



# **NH DHHS Operations Assessment**

**November 2020 Phase IA**

**Prepared by Alvarez and Marsal Public Sector Services, LLC**

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## PROJECT OVERVIEW

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### Executive Summary

#### **Background**

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

Founded in 1983, A&M is the world's largest turnaround firm. A&M's Public Sector Services practice (A&M PSS) was established in 2003. A&M PSS combines the firm's expertise in finance and data analysis and organization efficiency with the policy knowledge of subject matter experts to provide a balanced approach to program assessment, redesign, and transformation.

#### **Scope**

A&M's assessment has been subdivided in two distinct phases: Phase IA (August 24 – October 30, 2020) and Phase IB (November 2 – December 31, 2020). In Phase IA, the A&M Team focused on Department programs and services with the largest portions of allocated funding. Within each focus area or "workstream" A&M assessed the financial and operational impact of the pandemic to understand the 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. This report presents A&M's Phase IA analysis and recommendations.

In Phase IB, A&M will continue to assess the impact of the pandemic, supporting implementation of opportunities in which efficiencies and improvements may be realized in six to nine months. A&M will explore additional opportunities as requested by DHHS to formulate a long-term vision for DHHS to improve services to and outcomes for the citizens of New Hampshire.

#### **Approach**

Our approach acknowledges the essential nature of services administered by state health and human services agencies and the responsibility of state government to ensure that its citizens receive the best possible value from taxpayer-funded services. The A&M Team included experienced staff who have led similar engagements in other states and have previously served in leadership roles within other state health and human services agencies.

## Our Approach

### **Overall Process Review**

A&M followed a standard process to complete this efficiency study, though teams performed different analyses depending on the DHHS division under review. This engagement was subdivided into the following phases:

#### **1. Begin Initial Interviews**

A&M initiated this process by engaging with DHHS division leadership in order to develop a general understanding of the programs offered and issues faced. The DHHS Office of the Commissioner (OCOM) set up kickoff interviews with the following divisions, including division directors, bureau leaders, and their finance staff: Division of Medicaid Services, Legal Services, Behavioral Health (DBH), New Hampshire Hospital/Glenclyff (NHH/Glenclyff), Division of Economic & Housing Stability (DEHS), Division for Children, Youth and Families (DCYF), Division of Public Health (DPH), Division of Program Quality and Integrity (DPQI), Bureau of Information Services (BIS), Division of Long-Term Supports and Services (LTSS), the Office of Finance, and the executive leadership team (OCOM). These interviews helped the A&M team determine what data to begin collecting and which reports to begin reviewing.

#### **2. Collect Data**

Based on feedback from interviews, A&M requested data from DHHS division stakeholders to help inform early opportunity development. A&M requested various tranches of data, including budget data, COVID expenditures, organizational charts, Single Audit reports, vendor performance evaluations, MMIS data extracts, DHHS human resources data, vendor contracts, CMS Waivers, and other division-specific items. As the engagement progressed and as A&M pursued specific opportunities, divisions provided more specific data.

#### **3. Conduct Analysis and Develop Recommendations**

A&M conducted some standard analysis across the project team, including a review of select contract groups and a study of federal funding streams (specifically, a study of COVID-related funding). These analyses enabled A&M to develop opportunities and determine what additional inputs were required to translate an opportunity into a tangible recommendation.

### **Contract Review**

At the outset of the engagement, A&M reviewed 12 contract groups (listed below in Table/Figure 1). A&M's objective was to evaluate DHHS statewide service delivery model in key service areas and to identify opportunity areas to increase efficiency, produce cost savings, and improve delivery of services. A&M reviewed other contract groups as analysis progressed, so the following list is not intended to be an exhaustive view of contracts reviewed.

**Table/Figure 1. Contract Groups Reviewed**

<b>Contract Groups</b>	<b>Agreements</b>
Managed Care Organizations	3
Integrated Delivery Networks	7
Regional Public Health Networks	13
Community Mental Health Centers	10

“Doorways” Access and Delivery Hub for Opioid Use Disorder Services	10
Primary Care Services	9
Adult Day Care Services	5
Developmental and Acquired Brain Disorder Services	10
Nutrition and Support Services	15
Comprehensive Family Support Services	11
Family Planning Services	9
ServiceLink Aging & Disability Resource Center Services	7

A&M followed a standard process in reviewing these contracts. To complete this review, A&M:

1. Reviewed contracts in groups organized by workstream;
2. Created an inventory of key details across contract groups;
3. Identified key findings both within contracts and across contract groups;
4. Hypothesized improvement opportunities based on initial observations; and
5. Developed next steps to more fully investigate opportunities.

In this analysis, A&M sought to identify areas where DHHS could reduce overlap in services provided across contracts, maximize value through utilization of federal funding and increased assurance of contract compliance, and streamline redundancies in coordination. The goal of this contract review was not to develop solely contract improvements, but this review informed A&M’s division-specific reviews.

### **COVID Funding Review**

A&M also examined DHHS’ COVID expenditures from a two-pronged approach in order to identify opportunities for general fund savings by maximizing federal fund revenue sources:

#### *Approach #1: Matching DHHS Spending to Designated Federal Funding Opportunities*

The purpose of this approach was to identify federal funding programs that New Hampshire may be underutilizing. A&M utilized a federal funding inventory developed and vetted by A&M’s COVID taskforce and A&M’s Health and Human Services subject matter experts. A&M traced federal funding usages from the inventory to the actual expenditure list provided by NH DHHS. A&M then identified whether funding sources were fully utilized or underutilized.

#### *Approach #2: Identify Other Opportunities for Coronavirus Relief Fund Usage*

The purpose of this approach was to identify alternative opportunities for New Hampshire to utilize Coronavirus Relief Funds (which are slated to expire 12/30). A&M identified ideas through other client engagements, outside research, and resources from the National Conference of State Legislatures. After identifying different opportunities, A&M identified through our research into various sources. A&M discussed potential opportunities with stakeholders to determine applicability and feasibility of initiatives.

### **COVID Impact**

In each analysis of divisions, A&M considered the impact of the COVID-19 pandemic on DHHS operations in a particular area. These findings are presented in each section.



## Workstream Approach

A&M organized our analyses and recommendations into seven focus areas, shown below in Table/Figure 2.

**Table/Figure 2. Focus Areas**

Focus Area	Description of Analysis Conducted
1. Behavioral Health	Reviewed the current continuum of care across the Behavior Health System, identifying potential gaps within care coordination; narrowing down near-term opportunities for increasing capacity for Psych-related treatment currently impacting New Hampshire Hospital due to the impact of COVID-19.
2. Developmental Services	Performed a comprehensive review of the waiver and service delivery construct, conducted a participant-level analysis to compare costs to level of need, prescribed various structural changes to this system as detailed in this report.
3. Children, Youth, and Families	Assessed the process by which the Department collects information, applies for and tracks outcomes for IV-E foster care funding.
4. Economic and Housing Stability	Conducted a mapping exercise of the eligibility determination process to identify opportunities for improving performance metrics and investing in infrastructure while offsetting costs within the context of increased caseloads due to COVID-19.
5. Medicaid Services	Conducted a review of MCO contracts to identify opportunities for short or near-term opportunities to improve provider management practices as well as to assess the need to plan for the Post Health Emergency period.
6. Medicaid Management Information System (MMIS)	Compared current and historic spending levels on the MMIS to benchmarks as well as best practices in MMIS strategy development to begin forecasting go-forward expenditure scenarios as well as implementation frameworks.
7. Department-wide Staffing Levels	Analyzed detailed staffing information by division, position, level and function, comparing metrics to peer state agencies providing analogous services, identified the most acute need for staffing support and assessed the impact of COVID-19 on vacancy rates.

A&M has identified other opportunities for improvement within other focus areas but is continuing to vet these opportunities at a deeper level of detail. As such, these opportunities will not be presented in this October 2020 report.

## Recommendations

### Short-Term

The A&M Team identified the following short-term recommendations seen in Table/Figure 3. Short-term is defined as having implementation time frame of under 18 months. All figures reflect the general fund savings to New Hampshire (not federal funds). All costs reflect one-

time and annual expenditures. The savings estimates are annual. Further information on the savings estimates can be found in each workstream section. The reference numbers are used for navigation throughout this report.

**Table/Figure 3. Short-Term Recommendations**

#	Recommendation	Description	Est. Costs (\$M)		Est. Savings (\$M)	
			Low	High	Low	High
C.1	Maximizing Federal IV-E Funding – Foster Care	In order to maximize federal IV-E revenue, DCYF will need to evaluate policies/procedures to identify current process-related problems and develop new procedures to ensure that all eligible youth are identified, and appropriate documentation is established to maximize IV-E funding.	\$0.05M <sup>^</sup>	\$0.05M <sup>^</sup>	\$1.1M	\$4.5M
D.1	Increase Workforce Capacity	Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies to improve caseload metrics and application timeliness.	\$0.10M	\$0.16M	Variable	Variable
D.2	Implement Technology Projects using COVID Dollars	Implement technology improvements to DEHS systems and other areas to alleviate increased workload due to COVID-19 and improve client experience.	--	--	\$2.1M	\$2.1M
E.1	Eligibility Redetermination	Collect data and complete analyses to inform decision making on eligibility policy, process and system changes, such as the targeted use of automated case closures. Detail tasks and timelines end-to-end. Identify and allocate resources required.			Variable	
<b>TOTAL</b>			<b>\$0.15M</b>	<b>\$0.21M</b>	<b>\$3.2M</b>	<b>\$6.6M</b>

<sup>^</sup> one-time costs

### Long-Term

The A&M Team has identified the following long-term recommendations seen in Table/Figure 4. Long-term is defined as requiring an implementation time frame of 18 months to ten years. All figures, (with the exception of recommendation F.1) reflect general fund impact. All costs reflect one-time and annual expenditures. The savings estimates are annual. For recommendation F.1, figures represent savings over the duration of the timeframe. Further information on the savings estimates can be found in each workstream section. The reference numbers are used for navigation throughout this report.



