.

Observations: Among the most prominent reasons for the decreased census is the decline in secure facilities to incarcerate juvenile offenders. Most recently, decreased census was driven by changes to sentencing and the implementation of sentence review enacted by the Legislature under HB 517.

- Admissions of committed juveniles have decreased by 56% between FY17 and FY20
- Average utilization of SYSC in FY20 was 12%, an average daily population of 16.9 in a building with a capacity of 144.
- Recidivism rates have increased since the implementation of HB 517; FY19 saw a recidivism rate of 81.5%. The high recidivism rates are consistent with gaps in the System of Care.

Benefits

Focusing on the gaps in the current System of Care will allow:
1) More alternative placements for youth
2) Step-down and transitional options for eligible youth committed at SYSC with the opportunity to reduce recidivism rates
3) DHHS to more effectively plan for a long-term transition from the SYSC facility

Identifying concurrent uses of the SYSC facility will allow for:
1) DHHS to offset high costs

	Low	High
Savings	*Proper cost and savings estimates require further review and depend on future actions of the State.*	
Costs		
Net Benefit		
Timeframe	1 – 5 years	
Complexity	High	

SYSC | Summary (2 of 2)

Recommendation

Continue to build out the System of Care for DCYF to inform a feasible timeline and long-term plan to right-size the SYSC facility, while simultaneously identifying concurrent uses for the SYSC facility.

Implementation Requirements

People	• Establish a working group/task force responsible for creating a long-term feasible plan to right-size the SYSC facility. Task force should include stakeholders from DCYF, DHHS, Law Enforcement, Public Defenders, etc.
Process	N/A
Technology	N/A
Prep. Work	• Read all reports/audits that have been conducted on SYSC in the past ten years • Continue to procure services that will build out the DCYF/JJS System of Care • Identify DOJ requirements
Statute	• Conduct a statute review of all recent legislation to affect JJS youth, and identify potential changes necessary to build out the continuum of care

Timeline Outline

Target Start Time: To Be Determined

Time Range	Basic Tasks
Year 1	• Continue to build out the continuum of care • Select viable concurrent uses of the SYSC facility
Year 2-4	• Continue to build out the continuum of care • Track and monitor outcomes of building out system of care • Implement selected option for concurrent uses of the SYSC Facility • Begin drafting a long-term plan to shift from SYSC facility
Year 5	• Begin transition from SYSC facility

Risks

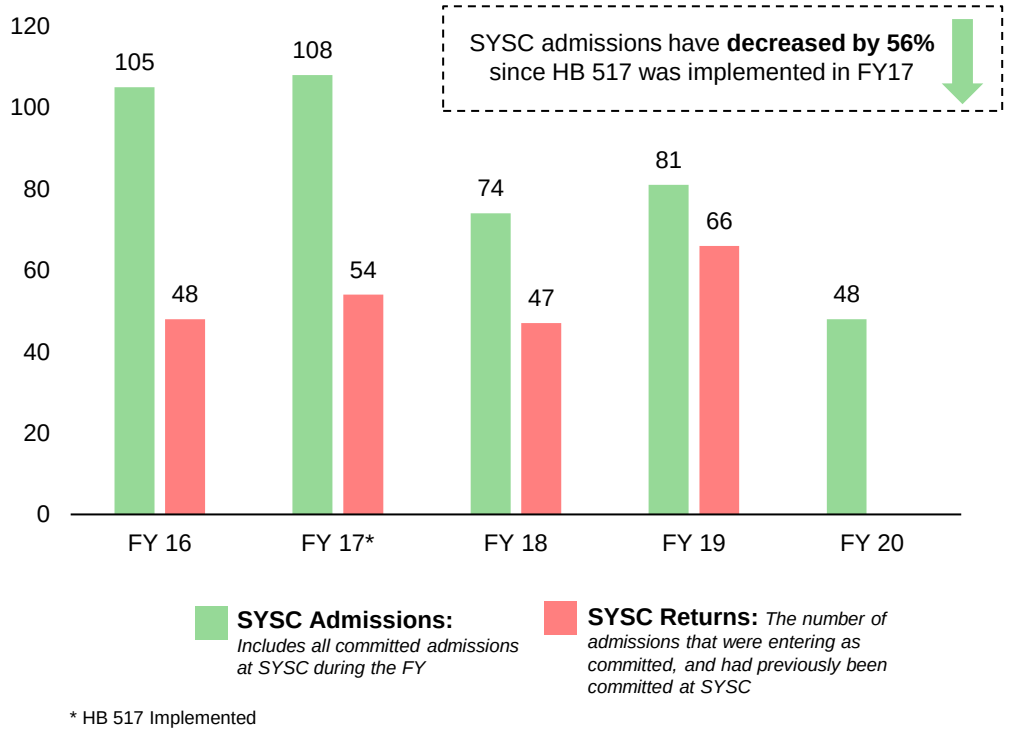
- SYSC was built using Federal DOJ Grant dollars ($13.4M) that requires the State to obtain DOJ approval in altering the purpose of the SYSC facility
- No other in-state correctional placement option in NH to place youth

SYSC | Reform Efforts in New Hampshire

Recent trends in juvenile justice have focused on diverting youth from the juvenile justice system, shifting resources from incarceration to community-based alternatives. In recent years, New Hampshire enacted the following juvenile justice reforms:

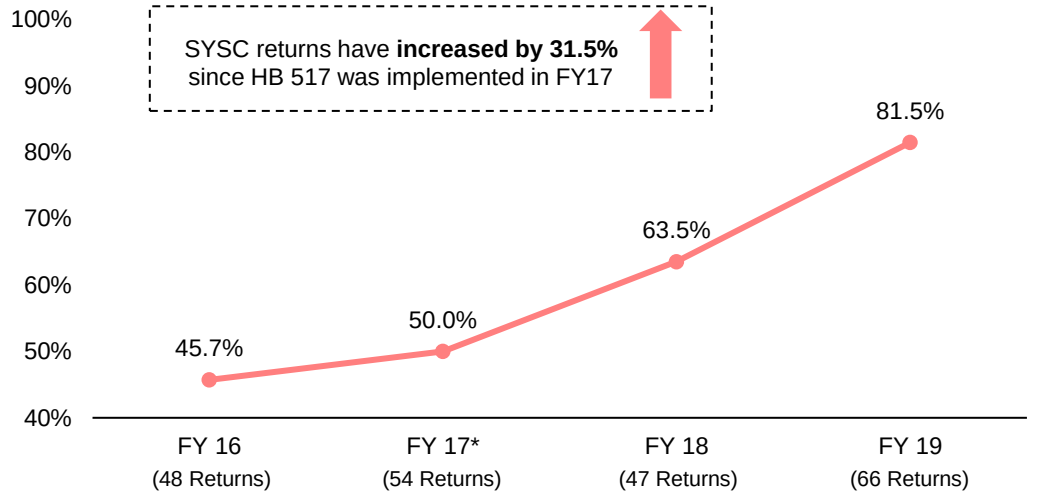
- **HB 517**, enacted in June 2017, limited the types of youth that could enter SYSC and shortened the timeline youth spent at SYSC.
- **SB 592**, enacted in June 2018, waives reimbursement for voluntary services under the child protection act, establishes a home visiting services initiative, expands certain childcare services and establishes a committee to study family drug court models.

A) SYSC Admissions vs. Returns



* HB 517 Implemented

B) SYSC Recidivism Rates



Increasing recidivism rates suggest gaps in the JJS/DCYF System of Care: 1) youth who leave SYSC are not receiving the level of care necessary to support them outside of the correctional setting; 2) youth who stay at SYSC for a short time (i.e., 3 months) often do not have enough time to receive the treatment they need.

SYSC | DCYF System of Care

DCYF and Children's Behavioral Health should continue to develop the System of Care (depicted below) for children in SYSC, with the goal of reducing recidivism and offering more comprehensive aftercare before moving to close or repurpose the facility.

Low — Intensity — High

1	2	3	4	5	6	7	8	9	10	11
Child Health Support Services (CHS)	Home-Based Therapeutic Services (HBT)	Therapeutic Day Treatment Services Programs (TDT)	Adolescent Community Therapeutic Services (ACT)	Individual Service Options In-Home	Supportive, Community Level Treatment	Intermediate Treatment	Intensive Treatment	High Intensity/Sub-Acute	Psychiatric Residential Treatment Facility (PRTF)	Sununu Youth Services Center
					Transitional Living, Supervised Living, Therapeutic Foster Care		*Intensive Treatment, Shelter Care, Assessment Treatment, Crisis Treatment*	*High Intensity/Sub-Acute, CBAT, ICABT, ERT*		

Gaps in the JJS System of Care

7 The depth and breadth of services available and accessible to youth involved in the **juvenile justice system and SYSC are inadequate,** especially with regards to mental health and substance abuse services. **Youth being released from SYSC are often linked to needed mental health services and often re-offend due to long wait periods for such services.**

11 Due to the requirements outlined in HB17, youth released from SYSC are often returned to parent/guardian with minimal or no requirements to “step-down” into a more appropriate placement. Without adequate post-discharge treatment, youth are more likely to reoffend. From FY16 to FY19, recidivism rates have **increased by 31.5%.**

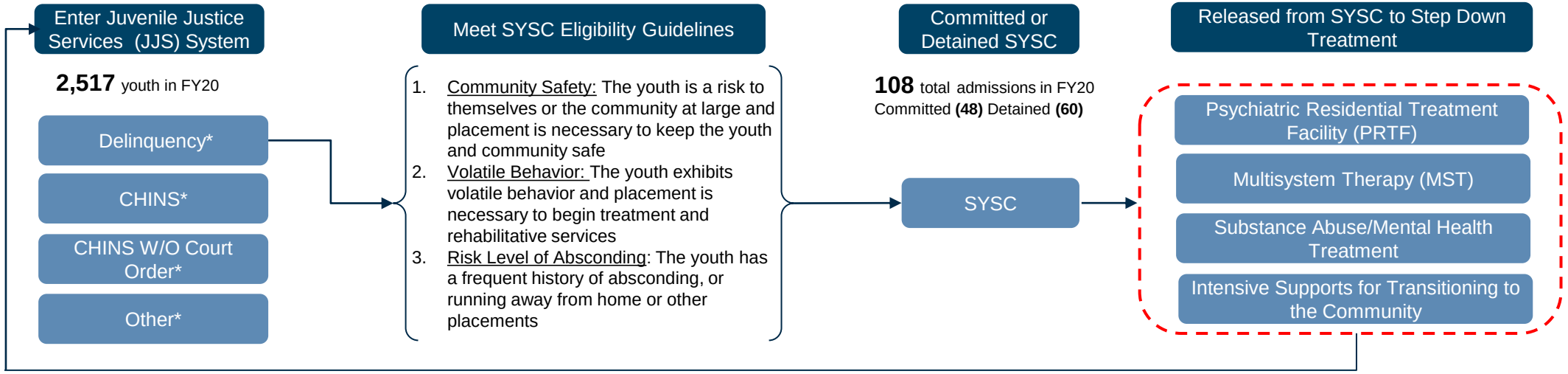
Addressing Gaps in JJS System of Care

10 In addition to procuring a PRTF, New Hampshire is in the process of procuring the following additional services to address gaps in the DCYF/JJS System of Care:

- Psychiatric Residential Treatment Facility *(RFP Released 10/23/20)*
- Residential Services *(RFP Released 12/10/20)*
- Expansion of CME *(contract amended in June of 2020)*
- Establishing Multi-Systemic Therapy (MST) *(projected RFP release 1/8/21)*
- Establishing a Children's Mobile Crisis *(RFP released 9/21/20)*

SYSC | SYSC System of Care

Prior to closing or repurposing SYSC, DCYF and Children's Behavioral Health should continue to develop the System of Care for youth in order to reduce SYSC returns.