**Table/Figure 4. Long-Term Recommendations**

#	Recommendation	Description	Est. Costs (\$M)		Est. Savings (\$M)	
			Low	High	Low	High
A.1	SMI IMD Waiver	Pursue an SMI IMD Waiver as an amendment to its Substance Use Disorder (SUD) IMD Waiver as soon as Amendment #1 is approved by the Centers for Medicare and Medicaid Services (CMS). While the dual SMI-SUD IMD Waiver is pending, DHHS should immediately begin re-engaging with private sector IMD providers who have previously expressed an interest in entering the State subject to approval of an SMI IMD Waiver.	\$0.07M \$0.3M <sup>^</sup>	\$0.2M \$0.3M <sup>^</sup>	\$3.3M	\$4.4M
B.1	Conduct a 1915(c) Waiver Redesign by Implementing Tiered Waivers	Develop tiered waivers to identify, limit, and address instances where level of need does not align with current funding to better promote equity.	--	--	\$0.1M	\$0.6M
B.2	1915(c) Waiver Reimbursement Redesign	Develop tiered reimbursement rates to better align payment with level of need.	\$0.7M \$0.4M <sup>^</sup>	\$0.9M \$0.7M <sup>^</sup>	Variable	
B.3	Information Technology Systems Development	Establish a comprehensive IT system to better manage, report and utilize data in strategic decision-making.	\$0.1M \$0.2M <sup>^</sup>	\$0.2M \$0.3M <sup>^</sup>	Variable	
B.4	Modified Wait List Funding	Reduce the available funding for waitlist participants to more closely align allocated funding with trends in spending.	--	--	\$4.1M*	\$4.1M*
B.5	Intensive Treatment Service (ITS) Options Development	Develop in-state Intensive Treatment Service (ITS) residential options to reduce or eliminate the need for out-of-state placement of individuals with complex care needs currently at an average cost per person of \$385,000.	\$4.9M <sup>^</sup>	\$6.5M <sup>^</sup>	\$0.7M	\$2.6M

			Est. Costs (\$M)		Est. Savings (\$M)	
D.3	Redesigning Business Processes	Conduct further analysis into current business processes including call center operations, and case-based eligibility model. Consider implementing enhanced Interactive Voice Technology (IVR) and a triage process within the call center and shifting case-based model to a task-based model.	Variable			
E.2	Health Plan Performance Incentives	Shift NH DHHS's approach to performance incentives for health plans from monetary penalties and a withhold of capitation payments to an auto-assignment algorithm that rewards higher-performing plans with increased membership.	Variable			
F.1	New MMIS Strategy Adoption	Develop a comprehensive, long-term MMIS strategy and vision to maximize MMIS value and minimize cost over time.	Variable	Variable	\$5.5M	\$21.6M

\* Revisions to these numbers are underway and subject to change  
 ^ one-time costs

## Implementation

For each recommendation, A&M will present the implementation requirements, including the people needed, process adjustments required, technology implications, preparation work required, and statutory restrictions or changes needed.

## A. BEHAVIORAL HEALTH

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### Executive Summary | Overview

#### **Scope**

A&M was tasked with performing a strategic assessment of the Behavioral Health system in the State of New Hampshire in order to identify opportunities for programmatic improvement while increasing the efficiency of department operations. A&M's review of the behavioral health system included the programs throughout the behavioral health continuum of care from the key points of entry (e.g., mobile crisis units or emergency departments) to the most intensive levels of care (i.e., psychiatric hospitalization). A&M also was tasked with analyzing the financial information and other operational indicators of the Division of Behavioral Health (DBH) and various entities such as New Hampshire Hospital (NHH), New Hampshire's Community Mental Health Centers (CMHCs), and other providers.

#### **Approach**

A&M began by developing an understanding of both the current services offered by New Hampshire's behavioral health system and the future services that New Hampshire aspires to offer as outlined in the 10-Year Mental Health Plan (the 10-Year Plan). With this guiding vision in mind, A&M interviewed stakeholders and reviewed documentation to identify recurring issues and pain points for the various stakeholders in the system. After completing a review of contracts with providers, the existing grants, and financial information of the provider institutions, A&M focused on the opportunities for improvement related to improving capacity in the system and exploring opportunities for leveraging Medicaid funding for services.

#### **Results**

In this initial phase, A&M recommends that New Hampshire pursue a Serious Mental Illness (SMI) amendment to its Substance Use Disorder (SUD) Institution for Mental Disease waiver (IMD Waiver) with the Centers for Medicare and Medicaid Services (CMS) on the grounds that it would increase federal dollars available to the state in the short term and increase the overall capacity of the system by enticing new market entrants in the long term. Overall, the A&M team estimates that the SMI IMD Waiver could result in \$3-4 million of net positive annual impact to the State general fund.

A&M has identified other opportunities for improvement but is continuing to analyze and vet these opportunities at a deeper level of detail. As such, these opportunities will not be presented in this October 2020 report.

## Executive Summary | Recommendations (Short-term)

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
A.1	SMI IMD Waiver	Pursue an SMI IMD Waiver as an amendment to its Substance Use Disorder (SUD) IMD Waiver as soon as Amendment #1 is approved by the Centers for Medicare and Medicaid Services (CMS). While the dual SMI-SUD IMD Waiver is pending, DHHS should immediately begin re-engaging with private sector IMD providers who have previously expressed an interest in entering the State subject to approval of an SMI IMD Waiver.	\$0.07M \$0.3M <sup>^</sup>	\$0.2M \$0.3M <sup>^</sup>	\$3.3M	\$4.4M

<sup>^</sup> one-time costs

## Other Areas Reviewed

#	Opportunity	Determination
1	Maximize efficiency of service delivery through State-operated facilities / programs (e.g., New Hampshire Hospital, Glenclyff Home).	Given time constraints, the A&M team de-prioritized this opportunity relative to the potential to enhance Medicaid funding for services through an SMI IMD Waiver.
2	Maximize administrative funding drawn on block grants.	Further review is required.
3	Minimize usage of State General Funds to support and oversee New Hampshire's CMHC system.	Further review is required.

## A.1 | SMI IMD Waiver

**Recommendation:** Pursue an SMI IMD Waiver as an amendment to its Substance Use Disorder (SUD) IMD Waiver as soon as Amendment #1 is approved by the Centers for Medicare and Medicaid Services (CMS). While the dual SMI-SUD IMD Waiver is pending, DHHS should immediately begin re-engaging with private sector IMD providers who have previously expressed an interest in entering the State subject to approval of an SMI IMD Waiver.

<b>Timeframe</b>	7-10 months for approved waiver; 24-36 months for new system capacity	<b>Complexity</b>	High
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### Problem Statement

States have limited options to cover inpatient behavioral health (BH) care within the Medicaid system due to the IMD Exclusion Rule, a longtime limitation that generally prohibits reimbursement for inpatient BH care for Medicaid beneficiaries aged 21-64. According to MACPAC (Medicaid and CHIP Payment and Access Commission), the IMD exclusion has been in place in Medicaid statute since 1965.<sup>1</sup> From the same source, an IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes SUD.

As a result of this rule, states have generally been compelled to finance most inpatient BH care for Medicaid beneficiaries aged 21-64 from state general funds, with no Federal Financial Participation (FFP). New Hampshire, through its Disproportionate Share Hospital (DSH) program, has found a legitimate way around this limitation whereby 93 percent of the cost of IMD Exclusion days is covered with 50 percent FFP. In many other states, the lack of federal funding for IMDs reinforces the imperative—on top of statute (e.g., Americans with Disabilities Act of 1990 and Rehabilitation Act of 1973) and caselaw (e.g., *Olmstead v. L.C.*)—to develop the full continuum of care for behavioral health treatment including community-based settings. Absent such financial incentive, New Hampshire has subsisted with a fragmented continuum of care as evidenced by two measures: psychiatric boarding / Emergency Department (ED) waitlists and long inpatient length of stay (LOS), especially in terms of non-certified days (i.e., administratively necessary, but not medically necessary) at NHH.

### *Psychiatric Boarding*

According to the 10-Year Plan, New Hampshire has experienced a waitlist of adults in EDs being boarded prior to admission to inpatient psychiatric care that averaged 38 patients, ranging from 20-70 adult patients per day. These figures reflect a capacity gap of approximately 14,000 patient days (38 patients per day multiplied by 365 days per year). In FY20, the gap equaled 9,819 patient days—an amount that may have been reduced by delay or avoidance of care during the first wave of COVID-19 in early spring and summer. It can reasonably anticipated that post-pandemic demand for acute psychiatric care will, at a minimum, return to pre-pandemic levels or perhaps even increase due to heightened prevalence of behavioral health issues as discussed below.

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<sup>1</sup> MACPAC, Payment for services in institutions for mental diseases (IMDs). Available at <https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/>.