DCYF is in the process of procuring the following services to address the DCYF/JJS System of Care:

- Psychiatric Residential Treatment Facility (PRTF)
- Multisystemic Therapy (MST)

DCYF should continue to expand step down options to address the DCYF/JJS System of Care:

- Substance Abuse/Mental Health Treatment
- Intensive Supports for Transitioning to the Community

Building out the System of Care is crucial for youth committed for a short-term period. Youth committed to SYSC for a short-term period (i.e., 3 months) are often unable to fully benefit from the intensive treatment at SYSC, as the timeline of their stay limits the treatment they can receive.

*Does not mean immediate placement to SYSC, Youth that fall under these categories can be placed in alternative placements other than SYSC

SYSC | Juvenile Justice Facility Closures

A&M compared SYSC to facilities in other states using key metrics such as cost per youth per year and utilization. SYSC does not currently have the ability to close and move youth to another correctional setting within the State.

- Six of the facilities listed below had more than one in-state correctional placement option to place youth after closure.
- Woodside Juvenile Rehab Center (VT) intended to privatize its correctional operations by 10/1/2020. Until it is operational, they are utilizing community-based residential treatment programs in VT and NH SYSC when needed.
- New Hampshire does not have any other in-state correctional facility placement options.

State	Facility	Facility Size	Cost/ Youth/ Year *(avg. cost across state)*	Utilization	Placement after Closure
AR	Lewisville Juvenile Treatment Center	35 beds	$87,000	22%	Moved to other in-state facility
CA	Cochise County Juvenile Detention Center, Tuolumne County Mother Lode Regional Juvenile Detention Center	32 beds, 30 beds	$304,259	N/A	
NM	Santa Fe County Juvenile Detention Facility	25 beds	$233,000	16%	
MD	Savage Mountain Youth Center	48 beds	$414,929	20%	
MN	Olmstead County Juvenile Detention Facility	16 beds	$145,000	13%	
VT	Woodside Juvenile Rehab Center	30 beds	$528,155	13%	Intended to renovate a facility that is privately run. Youth are currently placed in NH SYSC.
NH	Sununu Youth Services Center	144 beds	$540,000	12%	**SYSC does not have any other in-state correctional facility placement options.** **Closing SYSC would require NH to build/procure a new correctional facility.**

SYSC | Juvenile Justice Facility Repurposing

Research shows successful prison repurposing efforts with adult prisons, and states and localities are beginning to recognize opportunities to transition former youth juvenile justice facilities into sustainable outlets for community development. Publicly available information on such efforts is limited, however, and little is known about successes or lessons learned from these efforts.

Youth Correctional Facility Repurposing Efforts in Six Communities

Whittier CA, is launching a large-scale development project

Beaumont, TX, will open a hub for social services

Apache County, AZ, built a LOFT teen community center

Fulton County, NY, is developing a sustainable mixed income housing community

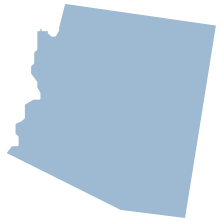
Hunts Point, NY, is creating a campus for affordable housing, open space, and development

Washtenaw County, MI, is developing a sustainable, mixed-income housing community

*Below is a deeper review of repurposing efforts in **Beaumont, TX** and **Apache County, AZ**, based on previous reports and current needs in New Hampshire.*

Beaumont, TX: Al Price Juvenile Correctional Facility, after remaining vacant for six years will be repurposed into a "one-stop shop for social services". A local volunteer-driven organization, The Dream Center, will use the buildings to provide social services, housing, and recovery support for residents in need, including people with substance abuse issues, at-risk youth, and veterans displaced after returning from service.

The land was transferred to the county, with the requirement that the land be used for a public purpose. The Dream Center in partnership with the Harbor House Foundation signed a lease for the property, providing an opportunity to fulfill a public purpose and relieve taxpayers of maintenance costs. The 20-year lease places the monthly rent at $1 and contains an option for two five-year renewals. Additionally, after an initial grace period for utilities costs, The Dream Center will absorb all the maintenance and renovation costs, which will be funded by grants and donations.



Apache County, AZ: The Apache County Juvenile Detention Center was converted into the LOFT Legacy Teen center, which offers communal space, free internet, a music room, and other entertainment for young people. Apache County had closed the facility in 2015 due to cost. Apache county is a small, rural county that lacked adequate social services for youth in need. Costs for repurposing were minimal, as much of the remodeling work was done by probation staff. It was also collaborative, with 12 students from a nearby high school offered ideas and suggestions on renovations.

Hanna Love et al., "Transforming Closed Youth Prisons" (Urban Institute , June 2018), https://www.urban.org/sites/default/files/publication/98628/transforming_closed_youth_prisons.pdf

SYSC | Concurrent Alternative Uses and Cost Saving Measures for SYSC Facility

The following table highlights previously suggested alternative uses and/or cost saving measures that could be implemented while continuing to operate the SYSC facility. Of the eight recommendations, DHHS was only able to implement one.

	Recommendation	Implemented?	Why or Why Not?
1	Explore the Possibility for SYSC to house an extension of New Hampshire Hospital services for psychiatric and substance abuse care	✘	• Cost • Extensive requirements for renovations • Concern about DOJ payback
2	Establish a Psychiatric Residential Treatment Facility (PRTF)	✘	• Cost • Extensive requirements
3	Privatize Education and Food Services	✘	• No cost savings associated
4	Private Provider operates a correctional facility on SYSC property	✘	• No cost savings associated • Concern about DOJ payback
5	Convert unused space into outpatient SUD juvenile treatment and housing for youth up to 21 years of age as they transition back into the community	✓	• A private provider was hired to run a SUD treatment facility in 2018. The program subsequently closed due to provider challenges.
6	Convert unused space into a pregnant and parenting teens program	✘	• Cost • Extensive requirements for renovations • Concern about DOJ payback
7	Use unused space as a place to relocate the Secure Psychiatric Unit patients, currently at State Prison	✘	• Cost • Extensive requirements • Concern about DOJ payback
8	Appropriate money for renovation and restoration of the Spaulding and Pinecrest buildings on the DHHS/SYSC site and utilize these buildings to provide community services such as outpatient drug treatment/residence for youth or outpatient mental health; alternatively, consider utilization as state office space for state and local needs	✘	• Cost (requires significant upfront cost to renovate and restore Spaulding and Pinecrest buildings)

Note: During the COVID-19 Pandemic, the unused space mentioned in recommendations 8,9,and 10 is being used as an additional correctional space to comply with social distancing

"Sticker Shock 2020: The Cost of Youth Incarceration ," justicepolicy.org (Justice Policy Institute , July 2020), http://www.justicepolicy.org/uploads/justicepolicy/documents/Sticker_Shock_2020.pdf.

SYSC | Prior Report Review

Potential alternative uses, cost saving measures, and improvements to SYSC have been evaluated in previous reports. A&M utilized these reports in addition to our expertise as part of this analysis.

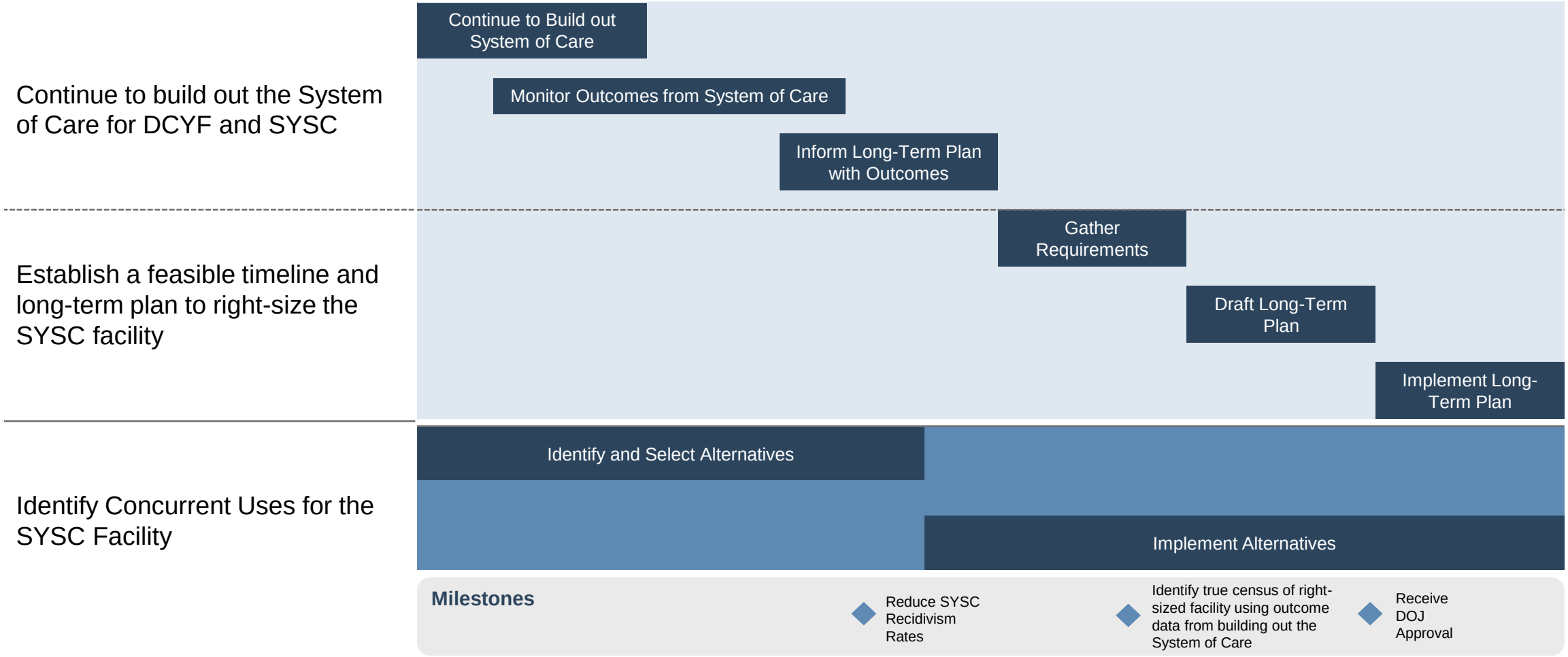
	Report to Fiscal Committee of the General Court as to Most Appropriate, Cost Effective, Long and Short-Term Uses of SYSC *(1/2014)*	Cost Reduction Plan for Sununu Youth Services Center *(11/2015)*	NH DCYF Adequacy and Enhancement Assessment *(7/2018)*	Committee to Study Alternatives to the Continued Use of SYSC Facility *(11/2018)*
Internal/External?	Internal	Internal	External	Internal
Authors/Reason for Commission	Completed by Legislative Committee	New Hampshire Fiscal Committee	Public Consulting Group, American Public Human Services Association, Human Services, Alliance	New Hampshire Legislative Commission
Reason for Commission	Directed by HB 260, Chapter 249, Laws of 2013	Directed by Chapter 276:206, Laws of 2015	Directed by DHSS after the recent organizational realignment of DHHS	Directed by HB 1743, Chapter 355:7, Laws of 2018
Areas Reviewed	• Advantages and disadvantages of the current facility use; • Potential alternative uses; • Viability of using another facility instead; • Ways the current cost could be reduced.	• Opportunities for privatization of services; • Additional compatible services at SYSC; • Consideration of the most appropriate, cost effective, long and short-term uses of the center	Reviews the adequacy and alignment of the current ecosystem of independent partners and stakeholders to ensure a comprehensive, child- and family-centered system that is more preventative, responsive, and effective for all children, youth, and families involved with the child welfare and/or juvenile justice system.	• Disposal of the existing facility; • Transition to a smaller correctional facility; • Transition to small residential treatment facilities with the capacity for secure placement; • Ability to use excess capacity at SYSC for an outpatient drug treatment facility for youth; • Evaluation of whether the Department has updated all policies procedures and practice consistent with the legislative intent of HB 517

While each report contains specific recommendations, all reports have identified the following themes regarding what should be done at SYSC:

- ***Continue to build out the System of Care for DCYF***
- ***Establish a feasible timeline and long-term plan to right-size the SYSC facility***
- ***Identify concurrent uses for the SYSC facility***

SYSC | High-Level Implementation Milestones

The recommendations for SYSC are intended to build upon one another with the purpose of empowering DHHS to effectively execute any decisions on the future uses of the SYSC facility.