So-called “psychiatric boarding” delays critical care for vulnerable patients and does so at high cost, much of which is financed with state general funds through the Medicaid program and DSH program. A 2013 study found that average boarding times across the United States for psychiatric patients in the ED range from 6.8 hours to 34 hours at an average cost per patient of \$2,264.<sup>2</sup> Furthermore, prolonged boarding in the ED puts both patients and staff at risk.<sup>3</sup>

### *Long Inpatient LOS*

Among the segment of patients who fell within the IMD Exclusion rule during Fiscal Year (FY) 2020, 44.2 percent of patient days were non-certified or not medically necessary, totaling around 5,661 days. These days represent extra time spent in the hospital primarily due to administrative or non-medical barriers to discharge, like a lack of step-down level of care or homelessness, or some other reason. These days are compensated at the DSH rate, meaning the gap in reimbursement is partially offset. But this situation also serves as an impediment to other patients in crisis who must wait for the administrative barriers to be addressed before a bed becomes available to provide the care they need in the most appropriate setting.

With non-certified days accounting for close to half the LOS among NHH’s IMD Exclusion cases, one would expect to see an impact in terms of NHH’s Average LOS (ALOS). For the 269 cases or admissions falling within the IMD Exclusion in FY20, the ALOS was 47.8 days (certified and non-certified days). The maximum total LOS for one patient (including non-certified days) exceeded 400. CMS expects short-term acute care in inpatient settings for SMI to average 30 days, and indeed, at NHH, the certified portion averages 26.7 days.

### *Summary*

New Hampshire has made significant strides in developing the community-based segments of the continuum of care especially since its Olmstead settlement (the Community Mental Health Agreement) was put in place in 2014. But given the anticipated increase in prevalence of SMI and SUD stemming from the COVID-19 public health emergency, New Hampshire can ill afford to maintain bottlenecks in its continuum of care such as those described in paragraphs above.

### **Findings**

Through interviews, research, and analysis, the A&M team determined the following:

1. In recent years, CMS has demonstrated a willingness to grant waivers of the IMD Exclusion rule to states for demonstration purposes as part of developing the full continuum of care of BH services. Washington, DC and the State of Vermont obtained dual SMI-SUD IMD Waivers in December 2019 and January 2020, respectively, based on the guidance issued by CMS in November 2018.

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<sup>2</sup> Zeller S, Calma N, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *West J Emerg Med.* 2014;15(1):1-6. Available at <https://escholarship.org/uc/item/01s9h6wp>.

<sup>3</sup> Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int.* 2012;2012:360308. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3408670/>.

2. While New Hampshire has assessed the potential for this type of waiver in the past, the benefits were determined to be inconclusive. The A&M team refreshed and focused the analysis solely on cases falling within the IMD Exclusion window, demonstrating that an SMI IMD Waiver would be both financially advantageous and operationally feasible.
3. The A&M team understands that private sector operators have been in contact with DHHS to discuss bringing on line new psychaitric inpatient capacity in New Hampshire subject to the approval by CMS of an SMI IMD Waiver. Additional inpatient capacity would reduce psychiatric boarding as patients are able to access treatment and become stabilized in a more timely manner. This is particularly true when approval of new inpatient capacity can be tied to developing other capacity to fill current gaps in the community-based continuum of care (e.g., mobile crisis services, transitional housing, community residences, etc.).
4. The primary rationale for pursuing an SMI IMD Waiver in New Hampshire is less about the reimbursement gains for NHH, although they are compelling on their own, but rather as a catalyst for change across the continuum of BH care. This strategy has three components: (A) increase diversion from EDs toward care in the community when appropriate, (B) increase throughput / decrease ALOS at NHH on the non-certified portion of stays, and (C) increase the options for step-down care once inpatient treatment is no longer medically necessary.
5. The high-level illustration below depicts the patient journey of a Medicaid beneficiary in mental health crisis both before and after a waiver is put in place. It is intended to illustrate the future vision and potential, but is not intended as a calculation of savings in the aggregate. Two different profiles of patient are analyzed, Standard Medicaid (Medicaid Care Management) and Expansion Medicaid (Granite Advantage), due to the differential in Federal Medical Assistance Percentage (FMAP) between the two programs. This example is focused on the patient’s stay in the ED (i.e., stabilization, assessment, and potentially boarding) and IMD (i.e., inpatient care, both medically- and administratively necessary days) of an episode of care. It shows how reimbursement changes after the Waiver as well as how LOS can be impacted by developing a more complete continuum of care. For baseline purposes, the A&M team has assumed that ED LOS goes from 4 days (including boarding) to 1 day for assessment & immediate transfer. The IMD LOS goes from 45 days (30 days under medical necessity, 15 days under administrative necessity) to 30 days (only medical necessity) based on the introduct of more robust step-down levels of care and care coordination.

**Table/Figure 5. Hypothetical Analysis of Mental Health Crisis Costs**

	Before Waiver	FMAP	State Share	LOS Reduction	After Waiver + Additional Step Down Capacity	FMAP	State Share
<b>Medicaid Beneficiary - Medicaid Care Management (Standard Medicaid)</b>							
ED LOS (days)	4.0	--	--	75%	1.0	--	--
ED Per Diem	\$2,250	--	--	--	\$2,250	--	--



<i>Observation</i>	\$1,125	50%	50%	--	\$1,125	50%	50%
<i>Uncompensated</i>	\$1,125	50%	50%		\$1,125	50%	50%
IMD LOS (days)	45.0	--	--	33%	30.0	--	--
IMD Per Diem	\$1,071	50%	50%	--	\$1,506	50%	50%
State Share	\$28,598	--	--	--	\$23,715	--	--
<b>Difference in State Share</b>	--	--	--	--	<b>(\$4,882)</b>	--	--
<b>Medicaid Beneficiary - Granite Advantage (Expansion Medicaid)</b>							
ED LOS (days)	4.0	--	--	--	--	--	--
ED Per Diem	\$2,250	--	--	75%	1.0	--	--
<i>Observation</i>	\$1,125	90%	10%	--	\$1,125	90%	10%
<i>Uncompensated</i>	\$1,125	50%	50%	--	\$1,125	50%	50%
IMD LOS (days)	45.0	--	--	33%	30.0	--	--
IMD Per Diem	\$1,071	50%	50%	--	\$1,506	90%	10%
State Share	\$26,798	--	--	--	\$5,193	--	--
<b>Difference in State Share</b>	--	--	--	--	<b>(\$21,605)</b>	--	--

6. Such a high-level analysis relies on many assumptions, most notably the reductions in LOS both in the ED and IMD. To fully illustrate the potential across a range of values for those key variables, the A&M team has calculated the following sensitivity table:

**Table/Figure 6. Impact of SMI IMD Waiver on State Financing of NHH**  
*Difference in State Share after Waiver – MCM (Standard)*

		Reduction in ED LOS				
		20%	40%	60%	80%	100%
Reduction in IMD LOS	10%	\$5,499	\$4,599	\$3,699	\$2,799	\$1,899
	20%	\$2,111	\$1,211	\$311	(\$590)	(\$1,490)
	30%	(\$1,278)	(\$2,178)	(\$3,078)	(\$3,978)	(\$4,878)
	40%	(\$4,667)	(\$5,567)	(\$6,467)	(\$7,367)	(\$8,267)
	50%	(\$8,055)	(\$8,955)	(\$9,855)	(\$10,755)	(\$11,655)

*Difference in State Share After Waiver – GA (Expansion)*

		Reduction in ED LOS				
		20%	40%	60%	80%	100%
10%		(\$18,538)	(\$19,078)	(\$19,618)	(\$20,158)	(\$20,698)

<b>Reduction in IMD LOS</b>	<b>20%</b>	(\$19,216)	(\$19,756)	(\$20,296)	(\$20,836)	(\$21,376)
	<b>30%</b>	(\$19,894)	(\$20,434)	(\$20,974)	(\$21,514)	(\$22,054)
	<b>40%</b>	(\$20,571)	(\$21,111)	(\$21,651)	(\$22,191)	(\$22,731)
	<b>50%</b>	(\$21,249)	(\$21,789)	(\$22,329)	(\$22,869)	(\$23,409)

*Impact of SMI IMD Waiver on State Financing of NHH*

- In FY20, 12,821 patient days fell within the IMD Exclusion window and were reimbursed through the DSH program. The rate applied under the DSH program reflects the “Reduced cost per day” reported in NHH’s Medicare Cost Report and is below NHH’s customary reimbursement rate as calculated under the existing State Plan Amendment and negotiated with private payers, i.e., \$1,071 instead of \$1,506.
- Table/Figure 7 summarizes all cases that fell within the IMD Exclusion window for any LOS. In order to conform to the guidance from CMS and previously approved waivers, the ALOS for all Medicaid beneficiaries must be below 30 days at the midpoint of the demonstration. If that’s not the case, CMS will adjust the maximum allowable reimbursement to be 45 days instead of 60 days—meaning cases over 45 days will not be reimbursed at IMD rates under that eventuality. Such cases would likely be reimbursable under the DSH program as uncompensated care as they are now.

**Table/Figure 7. Summary of Data for IMD Exclusion Cases – All Cases**

	Cases	Certified Days	Total Days	ALOS - Certified	ALOS – Total
Amerihealth	12	186	377	15.5	31.4
BEACON	122	2,779	5,422	22.8	44.4
New Hampshire Healthy Families	112	3,864	6,691	34.5	59.7
QMB	3	27	27	9.0	9.0
FFS	19	304	304	16.0	16.0
<b>Total</b>	<b>268</b>	<b>7,160</b>	<b>12,821</b>	<b>26.7</b>	<b>47.8</b>

- Table/Figure 8 summarizes all active cases with LOS less than or equal to 60 days. Cases with >60 days LOS, as well as Non-Certified Days, will not be reimbursed under the waiver, but will be reimbursable under the DSH program as uncompensated care.

**Table/Figure 8. Summary of Data for IMD Exclusion Cases – LOS <= 60 days**

	Cases <= 60 Days	Certified Days <= 60 Days	Total Days <= 60 Days	ALOS – Certified <= 60 Days
Amerihealth	12	186	377	15.5
BEACON	109	1,669	3,801	15.3
New Hampshire Healthy Families	90	1,561	2,816	17.3
QMB	3	27	27	9.0

FFS	18	225	225	12.5
<b>Total</b>	<b>232</b>	<b>3,668</b>	<b>7,246</b>	<b>15.8</b>

10. Table/Figure 9 compares reimbursement for IMD Days / cases before and after an SMI IMD Waiver can be implemented. Under the first scenario, Before Waiver, all days are reimbursed at the DSH payment rate. Under the second scenario, After Waiver, there are five primary categories of reimbursement:
- IMD Days for Medicaid Care Management (MCM), or Standard Medicaid. These days are reimbursed by the Managed Care Organizations (MCOs) at a collections rate that varies based on several factors, among them: prior authorization and timely filing. FMAP for these beneficiaries is New Hampshire’s Standard FMAP, or 50%.
  - IMD Days for Granite Advantage (GA), or Expansion Medicaid. These days are reimbursed by the MCOs at a collections rate that varies in the same ways outlined above. FMAP for these beneficiaries is New Hampshire’s Enhanced FMAP, or 90%.
  - IMD Days – Fee-for-Service (FFS) are days reimbursed for beneficiaries who remain in the State’s FFS Medicaid program, i.e. exempt from managed care. These days are not subject to the same collections dynamic as days reimbursed by the MCOs since they are billed directly to Medicaid.
  - DSH Days – Regular have two primary components: (1) days for stays over 60-day LOS (which are not reimbursable at all under the Waiver) and (2) Non-Certified Days for stays less than or equal to 60-day LOS (which are considered administratively necessary, but not medically necessary, and thus are not eligible for reimbursement under the Waiver).
  - DSH Days – MCO Uncollectible is the category that captures days that are medically necessary but for administrative reasons (see above) are not ultimately reimbursed by the MCOs.

**Table/Figure 9. SMI IMD Waiver Analysis**

	FY20	Collec tions Rate	Days Collected	Total Revenue	State share	FMAP	State General Funds	FFP
<b>Before Waiver</b>								
DSH Days	12,821	100%	12,821	\$13,729,368	50%	50%	<b>\$6,864,684</b>	<b>\$6,864,684</b>
DSH Rate	\$1,070							
MCM % Day (Standard)s	75%							
GA % Days (Expansion)	25%							
<b>After Waiver</b>								
IMD Days – MCM	2,562	60%	1,537	\$2,315,023	50%	50%	\$1,157,512	\$1.157.512
IMD Rate	\$1,506							

IMD Days – GA	854	60%	512	\$771,674	10%	90%	\$77,167	\$694,507
IMD Rate	\$1,506							
IMD Days – FFS	252	100%	252	\$379,512	50%	50%	\$189,756	\$189,756
IMD Rate	\$1,506							
DSH Days – Regular	9,153	100%	9,153	\$9,801,490	50%	50%	\$4,900,745	\$4,900,745
DSH Rate	\$1,070							
DSH Days – MCO Uncollectible	n/a	n/a	1,366	\$1,463,209	50%	50%	\$731,605	\$731,605
DSH Rate	\$1,070. 9							
<b>Total</b>							<b>\$7,056,785</b>	<b>\$7,674,124</b>
<b>Difference</b>							<b>\$192,101</b>	<b>\$809,440</b>

11. The table/figure scenarios above show a net benefit to NHH from implementing the waiver of approximately \$617,000. In other words, implementing the Waiver will result in an increase of State General Fund expenditures (i.e., approximately \$192,000), as some patient days draw a reimbursement amount that exceeds the DSH payment rate, which is more than offset by an increase in FFP (i.e., approximately \$809,000). It should be further noted that the “savings” in terms of DSH funds can be reallocated to enhance DSH funding for hospitals other than NHH, subject to applicable rules and regulations outlined in the 2018 Settlement Agreement and federal law, among other documents. Such additional DSH funding may be particularly beneficial to support post-COVID recovery efforts.

12. Table/Figure 10 is particularly sensitive to two variables: MCO Collections Rate and Days IMD Days in the Expansion Medicaid program. Furthermore, these variables are subject to change based on external factors, notably the potential implementation of a new claims & billing system at NHH and the demographics of future Medicaid enrollment, respectively. Accordingly, the A&M team calculated the following sensitivity table to show the range of possible increases to State general funds from implementing an SMI IMD Waiver (to be aggregated with cost reductions in following section for total net impact):

**Table/Figure 10. Additional State GF Required for NHH: After SMI IMD Waiver**

		% in GA Program (Expansion Population)				
		15%	20%	25%	30%	35%
<b>MCO Collections Rate</b>	<b>40%</b>	(\$228,655)	(\$187,500)	(\$146,344)	(\$105,188)	(\$64,032)
	<b>50%</b>	(\$272,112)	(\$220,667)	(\$169,222)	(\$117,777)	(\$66,332)
	<b>60%</b>	(\$315,569)	(\$253,835)	(\$192,101)	(\$130,367)	(\$68,633)
	<b>70%</b>	(\$359,025)	(\$287,002)	(\$214,980)	(\$142,957)	(\$70,934)
	<b>80%</b>	(\$402,482)	(\$320,170)	(\$237,858)	(\$155,546)	(\$73,234)

13. New Hampshire maintains a record of psychiatric patients boarding in the ED. For FY20, FY19, and FY18 total boarding days were 9,819, 12,436, and 16,257 respectively.
14. Through discussions with DHHS leadership, the A&M team understands that boarding days are reimbursed through a mix of observation claims and DSH payments. For purposes of the analysis depicted below, the mix was assumed to be 50 percent claims and 50 percent uncompensated care / DSH payments.
15. According to a 2013 report published by Foundation for Healthy Communities,<sup>4</sup> the following characteristic were observed among the population of psychiatric boarding patients in New Hampshire:
  - a. 28 percent were ultimately admitted to NHH, while 48 percent were admitted to other hospitals / facilities; and
  - b. 36 percent were beneficiaries of the Medicaid program, 23 percent were self-pay / uninsured, and 41 percent had other insurance.
16. Applying metrics from the Foundation for Healthy Communities report to the FY20 ED wait list, the A&M team finds that of the 9,819 patient days:
  - c. 3,535 were for Medicaid beneficiaries with 2,686 ultimately admitted to inpatient hospitals (including NHH),
  - d. 4,026 were members of other payers with 3,060 ultimately admitted to inpatient hospitals (including NHH), and
  - e. 2,258 were for self-pay / uninsured patients with 1,716 ultimately admitted to inpatient hospitals (including NHH).
17. Assuming the per-diem cost of \$2,264 referenced in the Problem Statement, these three segments of psychiatric boarding would incur the following costs:
  - f. Medicaid beneficiaries: \$3 million in observation costs (50 percent State general funds) and \$3 million in DSH payments (50 percent State general funds),
  - g. Other payer members: \$3.5 million in observation costs (0 percent State general funds) and \$3.5 million in DSH payments (50 percent State general funds), and
  - h. Self-pay / uninsured: \$3.9 million in DSH payments (50 percent State general funds).
18. Total State general fund impact of ED psychiatric boarding under the assumptions outlined above is approximately \$6.7 million. Assuming that half the waitlist can be reduced from new capacity coming online following approval of an SMI IMD Waiver, the A&M team estimates the impact on State general funds to be a benefit of approximately \$3.3 million.
19. Table/Figure 11 is particularly sensitive to two variables: Share of Boarding Costs Reimbursed as Observation Claims and ED Psychiatric Boarding Per Diem cost. Accordingly, the A&M team calculated the sensitivity table below to show the range of possible outcomes.

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<sup>4</sup> Shawn V. LaFrance & Daniel J. Walsh, HELP: People Seeking Mental Health Care in New Hampshire, Foundation for Healthy Communities (February 2013). Available at [https://www.healthynh.com/images/PDFfiles/BehavioralHealth/HELP\\_Rpt\\_FINAL\\_02\\_22\\_13.pdf](https://www.healthynh.com/images/PDFfiles/BehavioralHealth/HELP_Rpt_FINAL_02_22_13.pdf).