SYSC | Next Steps for SYSC

In order to implement a plan to right-size SYSC, the following criteria should be met in order to inform key decisions and ensure there is no disruption to youth.

1) Address gaps in the to the System of Care
2) Reduce SYSC recidivism rates
3) Identify true census of right-sized facility using outcome data from building out the System of Care
4) Identify and select future use of SYSC facility (repurpose, sell, etc.)
5) Obtain DOJ approval before altering or closing SYSC as a correctional facility

Grants Management

Grants Management | Executive Summary | Overview

A&M reviewed the DHHS' grant management practices in order to identify opportunities for efficiency, with specific attention to the indirect cost allocation built into grant budgets.

1. **Scope:** As a part of the review of the overall cost efficiency of DHHS, A&M reviewed DHHS' indirect cost allocation practices. This review was initiated following kickoff interviews with stakeholders whereby representatives from multiple divisions identified grants management and contracting as an area of difficulty for stakeholders. Reports of insufficient staffing support for grants management indicated that indirect cost allocation should be further examined. A&M began by identifying the indirect cost allocation percentage of selected large grants. Upon identifying a wide range of cost allocation percentages in this selection, A&M determined that the grants management processes should further be studied in order to identify if DHHS could improve upon the existing grant development system.

2. **Approach:** A&M began by developing an understanding of the grant selection and cost allocation processes and learning the historical context and issues that have arisen in DHHS' grant selection processes. A&M also reviewed federal grant applications and reports in order to understand the indirect cost allocation levels of recently executed federal grants. This review also incorporated cost allocation results in order to understand the funding source breakdown of select administrative functions. A&M's assessment of DHHS' indirect cost allocation practices incorporated a maturity framework based on the application of the matching principle.

3. **Results:** A&M aggregated the indirect costs of several large grants and determined that while for some grants, the indirect cost allocation was at or near the ten percent level, not all grants conformed to this best practice-level of administrative allocation. The following review will include the following: an overall assessment of DHHS' cost allocation budgeting and reporting against the organizational maturity framework, a brief overview of recent changes in grant selection and cost allocation made by DHHS, prior state process findings and key pain points, current state process findings and ongoing issues, and key assumptions in the current state that DHHS should rethink. Select projections and sensitivity tables will be presented to highlight the financial impact of these cost allocation decisions.

A&M hypothesized select process control changes to help tackle the indirect cost allocation issues that have led to potential underutilization of federal funding for administrative activities.

Grants Management | Executive Summary | Recommendations (Short-Term)

A&M developed the following short-term recommendation for grants management. This recommendation is not projected to include additional costs to implement.

			Est. Costs ($M)		Est. Savings ($M)*	
#	Recommendation	Description	Low	High	Low	High
C.1	Restructure Grants Selection Process	Restructure the discretionary grant application and selection process to increase the potential to draw more administrative dollars from federal grants by building more indirect cost allocation into grant applications. DHHS should also mandate and enforce Finance final approval on both new discretionary grants and discretionary grant renewals.	*Retroactive projections have been provided, but forward-looking savings are dependent on grants pursued.*			

Grants Management | Executive Summary | Approach

Stakeholder Engagement

Key Personnel Interviewed

DHHS

- Kerrin Rounds, CFO
- Mary Calise, Deputy CFO
- Hannah Glines, Revenue Director
- Melissa Kelleher, Grants Administrator

Key issues in grants management were also identified through introductory Phase IA interviews and ongoing meetings with stakeholders in various program divisions, as well as the Bureau of Contracts and Procurement, among others.

Data Request

Key Data Reviewed

- Grant budget narratives from the Divisions of Public Health and Behavioral Health
- Cost allocation results from 2019 and 2020, including state, federal, and other funding sources
- Grant expenditure analysis provided by the Office of Finance
- Program inventory data

Grants Management | Process Restructuring | Summary (1 of 2)

Recommendation

Restructure the discretionary grant application and selection process to increase the potential to draw more administrative dollars from federal grants by building more indirect cost allocation into grant applications. DHHS should also mandate and enforce Finance final approval on both new discretionary grants and discretionary grant renewals.

Findings

A&M identified significant variance in the indirect cost allocation percentage built into discretionary grants. Stakeholders from program divisions and support functions alike identified grants management as an ongoing area for improvement. Based on historic grant selections from recent years, the dollar impact of under-allocation could have a material financial impact.

Observations:

- Some grants under-allocate indirect costs and others do not report any.
- The legacy grant selection process led to insufficient controls over the grant selection process.
- The new grant selection process has solved for the involvement of Finance within the grant process, but incentives between the Finance Office and program offices could be misaligned.
- The incentive mismatch stems from ingrained assumptions that must be rethought as a part of a larger cultural shift around grant selection.

COVID Impact: The importance of appropriate indirect cost coverage is amplified by the COVID-19 pandemic due to the heightened use and involvement of federal grant award dollars from the CARES Act and other funding sources. COVID has shifted the activities of many DHHS staffers, as the agency is responsible for a significant portion of the PHE response.

Benefits

This process change would produce the following benefits:

- Increased ability to staff indirect activities due to a larger administrative allocation available within grant budgets
- Increased ability to engage in new programs with more support staff available funded by federal funding
- Improved financial control by the Finance Office over the financial activities of the Department

	Low	High
Savings	*Retroactive views of past grant spending have been provided, but forward-looking savings are dependent on grants pursued.*	
Costs		
Net Benefit		
Timeframe	3 to 6 months	
Complexity	Low	

Grants Management | Process Restructuring | Summary (2 of 2)

Recommendation

Restructure the discretionary grant application and selection process to increase the potential to draw more administrative dollars from federal grants by building more indirect cost allocation into grant applications. DHHS should also mandate and enforce Finance final approval on both new discretionary grants and discretionary grant renewals.

Implementation Requirements

People	The effort to change this process would require a "change champion" from the contracting and grants office to run point on communication and compliance. The finance team would need to receive training on the new approval process; a change management effort would need to be completed to communicate process change within program teams.
Process	A fully reformed process map would need to be rolled out as an additive procedure for the August 2020 policy and procedure document. DHHS should consider appropriate corrective measures to address potential noncompliance.
Technology	N/A. DHHS recently engaged in a procurement process to secure more cost allocation capabilities within their software platform, ultimately re-hiring the previous vendor after considering other options.
Prep. Work	A grant approval form would need to be created for documentation of approval by Finance for each grant to go forward. A system to review and maintain these records would be required to ensure ongoing compliance.
Statute	DHHS should codify the changes to the grant process within the policy and procedures.

Timeline Outline

Target Start Time: To Be Determined

Time Range	Basic Tasks
Month 1	Policy development and change management plan creation
Month 2	Policy rollout with stakeholders through training, approval documentation finalization
Month 3	Ongoing management of new process and communication with stakeholders

Risks

- Noncompliance among stakeholders, as this change is a shift in the responsibility balance among program teams and the Office of Finance

Grants Management | Process Restructuring | Background (1 of 3)

If indirect activities are not funded by federal funds through cost allocation in the grant application, then the State must pay for the remainder of these activities.

1. A state agency builds the grant budget and applies for the grant.
2. Upon securing the grant, an agency must now execute the activities in the grant
3. Regardless of the feasibility of the budget in the grant application secured, an agency must allocate costs according to the plan outlined in the grant budget narrative.

Grant Budget Building

What costs may be included: Costs should be separated into indirect and direct costs. Indirect cost that could apply to the grant should be determined to be allowable or not allowable by the grant application. The determination of which indirect costs are allocated to administration is made according to both the state's cost allocation plan (CAP) and the specific stipulations of a grant

Amount to include: The amount allocated to indirect cost must be determined based on the CAP and other factors

Direct Activities

- Goods to purchase
- Contracted services
- Direct program staff
- Travel and supplies

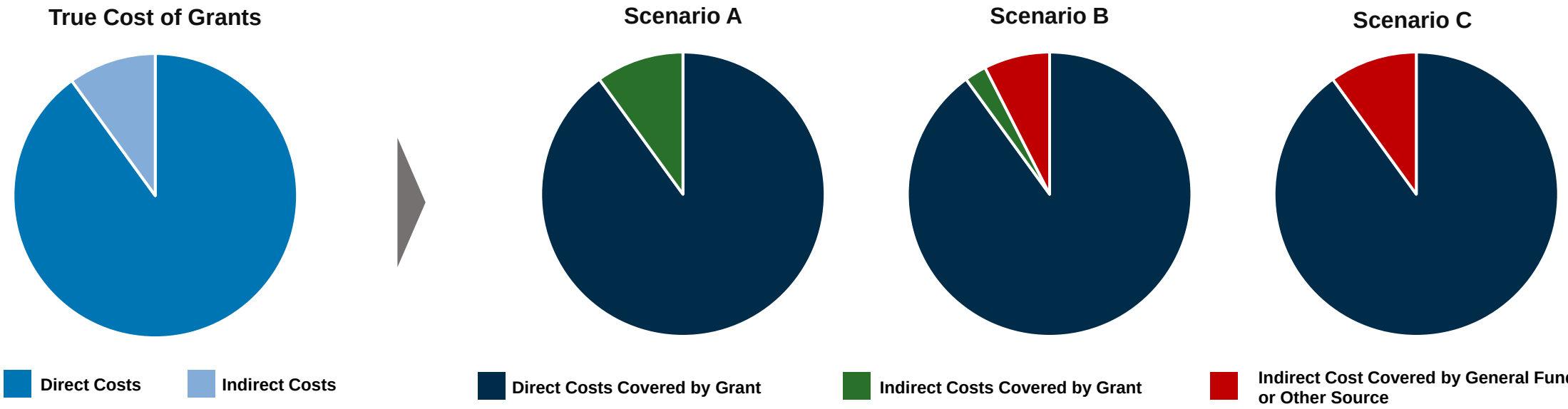
Indirect Activities

- Support staff: human resources, finance, IT, etc.
- Management time
- Property, plant, and equipment

Bottom Line: Indirect activities must be performed for grant programs to proceed successfully. Neglecting to include indirect cost allocation means it is more likely support functions would be understaffed.

Grants Management | Process Restructuring | Background (2 of 3)

Indirect cost allocations help state agencies recoup the full cost of executing the grant. The following scenarios represent the three levels at which organizations could draw down indirect allocations.



The true cost of a grant includes direct and indirect activities. State agencies must include these indirect costs into grant budgets in order to avoid them being covered by the General Fund. While under-allocating indirect costs does translate to more funds for direct services, **the State General Fund must foot the bill for the remainder of the true cost of the grant.**

	Scenario A: Indirect Fully Included	Scenario B: Indirect Partially Included	Scenario C: Indirect Not Included
Direct Costs	Fully funded by the federal award	Fully funded by the federal award	Fully funded by the federal award
Indirect Costs	Funded by the federal award. This scenario provides funding coverage for indirect activities, allowing an agency to expand staffing capacity.	Funded fully by State General Fund, reducing the General Fund dollars available for other activities and programs	Funded fully by State General Fund, reducing the General Fund dollars available for other activities and programs

Grants Management | Process Restructuring | Background (3 of 3)

Realizing indirect cost allocation depends on two interrelated factors: building indirect cost allocation into grant budgets and appropriately monitoring, reporting, and drawing down the indirect allocation.