**Table/Figure 11. 50% Reduction in State Share of ED Psych Boarding Reimbursement for Hospital Admissions**

		ED Psychiatric Boarding Per Diem				
		\$1,250	\$1,750	\$2,250	\$2,750	\$3,250
Share of Boarding Costs Reimbursed as Observation	35%	\$1,997,369	\$2,796,316	\$3,595,264	\$4,394,211	\$5,193,159
	40%	\$1,949,562	\$2,729,387	\$3,509,212	\$4,289,037	\$5,068,862
	45%	\$1,901,756	\$2,662,459	\$3,423,161	\$4,183,864	\$4,944,566
	50%	\$1,853,950	\$2,595,530	\$3,337,110	\$4,078,690	\$4,820,270
	55%	\$1,806,144	\$2,528,601	\$3,251,059	\$3,973,516	\$4,695,974
	60%	\$1,758,337	\$2,461,672	\$3,165,007	\$3,868,342	\$4,571,677
	65%	\$1,710,531	\$2,394,744	\$3,078,956	\$3,763,169	\$4,447,381

### COVID Impact

The A&M team expects the volume of patients seeking inpatient BH care to increase as a result of Mental Illness and Substance Abuse being exacerbated by COVID-19 pandemic. New Hampshire must be prepared for the potential influx of individuals into the BH system.

According to a recent CDC publication,<sup>5</sup> 40.9 percent of survey respondents reported at least one adverse mental or behavioral health condition during the pandemic, including:

- Symptoms of anxiety disorder or depressive disorder (30.9 percent);
- Symptoms of a trauma- and stressor-related disorder (TSRD) related to the pandemic (26.3 percent); and
- Having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3 percent).

The same publication posited that “the prevalence of symptoms of anxiety disorder was approximately three times those reported in the second quarter of 2019 (25.5 percent versus 8.1 percent), and prevalence of depressive disorder was approximately four times that reported in the second quarter of 2019 (24.3 percent versus 6.5 percent).” The authors noted that due to methodological differences the results may not be directly comparable, but there is little doubt that the prevalence of behavioral health issues has increased as a result of COVID-19, particularly anxiety disorder, depressive disorder, and substance abuse.

Along those lines, a tracking poll from Kaiser Family Foundation (KFF) found that the percentage of adults reporting that their mental health had been negatively impacted due to worry and stress over the coronavirus increased from 32 percent in March 2020 to 53 percent in mid-July.

<sup>5</sup> Centers for Disease Control and Prevention. (2020, August 14). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. Morbidity and Mortality Weekly Reports. Available at <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>.

## Benefits

The direct benefit of this action would be to enhance the reimbursement for services at NHH. There is no negative impact anticipated on quality of services or performance. The A&M team understands that entry into the New Hampshire market by private sector operators is contingent upon the State receiving approval for an SMI IMD Waiver. Once that waiver is in place and new capacity (inpatient / IMD and community-based / step-down) can be brought on line, the ED wait list is expected to decrease. Since a large portion of psychiatric boarding is funded either directly through the Medicaid programs for eligible beneficiaries or indirectly through uncompensated care / DSH payments across all patients, any reduction in boarding days results in cost reduction or avoidance for the State. The amount of cost avoidance or savings is directly proportional to the reduction in boarding days as described more completely in Findings.

## Cost-Benefit Estimate

Cost-Benefit	Low	High	Justification
<b>Savings</b>			
Reduction in Psychiatric Boarding Costs	\$3.3M	\$4.4M	SMI IMD Waiver attracts new private sector operators to enhance continuum of care, relieve bottlenecks in EDs and at NHH
<b>Investments<sup>6</sup></b>			
Increase in SGF to NHH from implementing SMI IMD Waiver	\$0.07M \$0.3M <sup>^</sup>	\$0.2M \$0.3M <sup>^</sup>	
<b>Net Benefit</b>	<b>\$3.0M</b>	<b>\$3.9M</b>	

<sup>^</sup> one-time costs

## Implementation

Area	Requirements
<b>People<sup>7</sup></b>	A team of individuals is required to develop Amendment 2 to the waiver (e.g., senior Medicaid lead, Medicaid data lead, BH policy expert, and actuarial support from Milliman). The A&M team expects the effort to take 2-3 months of dedicated, but part-time, project work as well as 4-7 months of implementation planning from a subset of the initial group.

<sup>6</sup> CMS financial reporting burden will increase (i.e., CMS-64), but can be handled by currently budgeted (but unfilled) position reporting to Hannah Glines. NHH billing & collections capabilities may need to be reinforced with two additional staff positions, which would be funded through increased reimbursement anticipated at the hospital (no incremental State GF impact) as a result of the SMI IMD Waiver.

<sup>7</sup> Based on experience with the SUD IMD Waiver, there may be incremental ongoing waiver oversight staff and other support required. The A&M team continues to explore the details with Medicaid and DBH, but this incremental requirement may include one full-time waiver coordinator (similar to Bureau of Developmental Services) and additional contract hours from Milliman to provide actuarial support for budget neutrality.



Area	Requirements
	In parallel and beginning as soon as a decision is made to pursue the SMI IMD Waiver, Senior DHHS leadership would be required to engage with the private sector operators. Senior DBH leadership and regulatory technical assistance would be required to facilitate the approval and development process for the new facility.
<b>Process</b>	Once approved, the appropriate processes for movement of patients throughout the behavioral health system of care must be adjusted to accommodate new providers (e.g., statewide waitlist, triage, and referral mechanism).
<b>Technology</b>	N/A
<b>Preparation Work</b>	The waiver amendment application must be prepared by a knowledgeable team with adequate experience in preparing CMS waivers and actuarial support from Milliman.
<b>Statute</b>	Not a change in statute <i>per se</i> , but this amendment is dependent on Amendment 1 being approved by CMS.

## Timeline

Time Range	Basic Tasks
Weeks 1-10	Actuarial analysis, draft waiver application
Weeks 11-14	Public notice period
Weeks 15-16	Final waiver application; engage private sector operators
Weeks 17-40	CMS review & negotiation; implementation planning
Week 41	Waiver approval & implementation kickoff
Weeks 41-144	Develop new private sector psychiatric center

Target Start Time: As soon as possible to parallel-process with approval of Amendment 1.

## Risks

The major risks associated with this initiative are as follows:

**CMS approval of Amendment 1** – based on precedent (e.g., DC & VT) and guidance from CMS, this will need to be pursued as an amendment to the existing SUD IMD Waiver. The SUD IMD Waiver is currently pending approval of Amendment 1, which was submitted in August 2020. Amendment 1 presents a risk both to timing and ultimate feasibility of pursuing Amendment 2.

**Support of community mental health advocates** – advocates for community mental health services are typically suspicious of any action that could be construed as supporting or promoting care in institutionalized settings. The rationale for pursuing this course of action

should be clearly articulated and shared in advance of and during the public notice period in order to mitigate any misunderstandings.

**Continued interest in New Hampshire on the part of private sector operators** – the A&M team has heard anecdotally of the interest expressed by private sector BH operators of entering the New Hampshire market contingent upon the approval of an SMI IMD Waiver. Whether such operators are still interested in pursuing this opportunity is an open question. It is currently unknown whether COVID-19 has a material adverse impact on such operators that could remove their capacity to act once an SMI IMD Waiver has been approved.

**Workforce availability to staff new facility** – New Hampshire, like many other states, is experiencing a shortfall in qualified providers that is particularly acute in the BH field. The State should work with its private sector partner(s) to ensure an adequate staffing plan through partnerships with higher education and other workforce development mechanisms from the earliest planning phases.

## B. DEVELOPMENTAL DISABILITIES

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### Executive Summary | Overview

#### **Scope**

Medicaid-financed services for individuals with intellectual and/or developmental disabilities (I/DD) are comprised of life-long supports to assist people with complex needs.<sup>8</sup> Individuals with I/DD account for roughly one percent of total Medicaid beneficiaries but 8.5 percent of total Medicaid expenditures.<sup>9</sup> Within New Hampshire, services for individuals with I/DD are administered by the Bureau of Developmental Services (BDS) operating under the Division of Long-term Services and Supports (DLTSS). Under NH RSA 171-A, DHHS delegates service delivery to 10 Area Agencies who also serve as intermediaries for a greater network of subcontracted providers. BDS and the Area Agencies work closely together to provide services to NH's DD population.

In total, BDS serves approximately 5,500 individuals with I/DD or Acquired Brain Disorders. Services provided to these populations are authorized and funded through an operating budget of \$402 million annually.<sup>10</sup> A significant portion of the operating budget is dedicated to the management and operations of three 1915(c) Medicaid waivers: the In-home Supports (IHS) waiver, the Developmental Disabilities (DD) Waiver, and the Acquired Brain Disorder (ABD) waiver. Separately, participants also receive Medicaid state plan services administered by Managed Care Organizations.

For this report A&M focused on the Developmental Disabilities waiver which provides services to approximately 4,700 individuals with I/DD at a total FY20 cost of \$280.2 million or approximately \$60,000 per person.<sup>11</sup> This number represents the greatest number of consumers (87 percent) and the largest amount of spending (82 percent of total waiver spend).<sup>12,13</sup> Nevertheless, A&M's review of BDS operations and programs also takes into consideration the additional waiver populations within the bureau's purview. A detailed approach is described in the following section.

#### **Approach**

Complexities inherent in I/DD service requires a detailed understanding of system operations so that recommendations issued pertaining to systemic redesign do not unintentionally introduce new inefficiencies or system complications. In recognition of such challenges, A&M established a strategic review process built around four cornerstones of service optimization to evaluate BDS operations:

- **Systems Economy and Efficiency** – Waiver and programmatic operations are established to promote the best alignment between assessed need and service authorization.

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<sup>8</sup> Including behavioral or medical needs. Services provided to this population can be costly and perennial.

<sup>9</sup> Larson, S.A., Eschenbacher, H.J., Anderson, L.L., Taylor, B., Pettingell, S., Hewitt, A., Sowers, M., & Bourne, M.L. (2018). In-home and residential long-term supports and services for persons with intellectual or developmental disabilities: Status and trends through 2016. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

<sup>10</sup> Includes payments to providers at the school district level for children receiving Medicaid through schools

<sup>11</sup> Costs from MMIS database representing total FY20 paid claims from 7/1/19-6/30/20.

<sup>12</sup> Users from MMIS database representing total unduplicated individuals from 7/1/19-6/30/20.

<sup>13</sup> Percentage waiver spend from the Enterprise Data Warehouse representing total FY20 expenditures from 7/1/19-6/30/20.

- **System Infrastructure** – Adequate systems are in place to collect, measure, monitor, and report service utilization for decision-making.
- **Access to Services** – Appropriate mechanisms are in place to (a) provide new or existing participants access to appropriate services, and (b) appropriate and adequate funding is available.
- **Community System Infrastructure** – Adequate community services are available to meet the needs of those deemed eligible to receive services.

Under this framework the A&M team, in partnership with DLTSS staff, gathered and reviewed key documents, policies, and budgetary information to conduct a comprehensive and data-driven analysis of BDS operations. The review included:

- 1915(c) approved waiver applications
- 18 months of MMIS claims data for active service participants
- Level of need assessment data
- Waitlist funding projection data
- Internal and external state operational policy
- Previously conducted BDS system assessments and recommendations

A&M also interviewed members of the DLTSS and BDS Executive Leadership team. This background information, paired with the A&M team’s significant expertise in I/DD service systems, formed the basis for the recommendations in this report.

## **Results**

The A&M team recommends three areas of large-scale reform to strengthen the BDS service delivery system: waiver structure, rate setting, and IT transformation. In addition, A&M recommends addressing two more targeted opportunities around the Waitlist and Intensive Care Services. Across all recommendation areas, the team encountered a persistent lack of data and analytical support needed to effectively manage a program with a scope as large as that of BDS. Deficiencies in data and staffing support at BDS hinder the ability to collect, analyze and manage systems data, in a planned and strategic way that promotes efficient and effective program management. The recommendations identified through this analysis focus on macro reform in the developmental disabilities space that will improve BDS operations and service administration when paired with well-informed policy and programmatic changes.

This review identified that the BDS service structure has structural programmatic and operational challenges, including:

- (a) inadequate information systems to reliably collect and analyze data;
- (b) an antiquated rate reimbursement methodology that is not based on current costs
- (c) an individualized budgeting and planning process that lacks transparency into authorized services and paid claims; and,
- (d) inadequate controls for aligning services to assessed need increasing the likelihood of over-funding and over-serving individuals.

The identified gaps in system controls identified during this analysis provide significant opportunities to improve system efficiencies and effectiveness. Addressing the identified opportunities will both improve service quality for the individuals served and increase system

sustainability by increasing overall system management and reducing BDS operating costs long-term.

### Executive Summary | Recommendations (Long Term)

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
B.1	1915(c) Waiver Redesign	Develop tiered waivers to identify, limit, and address instances where level of need does not align with current authorizations to promote equity.	--	--	\$0.1M	\$0.6M
B.2	1915(c) Waiver Reimbursement Redesign	Develop tiered reimbursement rates to better align payment with level of need.	\$0.7M \$0.4M <sup>^</sup>	\$0.9M \$0.7M <sup>^</sup>	Variable	Variable
B.3	Information Technology Systems Development	Establish a comprehensive IT system to better manage, report and utilize data in strategic decision-making.	\$0.1M \$0.2M <sup>^</sup>	\$0.2M \$0.3M <sup>^</sup>	Variable	Variable
B.4	Modified Wait List Funding	Reduce the available funding for waitlist participants to more closely align allocated funding with trends in spending.	--	--	\$4.1M*	\$4.1M*
B.5	Intensive Treatment Service (ITS) Options Development	Develop in-state Intensive Treatment Service (ITS) residential options to reduce or eliminate the need for out-of-state placement of individuals with complex care needs currently at an average cost per person of \$385,000.	\$4.9M <sup>^</sup>	\$6.5M <sup>^</sup>	\$0.7M	\$2.6M

<sup>^</sup>one-time cost  
\*Revisions to these numbers are underway and subject to change

### Other Areas Reviewed

#	Opportunity	Determination
1	Case Management	Case management is a complex, intertwined process within I/DD services and other service systems utilized by individuals with I/DD. While case management is a significant component of BDS services, a more in-depth review and analysis is needed prior to making recommendations.
2	CARES Act Funding	The COVID-19 pandemic significantly impacted the I/DD service system within New Hampshire and nationally. Program closures due to the pandemic destabilized provider networks and heightened the risk of individuals with I/DD becoming isolated. While this analysis reviewed the impact COVID-19 had on BDS and identified potential opportunities to leverage CARES Act Funding to stabilize programs, additional analysis and structures are needed prior to making recommendations at this time. Specifically, opportunities identified include: growth and stabilization of Enhanced Family Care services (including network growth and

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access to PPE), expanding access to technology for virtual supports, and enhanced training and credentialing activities to strengthen the Direct Support Professional workforce.

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**3** Autism  
Spectrum  
Disorder  
(ASD)  
Waiver

Nearly 900 participants in BDS services have Autism Spectrum Disorder (ASD) and no other I/DD. This sub-population places new stresses on I/DD service structures. Primarily, rates of ASD diagnosis have grown exponentially over the past two decades.

Persons with ASD often have significantly higher therapy-based services which are not currently available under the DD Waiver. Given these differences in service needs, BDS may wish to explore an Autism-specific waiver for targeted for people with ASD.

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## **B.1 | 1915(c) Waiver Redesign**

<b>Recommendation:</b> Conduct a 1915(c) Waiver Redesign by Implementing Tiered Waivers			
<b>Timeframe</b>	3 years	<b>Complexity</b>	Moderate

### **Problem Statement**

Under the current waiver structure, there are inadequate controls on the services waiver participants may access. Currently those eligible for I/DD waiver services have only one option: the DD Waiver. Within the waiver, participants have access to all waiver services including high-cost residential services with inadequate controls to ensure that only individuals with high levels of need access high-cost services. Systems must ensure that people receive services essential to their health and safety and must also ensure that people are not over-served, which inhibits opportunities to maximize independence. Controls, however, are essential to ensuring that services align with assessed need to improve individualized and systemic equity.

### **Findings**

Analysis of the DD Waiver identified significant spread across service utilization, an inability to discern if the appropriate types and level of service are being provided, and a low correlation between assessed need and authorized/paid services.

To analyze service spend and utilization, the A&M team used standardized assessment data from the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). BDS has gathered SIS results for 21 percent and HRST results for 86 percent of the current waiver population. Though neither tool is currently being used for rate setting or eligibility determination, A&M used the SIS and HRST results to assess whether a relationship could be identified and leveraged between assessed need and current spend.

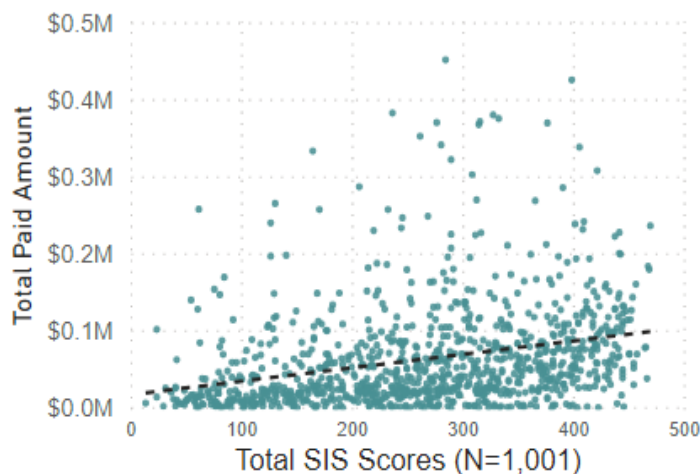
The SIS is used by over twenty states as a rate setting tool to align level of support needs (assessed need) with authorized funding. The assessment measures the degree to which an individual with I/DD needs support to meet Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) and extraordinary medical and/or behavioral support needs an individual may have – all functions correlated to service cost centers. The SIS also collects data that may be used for individual service planning including in areas such as: self-advocacy needs, recreational activities, and other socially-based activities that, while important to the support plan, do not impact funding needs.

The data presented in Table/Figure 12 below shows the spread in the current system where level of need is shown along the x axis and total per person spend on the y axis.



As indicated in the data, there is little to no relationship currently in the system when using the SIS as an anchor to total funding. This spread in the data is unsurprising because BDS does not currently use an assessment to develop funding allocations. However, the spread also suggests that there is no clear indicator or lever BDS can utilize to manage spend. If under the current waiver construct services were anchored to a more uniform process, one would expect to see a more linear progression in spending (y axis) as level of need increases (x axis) with less variation in individual expenses for each SIS score. As indicated in Table/Figure 12, SIS scores have very little explanatory power in determining individual expenditures ( $r^2 = 0.09$ ).