As more indirect costs are covered, the grants and finance support staff capacity can expand, which enables improved managing and reporting of grant spending.

The managing and reporting of grant spending and indirect activities is important if the indirect cost allocation dollars are to be realized. However, indirect cost allocation cannot be managed if it is not built in the grant budget.

The entire process depends on indirect cost allocations being included in the grant budget.

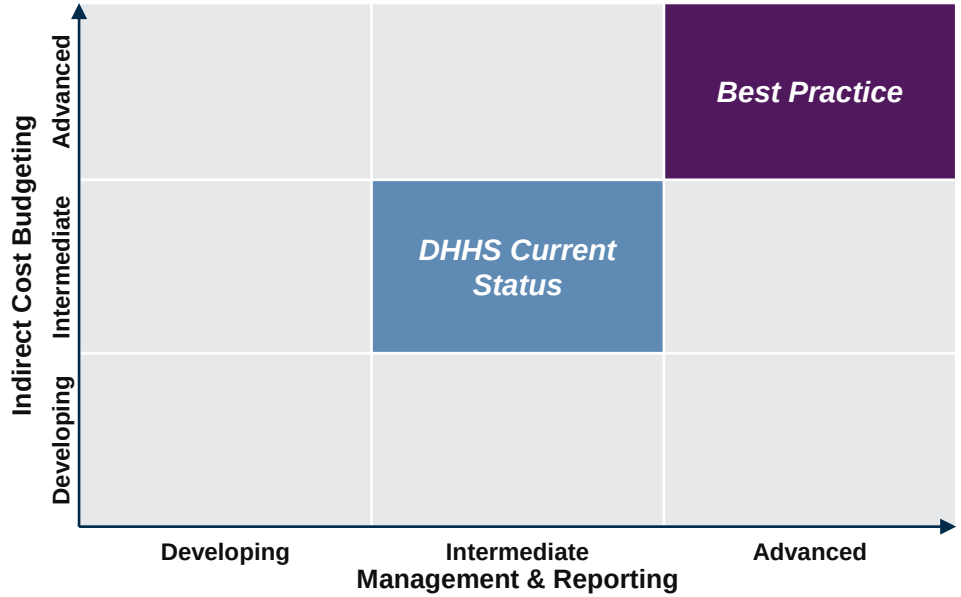
Improved managing and reporting of grant spending allocations would translate to increased funding support for indirect activities.

Focus Area

A&M examined both these interdependent areas, but the recommendation is focused on the **indirect cost budgeting portion** because of the **downstream effects** of drawing down administrative dollars. Improved management and reporting of existing grants would provide effective changes, but **DHHS is limited to the indirect allocation that has already been built into its grants**. Increasing future-state cost allocations must be addressed before the full benefits of improved management can be realized.

Grants Management | Process Restructuring | Organizational Maturity

A&M evaluated DHHS's budgeting and management of indirect cost allocation using the following maturity framework. Improving DHHS' indirect cost budgeting should improve management and reporting.



Status	Indirect Cost Budgeting	Management & Reporting
Finding	Indirect cost allocation is included at or near the upper bound of best practice range only in some instances. Some controls exist over the grant budgeting process.	Reports are created, but management of cost allocation reports is limited. Some grants do not allocate costs at all. Technology enhancements for reporting have been made.

Key

Status	Indirect Cost Budgeting	Management & Reporting
Developing	Little grant budgeting control exists; indirect cost allocation may or may not be included	Reports are not created, and cost allocation is not reviewed
Intermediate	Some controls implemented; indirect cost allocation included inconsistently	Reports are created, but management is limited
Advanced	Strong controls in place; indirect cost allocation consistently included	Reports are created and consistently reviewed

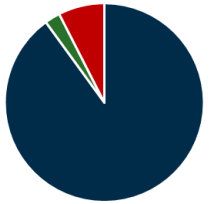
Framework Context

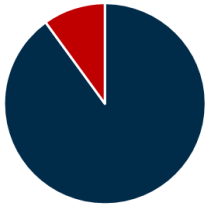
This framework is A&M's application of the matching principle from US GAAP. This bedrock principle states that expenses must be tied to the revenues that they generate. While the matching principle specifically relates to financial statements, the idea should be applied throughout an organization's practices for proper financial management. This maturity framework is a simple way to measure the level to which an organization applies the matching principle in its grant management activities.

Grants Management | Process Restructuring | Financial Impact (1 of 3)

A&M evaluated how effectively DHHS a) built indirect cost allocation into discretionary grant budgets and b) realized indirect cost allocations for active grants.

Approach	Finding
Grant Allocation Review: Identifying active grants and their indirect allocation range and calculating the sensitivity to increases in indirect allocation	Some grants fell within the best-practice range of indirect allocation while others allocated indirect costs well below this range, leaving DHHS to cover those activities with General Fund dollars.
Allocation Results Review: Identifying whether grants were executed with zero indirect activities recorded	8.5% of federally-funded grant programs had no indirect allocations recorded in the FY20 results.

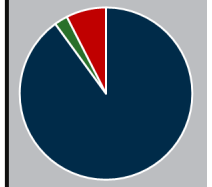




Grants Management | Process Restructuring | Financial Impact (2 of 3)

DHHS grant budgets do not consistently build in indirect cost allocation to the original budget, leaving those expenditures to be covered by General Fund sources.

Year	Grant	Grant $ per Year (K)	Indirect/Year (K)	Indirect %	Sensitivity: Indirect Allocation (K)		
					5.0%	7.5%	10.0%
2020	State Opioid Response II	$28,100.0	$175.0	0.6%	$1,231.6	$1,934.9	$2,638.2
2018	State Opioid Response I	$22,900.0	$7.5	0.03%	$1,137.4	$1,709.8	$2,282.2
2020	Public Health Emergency Preparedness (PHEP)	$5,300.0	$0.0	0.0%	$263.7	$395.6	$527.4
2019	Mental Health Block Grant	$4,800.0	$242.2	5.0%		*Capped at 5%*	
2018	Public Health Crisis Response (Opioid)	$3,900.0	$356.0	9.1%			$35.6
2019	Overdose Data to Action	$1,200.0	$122.4	10.0%			
2019	Preventative Health and Health Services	$2,400.0	$227.6	9.4%			$15.3
2020	Immunization	$2,300.0	$345.6	14.8%			
2020	ProHealth	$2,000.0	$5.8	0.3%	$94.2	$144.2	$194.2
2019	Maternal and Child Health Services (MCH)	$2,000.0	$176.4	8.9%			$22.5
2019	Strategic Prevention Framework-Partnership for Success	$1,900.0	$0.0	0.0%	$92.5	$138.8	$185.0
2020	MIECHV	$1,500.0	$137.2	9.1%			$13.7
2020	Breast and Cervical Cancer Early Detection Program	$1,200.0	$108.8	9.1%			$10.9
2016	Medication-Assisted Treatment (MAT)	$1,000.0	$38.5	3.8%	$12.8	$38.4	$64.0
2020	Cancer Registry Program	$600.0	$50.9	9.1%			$5.1
2017	MAT Grant (Supplement)	$300.0	$0.0	0.0%	$12.5	$18.8	$25.0
2020	Comprehensive Cancer Control Program	$200.0	$21.4	9.1%			$2.1



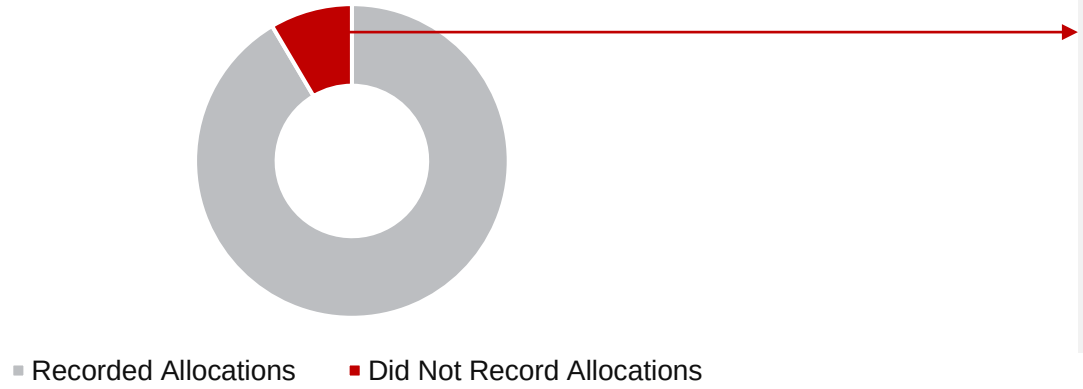
Findings

Some grants include an indirect allocation that nears the upper ten percent bound of the sensitivity table, while others are dramatically below the 5% floor of this range. In aggregate, the **missed indirect cost allocation on even these grants means that DHHS paid for these indirect activities with the State General Fund**. In the case of the State Opioid Response grants (both I and II), the **administrative allocation could have had a multimillion-dollar impact**. These grant selections are presented in order to provide a sample on the scope of the issue in DHHS with a backward-looking view. These figures do not represent forward-looking savings projections. Future projections are reliant on the types of new discretionary grants and grant renewals that DHHS pursues.

Note that these grants were not all concurrent [e.g., the State Opioid Response grants are successive in nature], and these should not be aggregated to represent a yearly savings projection).

Grants Management | Process Restructuring | Financial Impact (3 of 3)

8.5% of DHHS grant programs in FY20 did not record salary and benefit allocations, meaning those expenditures were covered by General Fund sources or charged to another grant.



Result	# of Grants	% of Grants
Recorded Allocations	203	91.5%
Did Not Record Allocations	19	8.5%

Implications

No recorded allocations implies one of the following situations**:**

1. The grant program required zero staff time to execute.
2. Another grant paid improperly covered those costs.
3. The grant program required staff time to execute but it was not allocated at all.

Findings

Based on the cost allocation results from FY20, some grants did not record any cost allocation to salary and benefits. As programs do not continue operating without staff supervision, the grant program must not have recorded the appropriate allocations. If cost allocations were built into budgets, the precise reason for this result must be identified on a case-by-case basis by finance and program teams. If these grants did not have cost allocation built into the budget, then indirect cost allocation for future grant renewal should be reevaluated. In either case, the result is the same: no cost allocations realized means that **the indirect activities of these grants were covered in full by the State General Fund.**

Grants Management | Process Restructuring | Process Assessment (1 of 2)

DHHS has recently made process changes to increase the draw-down of federal funding to cover indirect administrative costs. The legacy process steps and key issues are highlighted below.

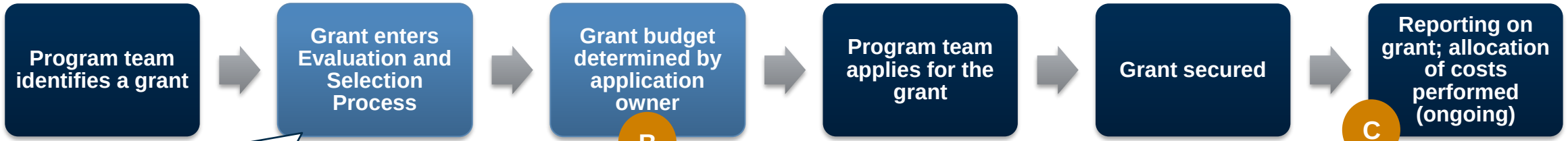
The program team members are incentivized to maximize the dollars to services to secure the largest amount possible to go toward the program. This incentive could lead to the perception that to not maximize dollars to program services would be to underserve the program. If program team members have no internal incentive to allocate more program dollars to the administrative indirect costs, then **the incentives of program teams and finance staff could be misaligned**.