**Table/Figure 12. Spread of SIS Scores by Total Paid Amount**



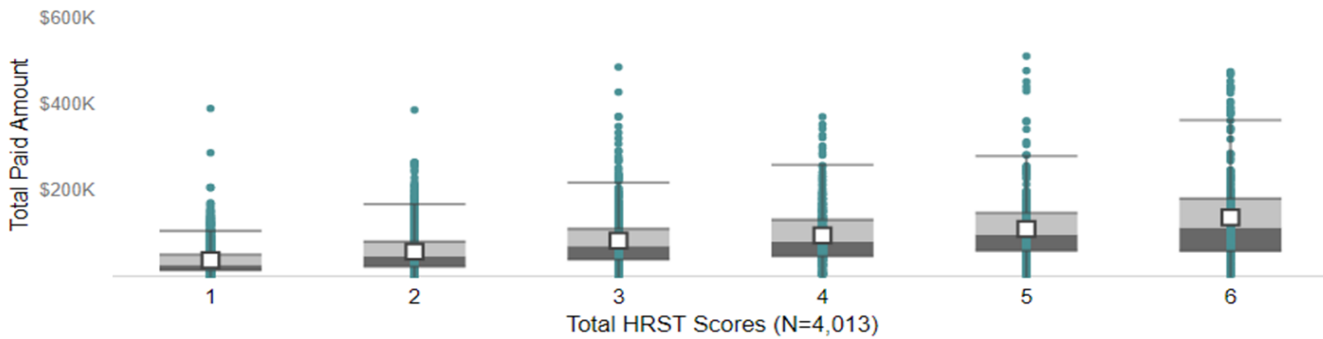
Table/Figure 12. Regression Output	
Correlation Coefficient	0.29
R Squared	0.09

As a secondary approach, A&M used scores from the Health Risk Screening Tool (HRST) to assess service need-to-expenditure parity in the current system.<sup>14</sup> HRST is a less frequently used assessment for allocating funding based on assessment score due to the heightened focus on medical and behavioral needs and less on whole-life support needs when compared to other tools like the SIS. However, given the tool’s validity and standard use in BDS, HRST does provide descriptive statistics which can be used to identify trends in waiver utilization and spend.

The analysis in Table/Figure 13 shows the spread of current funding within the constructs of the HRST scores. Of the sample of 4,013 individuals, A&M identified 162 outliers, or 4 percent of the sample group. Services for these individuals cost well in excess of their “predicted” assessed need when compared within their peer group. In addition, a portion of individuals grouped in level one of the HRST scoring spend up to the median spend of individuals in level six. This range in spend indicates there are opportunities to better align assessed need to service spend.

<sup>14</sup> The Health Risk Screening Tool (HRST) is a risk management tool to determine and detect areas of health destabilization. The HRST categories level of need into six classifications ranging from low (level 1) to high (level 6).

**Table/Figure 13. Spread of HRST Scores by Total Paid Amount**



Table/Figure 13. Outlier Analysis							
HRST Score	1	2	3	4	5	6	Total
Outlier (>1.5 IQR)	65	33	26	9	12	17	162
Total Population	1,318	1,145	641	349	304	256	4,013

In working sessions held with A&M, BDS acknowledged there are individuals whose annualized costs do not reflect their assessed need. This misalignment can be observed when expenditures are independently evaluated by both SIS and HRST scores. The data supports a common refrain within the DD space: the current waiver structure, with its ineffectual controls on service provision, perpetuates a system of “haves” and “have-nots”. To better align service authorization and utilization to assessed need, A&M recommends BDS design a clearly defined, tiered waiver structure with standardized and objective criteria for evaluating need and service authorization.

**COVID Impact**

New Hampshire, like other states, has been forced to identify ways to provide traditionally congregated, in-person services to individuals with complex needs in a socially-distanced environment. Through the COVID-19 pandemic, BDS has identified short-term ways to provide remote or virtual supports to individuals. This support structure has (a) allowed individuals to continue accessing supports and (b) stabilized the provider network by allowing mechanisms for providers to render and bill for services.

Flexibilities for remote support have been granted through the 1915(c) Appendix K application for short-term applicability to modifications in service delivery type. However, survey data collected by DLTSS revealed that roughly 80 percent of respondents received some form of virtual support during the pandemic. Of those receiving virtual supports, 73 percent would like to continue utilizing virtual supports post-pandemic. Given the positive reception to virtual support and the reduced cost structure relative to in-person supports, additional long-term flexibilities to promote virtual supports should be written into the State’s waiver structure as an approved delivery option. Such action could occur during a waiver redesign to ensure individuals have this continued opportunity.

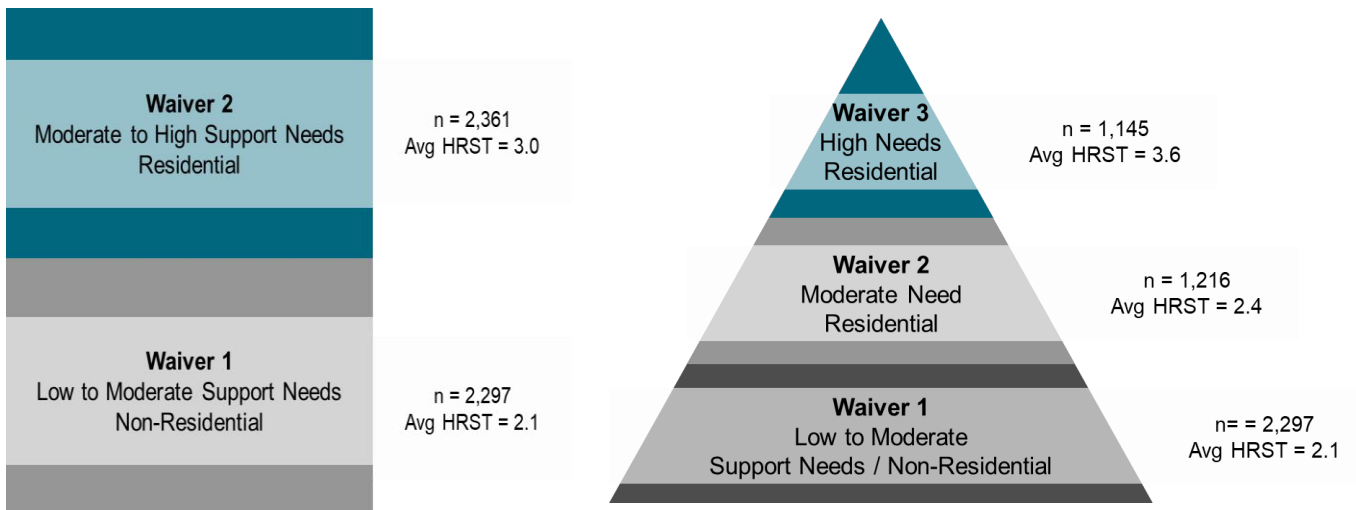
**Recommendation**

A&M recommends BDS introduce a tiered waiver structure in which service and funding caps are placed at specific levels to constrain service authorization and access. A&M analyzed the current MMIS claims data to identify the current average per person spending for individuals receiving services. Two groups in the data were identified: individuals receiving residential services and individuals not receiving residential services. Residential services are the most costly component to I/DD services. Currently, residential services represent 54 percent of total service costs under the DD Waiver. For illustrative purposes, after completing this initial analysis, A&M developed a model and structure to identify potential waiver capitation points that may serve as an initial tiered waiver framework.

A tiered waiver structure aligns initial waiver access to a service structure more directly correlated with assessed need. Implementing a tiered waiver is not meant to close the door to service for anyone who meets BDS eligibility. A tiered waiver structure ensures that as someone enters or utilizes services, they enter through the door most closely aligned with their assessed need.

Under this new construct, BDS would be able to incentivize access to lower-tier waivers through services promoting independence, individual choice, and control of services. Such options may continue to shift the role of high-cost congregate services as demand increases for lower-cost, high-value services. In both models, Waiver 1 focuses on less congregated care, greater independence, and a lower reliance on state funding. This focus is accomplished by promoting a service array which targets intermittent supports that are more individualized to the person than the setting.

**Table/Figure 14. Figurative Two- and Three-tiered Waivers Using FY20 DD Population**



Through this exercise, A&M identified two potential options for consideration, a two-tiered waiver and a three-tiered waiver. Both structures will provide BDS greater controls around service access and funding while accounting for acuity scores (assessed need). Under this modeling, A&M identified the following structures for discussion:

*Option 1 – Two Tiers*

- **Waiver 1** – Low to Moderate Support Needs/Non-Residential: Intermittent supports limited to non-residential services capped at \$40,000 annually
- **Waiver 2** – Moderate to High Needs / Residential: Day-to-day supports inclusive of any out-of-home residential services with no cap annually

*Option 2 – Three Tiers*

- **Waiver 1** – Low to Moderate Support Needs / Non-Residential: Intermittent supports limited to non-residential services capped at \$40,000 annually
- **Waiver 2** – Moderate Needs / Residential: Day-to-day supports inclusive of non 24/7 residential group home-based services capped at \$85,000 annually
- **Waiver 3** – High Needs / Residential: Day-to-day supports inclusive of 24/7 group home-based residential services with no cap annually

The two options differ in structure, fiscal impact, and risk while each still performs the same core function of more closely aligning the level of support an individual has with the type and amount of service available.

Table/Figure 15 below provides a risk/benefit analysis for each option to determine which approach may best meet the goals of BDS.