An instance could occur where a grant application was submitted **without budget review by the Finance Office**. If repeated and taken to its logical endpoint, the Department could theoretically continue to win grant awards but not have the contract management, finance, IT, program quality, and HR support required to fully manage and support the grant. In essence, the Department would have **plenty of federal dollars to spend on services but not enough General Fund dollars to support the oversight and management of the programs.**

If a grant has a lack of cost allocation drawdown built in, DHHS is left in a lean position: **with less indirect cost coverage, the Department is unable to staff key support functions that enable the whole Department to do its work.** The managerial staffing must be covered by proportionately more General Fund dollars. With lower staffing levels in these support functions and less funding available to cover managerial funds, the cost allocation issue leaves the organization unable to pursue programs, as leadership ought to elect against program expansion due to insufficient staff to support the grant.

Grants Management | Process Restructuring | Process Assessment (2 of 2)

In Autumn 2020, DHHS leadership identified shortcomings in the grant application process and instituted a new Evaluation and Selection Tool (EVST) in order to ensure that new grant pursuits meet the mandate and capacity of the Department, but some key issues remain.



1. The program team and finance team evaluate the grant by examining it across the criteria in the EVST
2. The program team and finance representatives provide separate evaluation scores
3. The evaluation mediator averages the scores and determines the award selection (average score of 50 is a go – less than 50 is a no-go decision)

A

Incentives remain out of alignment between the program team and finance team as the perception persists that budgeting for program services and indirect and administrative cost allocation is a zero-sum exercise. While the evaluation and selection process does require members of both program and finance to be at the table, the scoring selection (taking the average of finance and program scores, with equal weight) **could lead to an endpoint where participants in the process hedge their scores as a counterbalance to the other party in the process.**

B

This revamped process **solves the key issue from the legacy process of finance being included into the grant selection process,** but the process does not mandate finance sign-off on the selections. The team that put together the grant budget is supposed to follow the application policy, but no preventative or corrective controls exist to ensure the budgeting policy is followed.

C

The larger cost allocation issue of potentially propping up individual programs at the expense of the whole Department remains.

Grants Management | Process Restructuring | Rethinking Assumptions (1 of 4)

The zero-sum approach to indirect cost allocation is premised on the following assumptions that prevent DHHS from changing the cultural atmosphere in grant budgeting. This section will reexamine each assumption.

Assumption	Reexamined
#1: Indirect cost allocation justification: the baseline indirect cost allocation is zero percent of the budget	Stakeholders should assume that each grant will incur an estimable, material amount of indirect costs.
#2: Zero-sum funding: any funding allocated to indirect cost allocation will shortchange program services	Grants are not always fully utilized and therefore have room for additional allocations to indirect costs.
#3: Full utilization: funding allocated to indirect cost allocation in the case of a fully utilized grant will shortchange program services	Shortchanging indirect costs ends up hampering program efforts in the long run by draining General Fund dollars from other uses

Grants Management | Process Restructuring | Rethinking Assumptions (2 of 4)

The baseline assumption in grant budget development should be that each grant will rely on indirect activity support within a reasonable level.

Indirect cost allocation justification: the baseline indirect cost allocation is zero percent of the budget

Stakeholders should assume that each grant will incur an estimable, material amount of indirect allocation.

The program-driven approach that has led to instances of zero indirect allocation in select grant budgets is built on an underlying assumption that indirect activities and costs are not part of the grant execution unless they are specifically foreseeable, raising the following issues:

- Finance team members must fully justify and advocate for each indirect cost being built into the budget
- This approach **assumes zero indirect costs unless otherwise proven**; increases must be advocated
- Certain **unforeseeable but allocable costs can be ignored** and therefore not reimbursed

While the specific amount of an indirect activity may not be easily projected in the grant development process, grant budget developers must assume that indirect costs will be incurred. The exact nature and amount of the indirect costs may be unknown, but a relative range should be established where the program and finance teams **operate on the assumption that a grant of sufficient size will require indirect-type activities to be executed**.

DHHS cannot simply assume a fixed percentage on each grant, as indirect costs must be both allowable by the DHHS cost allocation plan and the specific grant; however, it is a reasonable that a **range of indirect cost allocation can be assumed.**

Result: Indirect costs are likely to be understated as a portion of the total administrative amount.

Result: Rethinking this assumption will help build a culture of incorporating indirect costs into a grant budget as a given.

Grants Management | Process Restructuring | Rethinking Assumptions (3 of 4)

The perception persists that the amount of money to be budgeted in a grant is a strictly zero-sum pool.

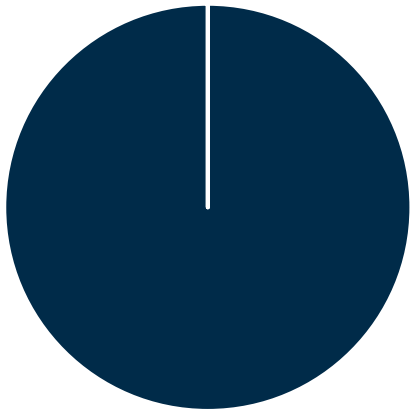
Zero-sum funding: any funding allocated to indirect cost allocation will shortchange program services

Grants are not always fully utilized and therefore have room for additional allocations to indirect costs.

While it is true that, in many cases, the maximum grant award is a set amount by the Federal Government and more dollars for one line item means less for another line item. However, this assumption implicitly assumes that the entirety of the grant funding award will be used.

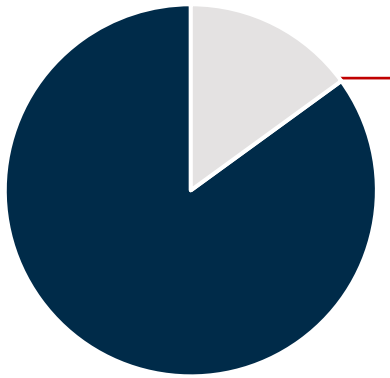
The underutilization of grant funding means that the budget inherently has room for additional expenditures. Underutilization specifically does not imply mismanagement of programs by the Department. In fact, it would be malpractice to overspend grant money on unnecessary services or to manufacture goods services on which to spend the grant money.

Grant Budget



■ Budgeted Direct Costs ■ Budgeted Indirect Costs

Grant Expenditure



Some unused direct costs could have been allocated to indirect costs with no program impact.

■ Actual Direct Costs ■ Unused Direct Cost

Grants Management | Process Restructuring | Rethinking Assumptions (4 of 4)

In scenarios where a grant is fully utilized, shifting allocation from program services to administrative services still should not be thought of as a zero-sum game due to the downstream effects.

Full utilization: funding allocated to indirect cost allocation in the case of a fully utilized grant will shortchange program services

Shortchanging indirect costs ends up hampering program efforts in the long run by precluding General Fund dollars from other uses

For grants that are fully utilized, indirect cost allocation should not be thought of as taking away from the program for the following reasons:

1. Federally granted administrative dollars can fund DHHS activities like DPQI, OCOM, Finance, IT, clerical support, and building funding. **General Fund dollars make up the remainder of what is not federally funded.**
2. Unutilized federal dollars for these indirect costs means the State is on the hook for a higher proportion of these costs. **To understate indirect cost allocation is to improperly match program expenses with program revenues**. Likewise, misallocating funds to the wrong grant takes funding away from a different program. **While the program may benefit in the short-term, the Department is hindered in the long-term.**

For an example of how this impacts DHHS, A&M created a sensitivity chart of hypothetical savings achieved by small shifts in the federal funding mix. The administrative spending amounts are based on ranges of the actual administrative fund results of a group of recent allocation results, but this table is meant to be illustrative in nature.

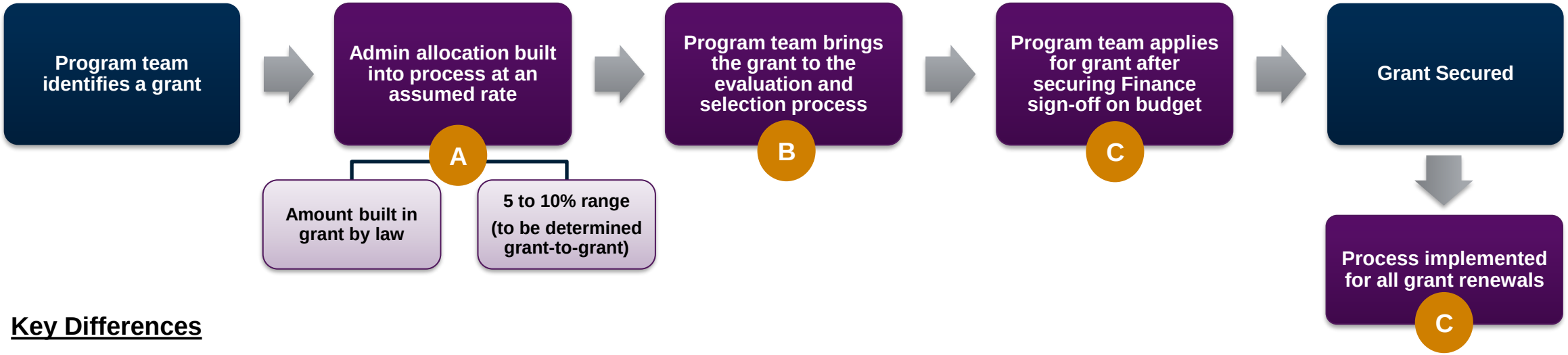
The following sensitivity table, demonstrates how small, incremental changes in funding mix percentage can lead to significant General Fund expenditure avoidance.

	Administrative Spend Starting Point (Illustrative, in M)			General Fund Expenditure Avoided (M)		
Funding Shift* (GF→Federal)	**$5.0**	**$10.0**	**$20.0**	**$5.0**	**$10.0**	**$20.0**
1.0%	$5.0	$9.9	$19.8	$0.05	$0.10	$0.20
2.0%	$4.9	$9.8	$19.6	$0.10	$0.20	$0.40
3.0%	$4.9	$9.7	$19.4	$0.15	$0.30	$0.60
4.0%	$4.8	$9.6	$19.2	$0.20	$0.40	$0.80
5.0%	$4.8	$9.5	$19.0	$0.25	$0.50	$1.00

*1.0% = 1.0% increase in federal fund/General Fund ratio toward the General Fund

Grants Management | Process Restructuring | Future State

A&M recommends the following process in be implemented in order to address some of the indirect cost allocation budgeting issues.



Key Differences

A The finance team determines how much allocation that grant should receive based on the factors implicit in the grant and either the maximum amount allowed by the grant maker and/or a fixed percentage. By building in the admin allocation into the budget before the evaluation and selection process, the amount of indirect allocation cannot be used as a negotiation piece for securing finance buy-in for pursuing the grant. Including the maximum amount of indirect cost allocation as a given – a fixed piece of the grant budget – will ensure that the grant budget is built with appropriate respect to the true, full cost of the grant.

B The team decides on whether the grant is worth pursuing based on the assumed administrative load available and assuming that amount is within an assumed range.

C Finance sign-off is mandated and enforced on both new discretionary grants and discretionary grant renewals. This increased financial control over grant budgets is a shift in decision-making responsibilities, but this will help DHHS grow to be more sustainable in the long term. This shift in responsibility aligns with financial management principles of segregation of duties. Given that the Office of Finance bears the responsibility for the financial health of the agency, this office should have ultimate authority on the expenditure of grant money, even if the grant is federally funded. Stronger control over the decision-making process must be granted to the Finance Office in order to ensure the opportunity for proper indirect cost allocation is given.

Long-Term Supports and Services: Community First Choice 1915(k)

LTSS | CFC 1915(k) | Executive Summary

Scope: Within the array of long-term supports and services (LTSS), personal attendant services (PAS) play a critical role in providing supports so that people with disabilities can maintain their independence. PAS assist people with activities of daily living (ADLs) such as preparing meals, eating, self-care, or mobility, and instrumental activities of daily living (IADLs) such as managing money, housekeeping, grocery shopping, and taking medication. PAS help people stay in their own homes and communities rather than live in a facility. To enhance community integration, the Affordable Care Act (ACA) added the Community First Choice (CFC) option, enabling states to leverage six percent enhanced federal funding to provide PAS to people who meet institutional level of care. States cannot use CFC to target a specific disability population; states must serve individuals who meet institutional level of care (LOC) based upon functional limitations.

Approach: To understand potential savings derived from shifting PAS to CFC authority, A&M conducted a review of (1) Medicaid State Plan Personal Care Attendant (PCA) Service expenditures for waiver participants and (2) PAS services available under the State's four 1915(c) waivers. To assess the risks of implementing a CFC program, A&M reviewed CFC reports from five states (CA, MD, MT, OR, and TX) and interviewed key staff from two states (OR and CT) that have implemented CFC programs and developed the following guiding principles to identify services that could be shifted to CFC:

- Focus CFC opportunities on supporting people to live in their own homes rather than group homes or provider-controlled settings
- Exclude residential services from CFC to maintain administrative flexibility afforded by the 1915(c) authority
- Minimize disruption to people by shifting existing services and leveraging existing providers to establish CFC program services
- Maximize opportunities for coordination – avoid potential for service duplication

Results: Services within the Choices for Independence (CFI) waiver for people with physical disabilities and seniors are closely aligned with the required components of a CFC program. Within the developmental waivers, the service alignment is less straightforward and will require a non-trivial effort to carve out the participants and the services most appropriate for CFC. Within the existing array of waiver services, A&M identified services that can be shifted to comprise the required and optional components of a CFC program.

Waiver participants also receive PAS under the Medicaid State Plan PCA service called Personal Care Attendant Services (PCAS). Of the $6.2 million of PCAS spending for waiver participants, $6.0 million was for CFI participants. Shifting Medicaid State Plan PCA and 1915(c) wavier services to CFC authority will increase federal participation in service expenditures, improve coordination, and reduce the duplication of home and community-based service benefits.

A&M recommends that DHHS engage stakeholders in planning and implementing a CFC program that prioritizes the independence and community integration of people with disabilities to live in their own homes and receive supports with ADLs and IADLs.

LTSS | CFC 1915(k) | Executive Summary | Recommendations (Long-Term)

A&M identified the following recommendations to improve the community integration of waiver participants. All figures are General Fund; costs reflect one-time investments for program development and recurring costs of implementation; MOE requirements apply to the first calendar year of implementation; figures shown are annual saving.

			Est. Costs ($M)		Est. Savings ($M)	
#	Recommendation	Description	Low	High	Low	High
D.1.a	Shift 1915(c) waiver services to 1915(k) CFC	Shift Personal Attendant Services (PAS) and related services from the CFI waiver to CFC. Services must also be available to developmental waiver participants as an alternative, and not in addition to comparable waiver services.	$.07M* $.15M^	$.11M* $.25M^	$3.9M	$3.9M
D.1.b	Shift Medicaid State Plan PCA services to 1915(k) CFC	Shift Medicaid State Plan Personal Care Attendant services for waiver participants to 1915(k) CFC.	--	--	$.37M	$.37M
D.1.c	Improve coordination of HCBS	With the implementation of CFC, create utilization management protocols to ensure PAS benefits for waiver participants are coordinated and are not duplicative.	--	--	$0.0M	$3.1M

**as a Medicaid service the administration of CFC may be claimed at 50% general / 50% federal funds as approved within the state's cost allocation plan*
^ one-time costs, assessment fee

LTSS | CFC 1915(k) | Executive Summary | Approach

Stakeholder Engagement

Key Personnel Interviewed

DHHS

- Deb Scheetz, DLTSS Divisions Director
- Jane Hybsch, Administrator, Medicaid Medical Services, Coverage and Benefits Unit
- Jennifer Doig, DLTSS Business Manager
- Wendi Altman, BEAS Bureau Chief
- Sandy Hunt, BDS Bureau Chief
- Kerri King, IT Manager, Options Helpdesk
- Andrew Chalsma, Director of Data Analytics and Reporting, Bureau of Program Quality

External Stakeholders

- Anna Lansky, Office of Developmental Disabilities Service, Deputy Director, OR
- Lilia Teninty, Office of Developmental Disabilities Services Director, OR
- Dawn Lambert, Division of Health Services, Co-Leader, Community Options Unit

Data Request

Key Data Reviewed

- Medicaid expenditure data for the CFI/DD/ABD/IHS waivers **FY19** (DHHS)
- Medicaid encounter claims data for the CFI/DD/ABD/IHS waivers **FY19** (Milliman)

LTSS | CFC 1915(k) | Summary (1 of 2)

Recommendation

DLTSS should a) shift PAS and related services from the CFI waiver to CFC; b) shift Medicaid State Plan PCA services for waiver participants to 1915(k) CFC; and c) create utilization management protocols to ensure PAS benefits for waiver participants are coordinated and are not duplicative.

Findings

Virtually all demographic changes in the United States point to large future increases in demand for long-term supports and services (LTSS) which encompass a variety of services that assist people who have functional limitations. As the State responds to the growing demand for LTSS, DHHS must minimize the administrative burden of delivering these services, ensure eligible citizens can easily access coordinated services, and leverage federal funds to maximize the economic benefits of the predilection for services provided in home and community-based settings.

Observations:

- By shifting Medicaid State Plan PCAS for waiver participants and PAS services provided under the waiver to 1915(k) CFC, the State can derive efficiencies by improving coordination of care and from leveraging the enhanced 6% FMAP.
- A&M identified $4.2M in potential savings which would come from the enhanced 6% FMAP reimbursement for applicable CFC services:
  - $3.8M from Required Services
  - $.1M from Optional Services (Emods, transitional, etc.)
  - $.4M from shifting PAS from the State Plan to a 1915(k)

COVID Impact: The public health emergency created by COVID-19 underscores the risk of providing services in congregate settings. Expanding service options that enable people to maximize their independence may afford them greater control to limit the risk of exposure based upon an individual assessment of their needs and circumstances.

Benefits

The 1915(k) Community First Choice Option was introduced in the Affordable Care Act to provide long-term services and supports to individuals in homes and communities. As a service vehicle, the 1915(k) represents a step in the right direction in the rebalancing effort. As a financial decision, the 1915(k) generates a 6% additive, enhanced FMAP for all included services which can offset the required administrative costs. For the State, a 1915(k) implementation also offers DHHS the opportunity and incentive to review siloed services within the Department and between vulnerable populations.

	Low	High
Net Savings	$4.2M	$7.3M
Impl. Costs	$.07M $.15M^	$.11M $.25M^
Net Benefit	**$4.1M**	**$7.2M**
Timeframe	2 years	
Complexity	Moderate	

^ one-time cost, assessment fees

LTSS | CFC 1915(k) | Summary (2 of 2)

Recommendation

DLTSS should a) shift PAS and related services from the CFI waiver to CFC; b) shift Medicaid State Plan PCA services for waiver participants to 1915(k) CFC; and c) create utilization management protocols to ensure PAS benefits for waiver participants are coordinated and are not duplicative.

Implementation Requirements

People	BDS should hire) one CFC Program Director who should be part of the LTSS team and work collaboratively with the Medicaid Director and/or designee to plan and implement a CFC Program; and b) one CFC/waiver program specialist.
Process	A 1915(k) CFC implementation would require an estimated one year of planning, stakeholder engagement and internal preparation followed by a one-year implementation process.
Technology	The major implication on the existing IT infrastructure is the added complexity in managing/creating procedure codes for the CFC SPA. As such, A&M does not anticipate additional technology is required for this recommendation.
Prep. Work	DHHS will need to create a CFC application process. Significant work will be needed to implement a standard needs assessment and service authorization process. Medicaid must prepare and submit a SPA, and stakeholder engagement should begin concurrently with internal cost-benefit and gap assessments.
Statute	N/A

Timeline Outline

Target Start Time: To Be Determined

	Year 1	Year 2	Year 3	Year 4
Stakeholder Engagement				
Gap/C-B Assessments				
Implementation				

Risks

- The State cannot target specific groups with the 1915(k)
- Natural supports are currently obscured which may inflate cost estimates
- There is added complexity when including CFC services in a managed care environment
- There are entrenched stakeholders who rely on revenue generated from PAS
- Rate differentials under existing, siloed systems will need to be addressed
- Other unknown variables (from the wait list, from external stakeholders, etc.) outside of the State's purview may affect cost and revenue projections
- There are operational challenges resulting from an aging IT infrastructure
- The MOE requirement must be met

LTSS | CFC 1915(k) | Community First Choice Overview

The 1915(k) allows states to amend their Medicaid State Plan to provide attendant services and related supports in HCB settings.

Quick Facts

- Authorized by the ACA
- Effective October 1st, 2011
- Implemented in 8 states (CA, CT, MD, MT, NY, OR, TX, WA)
- Participants must meet institutional level of care (LOC)
- Required components include supports with ADLs, IADLs, and health related tasks; acquisition of skills to accomplish ADLs and IADLs; back-up systems to ensure service continuity; and voluntary training to recruit and manage attendants
- Optional components include transition services and expenditures related to a need that increases independence

Benefits

- Seeks to improve the community integration of people with disabilities by reducing the administrative complexity that results from having multiple authorities provide similar types of services across different populations
- Focuses on maximizing participant independence to live in home and community-based settings as an alternative to what may be interpreted as the invasive or paternalistic nature of traditional services
- Beyond required components, the State has extended flexibility in defining CFC services
- Family members may be authorized as a service provider (currently prohibited by State Plan)
- 6% Enhanced FMAP

Challenges

- Cross-disability application compels substantive stakeholder engagement to reach consensus regarding operational protocols
- Implementation complexity merits careful planning requiring significant administrative resources
- NH's LTSS infrastructure has several vulnerabilities that will be strained by CFC adoption
- Less administrative flexibility than 1915(c) waiver authority, i.e., no waitlist
- MOE requirements in the first full year of implementation compel the reinvestment of initial year's savings
- Natural supports cannot supplant paid services – states report increased spending when unpaid supports shift to paid supports
- A Standardized approach to assess functional limitations, authorize and reimburse PSA services

LTSS | CFC 1915(k) | NH Waiver Structure Overview

NH has four 1915(c) waivers that have services that provide personal attendant services (PAS). CFI waiver services align with CFC; developmental waiver service alignment is much less straightforward.

	CFI (Seniors and adults with physical disabilities)	DD (People with I/DD)	ABD (Adults with acquired brain disorder)	IHS (In-home supports for children)
Personal Care (required)	Personal Care	Residential Hab Personal Care L1-2	Residential Hab Personal Care L1-2	Enhanced Personal Care
	Home Health Aide			
	Homemaker			
Backup Systems (required)	Personal Emergency Response Systems			
Voluntary Training (required)	Participant Directed and Managed Services	Participant Directed and Managed Services	Participant Directed and Managed Services	
Transitional (optional)	Community Transition Services	Community Support Services PDMS	Community Support Services PDMS	
	Enviro Mods	Enviro and Vehicles Mods	Enviro and Vehicles Mods	Enviro and Vehicles Mods
Independence (optional)	Home delivered meals			
Other (considered but not recommended)	Respite[1]	Respite	Respite	Respite
	Adult Medical Day[2]	Community Participation Services (Day Hab)	Community Participation Services (Day Hab)	
	Non-medical transportation	*transportation not a standalone service*	*transportation not a standalone service*	*transportation not a standalone service*

[1] Respite is a service to provide relief to a caregiver; for this service to be appropriate for CFC it must be re-configured to align with CFC requirements for all waivers
[2] Day services are typically provided in provider-controlled settings

LTSS | CFC 1915(k) | Estimated Savings by Waiver

A&M estimates $4.2M generated from the 6% enhanced FMAP reimbursement ($3.9M from Required + Optional Waiver Services and $0.4M from Medicaid State Plan PCAS).

Estimated Additional FMAP ($)	All Waivers	CFI Waiver	DD/ABD/IHS Waivers
Personal Care/Residential	$2,232,250	$2,149,681	$82,569
Backup Systems/Voluntary Training	$58,201	$58,201	$-
Other	$476,439	$476,439	$-
PDMS - Required	$1,019,138	$616,872	$402,266
Savings from Required Services	$3,786,027	$3,301,192	$484,835
Emods	$91,487	$48,128	$43,358
Transition	$94	$94	$-
PDMS - Optional	$-	$-	$-
Savings from Optional Services	$91,581	$48,222	$43,358
Personal Care (State Plan Service)	$369,960	$358,940	$11,019
Savings from the State Plan	$369,960	$358,940	$11,019
Savings from All Services	$4,247,567	$3,708,355	$539,212

LTSS | CFC 1915(k) | Medicaid State Plan PCAS | Estimated Savings

Data revealed that (1) participants were receiving both PCAS and waiver services; (2) many PCAS participants have long-term needs better served by the CFI waiver; and (3) PCAS and the CFI waiver use different assessment tools and protocols to assess the same needs with no coordination of benefits. Improved coordination and reduced service duplication may yield additional savings. A&M assessed a savings range calculated from a percentage of potentially duplicative waiver and State Plan services.

Estimated Annual Savings (Range)*	All Waivers	CFI Waiver	DD/ABD/IHS Waivers
Total FY19 Encounter Claims	$6,165,996	$5,982,338	$183,658
% of Potentially Duplicative Expenditures	Resultant Savings	Resultant Savings	Resultant Savings
0%	$ -	$ -	$ -
5%	$ 308,300	$ 299,117	$ 9,183
10%	$ 616,600	$ 598,234	$ 18,366
15%	$ 924,899	$ 897,351	$ 27,549
20%	$ 1,233,199	$ 1,196,468	$ 36,732
25%	$ 1,541,499	$ 1,495,585	$ 45,915
30%	$ 1,849,799	$ 1,794,701	$ 55,097
35%	$ 2,158,099	$ 2,093,818	$ 64,280
40%	$ 2,466,399	$ 2,392,935	$ 73,463
45%	$ 2,774,698	$ 2,692,052	$ 82,646
50%	$ 3,082,998	$ 2,991,169	$ 91,829

* Calculations assume in given year, FMAP% reimbursements are calculated and disbursed first, followed by savings from a reduction in potentially overlapping services.

LTSS | CFC 1915(k) | Risks and Mitigation

There are significant stakeholder, administrative and budgetary risks associated with a CFC program implementation.

Risks

1. CFC must be provided to Medicaid eligible individuals who meet institutional LOC. Unlike waivers, states cannot have a waiting list for CFC. States with extensive waiting lists for waiver services that have implemented CFC have reported a consequent increase in state spending.
2. CFC prohibits the non-voluntary supplanting of paid supports with natural supports. States that have implemented CFC report increased spending when unpaid supports shift to paid supports.
3. When a state includes a CFC payment in a health plan, the capitation rate must include a separate CFC section in their Actuarial Certification.
4. Because CFC serves cross-disability populations, there will be disparities, some significant, in how different populations access PAS. Stakeholders will have differing perspectives regarding protocols for assessment, service authorization, billing/payment, provider qualifications, and quality management.
5. Aligning assessed needs with CFC service authorization, while a sound administrative approach, may create operational challenges when people experience a reduction in authorized PAS.
6. There are several vulnerabilities within the LTSS infrastructure that present a risk to implementing new programs or services, including the robustness of CFI case management and PAS systems for service authorization, planning and utilization management, information systems and technology, and staff vacancies. Planning must seek to minimize disruption of services that people rely on and de-stabilization of service providers.

Mitigation

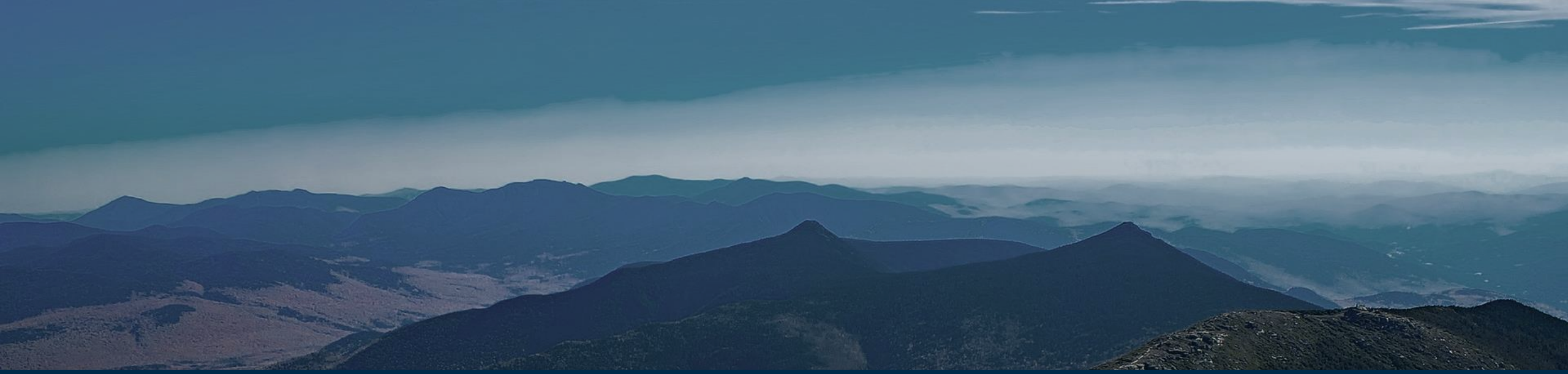
1. NH does not have waiting lists for waiver enrollment. CFC should target people living in their own homes that prioritize their independence. NH should not offer comprehensive residential services under CFC authority.
2. CFC program development and implementation planning should include a review of PCAS Care Plans to estimate the costs of shifting non-voluntary natural supports to paid supports.
3. Review Medicaid's actuarial contract to ensure this scope of work is included.
4. CFC program development and implementation must include extensive, broad-based stakeholder engagement. Planning must anticipate these costs to include staff support for stakeholder meetings, facilitation, and reporting and the costs associated with addressing disparities, such as standardizing assessment protocols and reimbursement rates.
5. NH should keep stakeholders informed of the potential negative impact of addressing service duplication and inequities. To ensure the health and safety of CFC participants, NH should explore strategies which phase in changes to service authorization levels.
6. NH should conduct CFC program development and implementation planning within the broader scope of DHHS transformation so infrastructure improvement costs can be shared across initiatives. NH should prioritize avoiding the disruption of services to people while balancing an understanding that changes are necessary to improve the efficiency of services and service outcomes.

LTSS | CFC 1915(k) | Next Steps

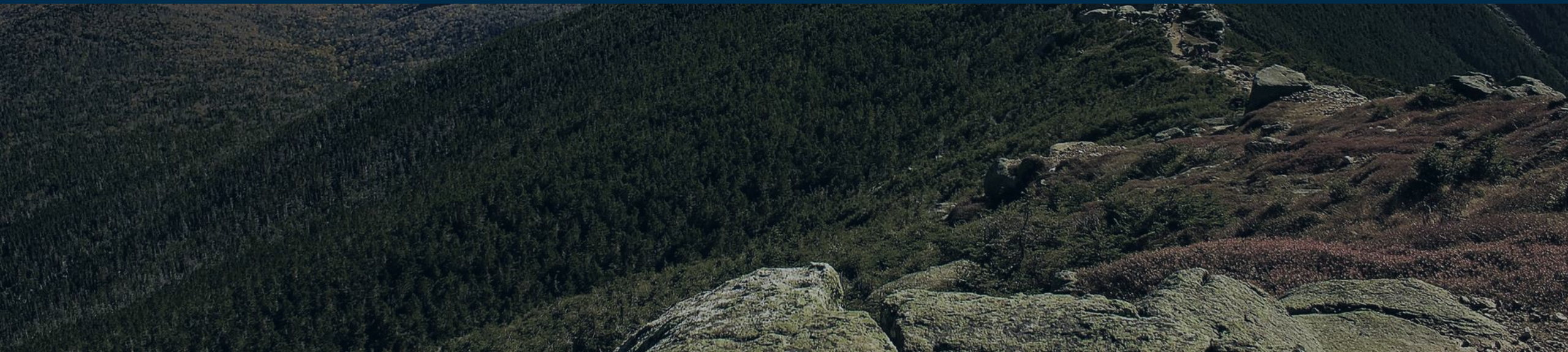
Prior to State Plan Amendment submission, DHHS must complete planning and preparation to ensure the smooth transition of existing services and the roll out of new services under CFC authority. Critical steps in this process include:

- Recruit / hire a CFC director who will be part of NH's LTSS team and coordinate PAS Medicaid State Plan CFC services for waiver participants ($40k-$60k / year)*
- Recruit / hire a CFC waiver program specialist who will be part of NH's LTSS team and coordinate PAS Medicaid State Plan CFC services for waiver participants ($30k-$50k / year)*
- Engage a broad base of stakeholders in an advisory capacity to guide program development and implementation
- Review existing application processes for State Plan HCBS and Waiver Services to create a CFC application process
- Review existing processes to assess functional needs and select a standardized tool for use by CFC to assess needs and inform LOC determination and service authorization ($150k-$250k one-time)*
- Identify existing waiver protocols that can be used or refined to support CFC operations (e.g., quality assurance and improvement)
- Review existing information systems to identify those systems that can support application/eligibility determination, needs assessment, planning, service authorization, and billing
- Create a CFC implementation plan to include a communication plan and training plan to minimize disruption to people receiving services, case managers, and service providers

*costs are General Fund dollars only and assume the availability of Medicaid 50/50 administrative match



IV-E Penetration Rate (Implementation Support)



IV-E Penetration Rate | Executive Summary

1. A&M was engaged to help advise DHHS on ways to increase the current IV-E penetration rate.

2. A&M and DHHS manually reviewed a sample set of residential placements for the month of November for I-VE eligibility.
   - Checked the total number of residential placements = 306
   - Selected a sample size of approx. 10% for a detailed review = 33*
   - Of the sample size reviewed 12% were identified as IV-E eligible but did not have an IV-E open case due to failure to provide = 4

3. A&M and DHHS are therefore focusing efforts on addressing the driving cause of “failure to provide” by assessing information gaps in how DCYF is collecting financial information and establishing recommendations for changes to that form which will increase data capture related to IV-E eligibility.

*DHHS sorted residential placements by highest cost

IV-E Penetration Rate | Scenario Discussion

Currently, DHHS's effort to increase the IV-E penetration rate focuses on improving the return rate of financial information.

Problem: Currently, IV-E Fiscal Specialists are responsible for obtaining family financial information after a child is removed. If it is identified that financial information is missing for a family, Fiscal Specialists will mail out a financial affidavit form to the families. Families are expected to fill out the form and return it to the Fiscal Specialists. It was identified that many families fill out the same information in the Court Affidavit Financial Form.

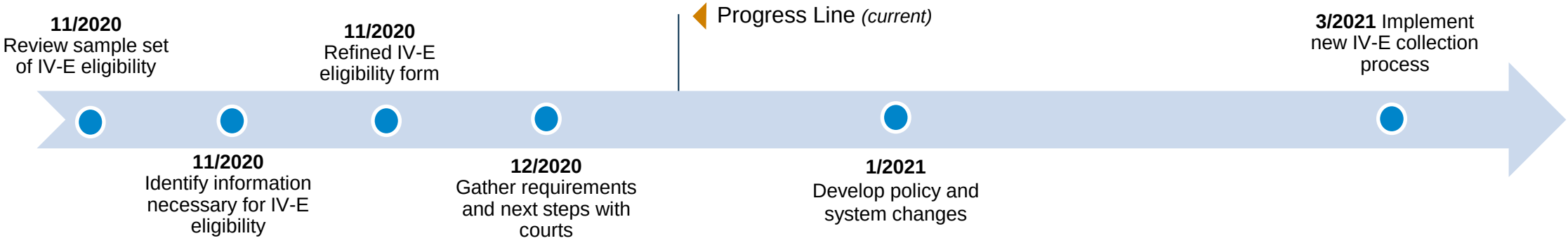
Because of the labor-intensive process, and little incentive for families to complete this form, the return rate of DCYF Financial forms is low.

Opportunities:

- Combine information with duplicative information filled out in the Court Affidavit Form
    - Pursued, however the return of court affidavit forms is no longer required
- Reduce the amount of information that is currently required to determine IV-E eligibility
- Establish shared responsibility for DCYF caseworker and IV-E for collecting financial information
- Identify opportunities for courts to be involved in the collection of missing financial data

IV-E Penetration Rate | Implementation Timeline

The following implementation timeline lays out the dependencies, achieved steps, and future steps necessary to implement a new IV-E Financial Affidavit.



	11/2020	12/2020	1/2021	2/2021	3/2021	Status	Description
Data Analysis							Completed data analysis of a sample size to identify magnitude of reasons for IV-E ineligibility.
Gather Requirements							Review financial forms from other Region 1 states. Conduct a review of information that is already collected through the DCYF investigation process.
Develop Policy							Identify policy changes required to share information between the courts and DCYF. Explore opportunities for policy changes that would require families to fill out these forms before they leave the courts.
Develop Systems Changes							Identify data-sharing mechanism between DCYF and the courts, if necessary. Identify options to minimize manual effort and increase IV-E efficiency such as an online form that families can access.
Implementation							Dedicate resources and measurable performance metrics on implementation.

IV-E Penetration Rate | Implementation Update

A&M continued to follow up on the Phase IA recommendation to increase IV-E penetration rate by focusing on increasing the return of Financial Affidavits.

Phase IA Determination		Phase IB Action	
Area	**A&M Implementation Requirements**	**Steps Taken**	**Next Steps**
People	1-3 Fiscal specialist unit (FSU) staff to assist in reviewing manual cases. 8-10 people that can serve as a workgroup from all stakeholders (DCYF, Courts, FSU, IT) to drive new process/system changes.	Worked with FSU staff to review manual cases.	• Identify individuals to maintain responsibility of leading this effort
Process	DCYF will need to make changes and modifications to the current processes FSU staff follows to identify IV-E funding.	Investigated opportunities to minimize manual processes through fillable online form. Determined best data sharing mechanisms to share information between DCYF and courts.	• Review current child removal process and identify places in the process suitable for collecting financial information from families
Technology	Bridges 2.0 will need to integrate to allow for utilization by FSU staff. New Heights needs an additional field to be able to tag reasons for child ineligibility so that performance metrics can be tracked moving forward.	Identified components necessary to be implemented in Bridges 2.0	• Continue to share findings with the Bridges 2.0 team
Prep. Work	Manually review 300 cases to identify the magnitude of each of the reasons for ineligibility.	Analyzed a sample set of 33 cases. Conducted a stakeholder group with both DCYF and courts.	• Review data collected in the DCYF investigative process • Review financial forms used in other Region 1 states • Refine current DCYF financial forms
Statute	N/A	N/A	N/A

Medicaid Disenrollment (Implementation Support)

Medicaid Care Management | Executive Summary

1. A&M continues to engage DHHS on implementation planning for promptly resuming renewals and disenrolling ineligible individuals after the COVID-19 public health emergency (PHE) ends.

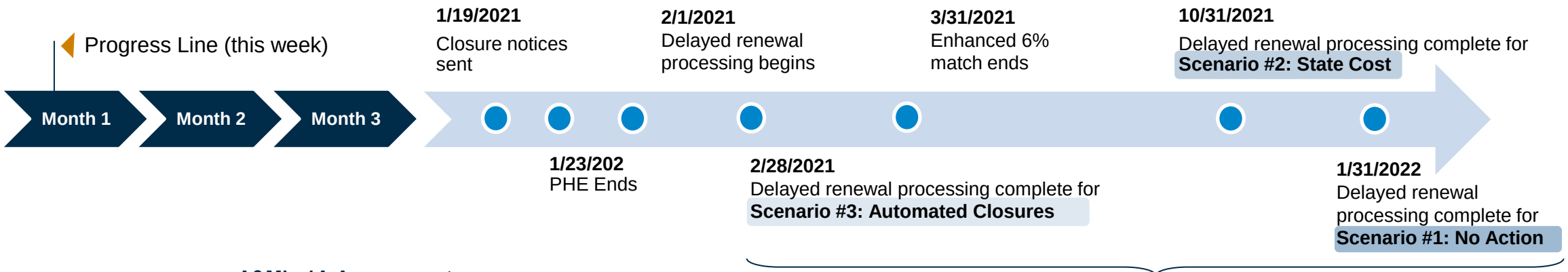
2. DHHS aims to maximize its capacity to work overdue redeterminations (“redes”) on an accelerated schedule through policy, process, and system changes. Currently, its planning effort is directionally aligned with scenarios #2 and #3 (outlined below per the A&M Phase IA report) and centers on quantifying the overdue rede volume and current workforce capacity.

3. A&M continues to advise DHHS on development of its disenrollment implementation plan, specifically providing counsel to the Medicaid Director on ways to coach staff through the action steps required.

Scenario	State Funds Cost	Operational Tactic
#1. Pre-COVID Renewal Process	$46.3M	Resume Pre-COVID renewal process, no change in annual timeline
#2. Reorganize Workload by State Cost	$34.0M	Prioritize disenrollment based on state share of per member per month cost
#3. Use Automated Closure Functionality	$18.8M	Maximize automation, minimize timeline

Medicaid Care Management | Scenario Discussion

Currently, DHHS's aim for the disenrollment implementation plan directionally aligns with Scenarios #2 and #3.



A&M's 1A Assessment

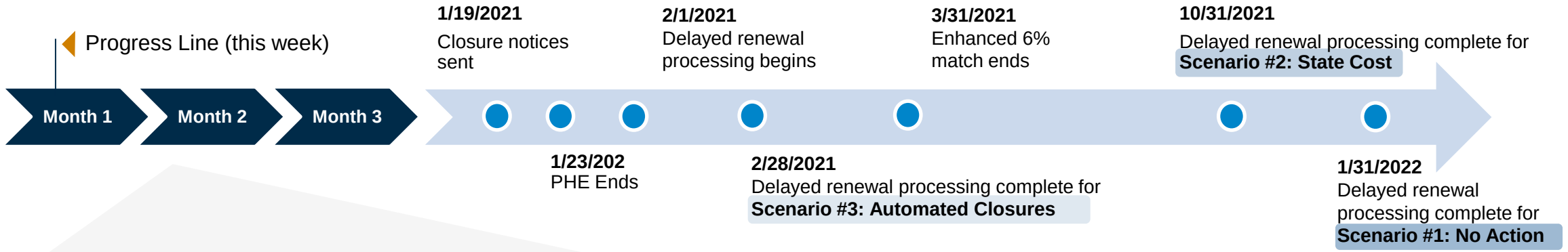
Scenario 1 estimates the "worst case" cost of no change from Pre-COVID practices. Scenarios 2 and 3 represent cost avoidance measures that could potentially lower costs from Scenario 1. Scenario 2 is estimated to potentially lower the state cost impact from the worst case by $12.3M in state funds, and Scenario 3 is estimated to potentially lower the state cost impact from the worst case by $27.5M in state funds. **These potential cost reductions are not to be understood as savings from amounts currently budgeted for the Medicaid program.** It is assumed that the increased costs of PHE FMAP-related enrollment were not foreseen and are not reflected in current appropriations.

Scenario	State Funds Cost	Operational Tactic
#1. Pre-COVID Renewal Process	$46.3M	Resume Pre-COVID renewal process, no change in annual timeline
#2. Reorganize Workload by State Cost	$34.0M	Prioritize disenrollment based on state share of per member per month cost
#3. Use Automated Closure Functionality	$18.8M	Maximize automation, minimize timeline

Discussion Point: DHHS' Scenario Choice

Medicaid Care Management | Implementation Timeline

Readiness for implementation of a plan to promptly disenroll Medicaid recipients who no longer meet eligibility requirements when the COVID Public Health Emergency ends remains a budgetary risk for NH.



	Month 1	Month 2	Month 3	Status	Dependencies
Gather Requirements					Develop a comprehensive view of policy, procedure, process, and systems variables to consider in disenrollment implementation planning
Data Analysis					Gather and analyze data needed to determine overdue rede volume and workforce capacity for routine and excess workload
Develop Policy					Identify opportunities and provide leadership with information and decision points on policy changes to increase capacity to work overdue redes on an accelerated schedule
Develop Systems Changes					Identify options to maximize automation, minimize manual effort, and increase workforce capacity to work overdue redes ahead of schedule
Implementation					Dedicate resources and sustain attention on implementation planning, to make as much progress as possible in advance of CMS guidance, regardless of the PHE end date

Medicaid Care Management | Implementation Update

A&M continued to follow up on the Phase IA recommendation to advise DHHS in understanding requirements for disenrolling Medicaid recipients who are no longer eligible when the COVID Public Health Emergency ends.

Phase IA Determination		Phase IB Action	
Area	**A&M Implementation Requirements**	**Steps Taken**	**Next Steps**
People	Sufficient workforce capacity, i.e., eligibility workers, call centers, mail rooms. Short-term staff augmentation, such as temp workers for less complex tasks, to prevent or reduce backlog from catch-up workload.	Analyzed data provided by DHHS to determine workforce capacity for routine and overdue rede volume.	Determine: volume of overdue redes that can be completed during the PHE due to new CMS guidance; volume of overdue redes likely to be completed as clients come up for renewal in other DHHS programs prior to their Medicaid renewal date; remaining overdue rede volume and workforce capacity available and/or needed to work on an accelerated schedule.
Process	Targeted policy, procedure and process changes to streamline work, economize administrative effort, and manage catch-up workload within workforce constraints.	Investigated current use of automated closures and decision points for leadership on expanded use to minimize manual effort on overdue redes.	Continue to advise on questions to be answered and data to be gathered to inform leadership decision making on potential policy/procedure changes to increase capacity to work overdue redes ahead of schedule.
Technology	Advance design, development and testing of eligibility system changes needed to resume renewals and closures with more automation and less manual effort. Call center (IVR) changes should also be addressed.	Same as Process actions above.	Same as Process actions above.
Prep. Work	Data analysis and research to inform decision making on a renewal strategy that balances concerns with administrative capacity, cost, and the well-being of vulnerable populations.	Same as People and Process actions above.	Same as People and Process actions above.
Statute	Determine fixed requirements (i.e., advance notice of adverse action) and flexibilities (i.e., interim verification of critical eligibility factors) at the federal and state level that will determine tasks and timelines.	CMS guidance remains forthcoming, limiting the state's ability to develop a detailed implementation plan.	Continue to gather and analyze data currently available to the State to inform the disenrollment implementation planning to the maximum extent practicable.