**Table/Figure 15. Waiver Options Risk/Benefit Analysis**

Management Dimensions	Current: One Tier	Option 1: Two Tiers	Option 2: Three Tiers
Manageability	Strong	Strong	Moderate/Strong
Cost Control	Low	Moderate	Strong
Projected Savings	--	\$0.07M-\$0.18M/annually	\$0.28M-\$0.58M/annually
Overall Level of Risk	Low	Low	Moderate

As identified above, both options will increase the degree of control BDS is able to maintain under its waiver program by ensuring more appropriate access to services that match the individual’s need to the services available. Nevertheless, there are considerable differences:

- Under Option 1, the overall risk to BDS when considering stakeholder buy-in, system disruption, and manageability remains low as the option is primarily structural. While a projected net savings under the illustrated model is achieved, it is minimal.
- Under Option 2, the overall risk increases due to greater stakeholder education needs, increased potential for stakeholder pushback, and increased reporting and monitoring requirements. However, under the proposed three-tiered structure, BDS would gain greater cost control and a projected savings of 3.3 times that of Option 1.

Under either option A&M expects that, in aligning current service participants into the new waiver structure, a small proportion of individuals will see either reductions or additions to their current waiver funding. The majority of individuals would see little or no disruption to service funding based on the existing data.

Deciding which option best meets the goals and capacity of BDS without adversely impacting service delivery should not be taken lightly. Waiver programs play a critical role in supporting individuals with I/DD and change can significantly impact people’s lives. BDS should carefully consider which option best achieves its overall goals of high-quality service delivery paired with system continuity and stability. Under either option, significant policy analysis and development will be needed to implement a structural change in the waiver program. BDS should engage actively with stakeholders to seek feedback and measure the level of support for either option to best form the decision moving forward.

### Cost-Benefit Estimate

Cost-Benefit	Low	High	Justification
<b>Savings</b>			
<b>Waiver Option 1: Two-Tiers</b>			
<b>Waiver 1</b>	\$70,000	\$175,000	Waiver savings are calculated by identifying the number of participants who, under the projected waiver construct, having funding above the cap of up to 15 percent of the total cap amount whose budgets would be reduced to the cap ceiling. Of those savings, a low/high range is calculated by applying a +/-10 percent modifier to account for individuals who may not be identified as moving to a higher tier but during implementation are identified for moving up (net decrease in savings) and those who may be flagged for moving up to a higher tier but during implementation are moved down (net increase in savings).
<b>Waiver 2</b>	\$0	\$0	It is not expected that any realized savings will be achieved under waiver three by the structural change alone. Savings would be identified in modified reimbursements rates within the waiver program and are discussed in detail under Recommendation B.2.
<b>Net Benefit W1</b>	<b>\$70,000</b>	<b>\$175,000</b>	
<b>Waiver Option 2: Three-Tiers</b>			
<b>Waiver 1</b>	\$70,000	\$175,000	Please reference detail above regarding cap funding assumptions.
<b>Waiver 2</b>	\$210,000	\$405,000	Please reference detail above regarding cap funding assumptions.
<b>Waiver 3</b>	\$0	\$0	It is not expected that any realized savings will be achieved under waiver three by the structural change alone. Savings would be identified in modified reimbursements rates within the waiver program and are discussed in detail under Recommendation B.2.
<b>Investments</b>	n/a	--	--
<b>Net Benefit W2</b>	<b>\$280,000</b>	<b>\$580,000</b>	--

## Implementation

Area	Requirements
<b>People</b>	BDS will need a dedicated Waiver Manager to plan, coordinate, implement, and monitor this structural change. This position is currently funded but vacant.
<b>Process</b>	An in-depth stakeholder engagement and committee structure is critical to begin this process to develop stakeholder buy-in. Additionally, a waiver re-write and public comment period will be needed prior to submission to the Centers for Medicare and Medicaid for approval.
<b>Technology</b>	Significantly increased IT infrastructure will be needed to collect and manage waiver data under the new structure. This is more fully addressed in Recommendation B.3.
<b>Preparation Work</b>	Additional analysis on service array (including type, frequency and duration) should be conducted when finalizing waiver “lines” for funding and authorization cut-offs.
<b>Statute</b>	n/a

## Timeline

	Year 1	Year 2	Year 3	Year 4
<b>Stakeholder Engagement</b>	█			
<b>Waiver Drafting</b>		█		
<b>Public Comment</b>		█		
<b>Implementation</b>			█	

Target start time: July 2021

## Risks

While the level of risk varies dependent on the option selected, common risks across both options are outlined below.

- Redesigning the waiver structure would introduce a significant change to waiver service delivery. This change may be met with reluctance among stakeholders wanting to maintain the status quo.
- Introducing caps in waivers will cause a small subset of individuals who currently utilize above the capped amount to reduce authorization and spending unless they can document sufficient need to move to the next waiver tier.
- BDS currently lacks the staffing capacity needed to manage a waiver redesign of this scope. If a waiver manager, at minimum, is not hired, it is unlikely that BDS would have the resources needed for project success.



## B.2 | 1915(c) Waiver Reimbursement Rate Redesign

**Recommendation:** Implement a new waiver reimbursement rate methodology to promote alignment between support needs and support budgets while increasing the opportunity to constrain overall waiver funding.

<b>Timeframe</b>	2 years	<b>Complexity</b>	High
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### Problem Statement

The most recent revision to the rate methodology used to reimbursement service providers was completed in 2007. Through discussions with DLTSS staff, A&M identified little to no remaining institutional knowledge of how the 2007 rate methodology was developed. Should BDS move forward with the waiver redesign as outlined in Recommendation B.1, the current rate structure would not support the agility needed to appropriately and adequately (a) fund services at the appropriate level based on assessed need and (b) adapt to changes in funding allotments allocated to BDS.

### Findings

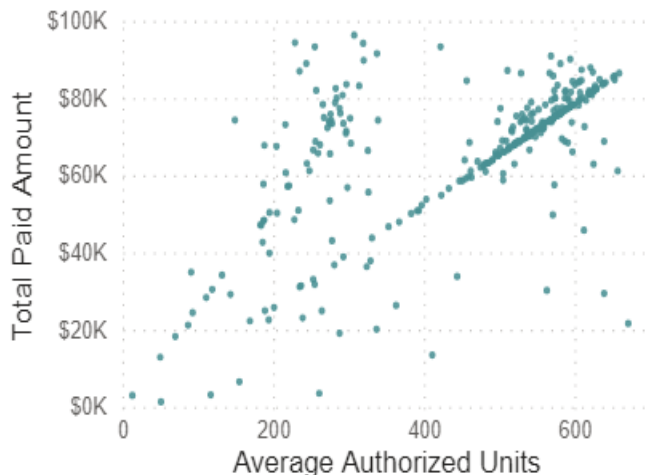
Reimbursement rate development is predicated on three primary functions: (1) service cost, (2) service utilization/utilization assumptions, and (3) policy. To analyze reimbursement rate structures, functions one and two must be reviewed together before layering policy considerations. A&M identified that by-individual-by-service there is significant spread within funding amounts. Table/Figure 16 illustrates the spread in authorization and funding for Day Habilitation Level 5 (day-based supports for individuals with high needs) during the period of July 1, 2019 – June 30, 2020. Table/Figure 16 authorization and funding for Residential Service Level 5 (primarily 24/7 residential care) from July 1, 2019 – June 30, 2020. As illustrated, participants accessing the same service based on initial determination of need are authorized for and utilize services at significantly differing levels. While BDS does utilize a common rate table there is significant spread in both (a) the amount of authorized and therefore billable service units and (b) the process in which individuals are attributed support levels.

**Table/Figure 16. Spread in Authorization and Paid Amount for Sample Services**

#### *Day Habilitation Level 5*



#### *Residential Habilitation Level 5*





From discussions with DLTSS program staff, A&M identified the following two factors as contributing to the spread in expenditures:

1. **Individual Budget Allocations:** BDS develops an Individual Budget Allocation (IBA) specific to the service participant. Within the IBA, person-specific authorizations are requested and approved. While IBAs provide greater flexibility in individualized service planning, they can reduce the standardization of service authorization and payment; increasing challenges for state financing and budgeting, as illustrated above.
2. **Budget Modifications to Meet Provider Revenue Needs:** BDS and Area Agencies develop and manage a provider network responsible for rendering services to the DD Waiver population. In managing this network, reimbursement rates and the reimbursement structure must be sufficient to support provider operations. Under the current reimbursement structure, BDS has identified that, at times, the authorization and/or funding allocation for individuals is increased to back into rate adequacy to better cover actual service cost. This reduces data reliability by inflating service expenditures without ensuring alignment with service delivery. This practice makes it difficult to analyze the sufficiency of current rates against factors such as assessed need, age, or program type accurately.

### **COVID Impact**

The COVID-19 pandemic has placed significant stress on the State's I/DD service system, which has been hampered by service program closures. Many providers in New Hampshire were forced to shut down operations to protect the health and safety of this population with heightened risk. During this time, providers, through flexibilities provided under the Appendix K, were able to create and implement new service delivery systems (virtual supports) under existing rate structures.

The new service delivery models, including virtual supports for Day Habilitation, Personal Care, or Behavioral Supports, are only allowable while the Appendix K is still active. During this time, however, providers nationally have identified that virtual supports both allow individuals greater independence, when appropriate for their needs, while increasing operational efficiencies. Following the expiration of the Appendix K, should interest in maintaining these flexibilities continue, states will have to ensure rate structures are in place and able to support dual delivery models. The development of agile rate structures that can incorporate not only in-person support structures but also virtual supports and other programmatic changes brought about by COVID-19 will be important post-pandemic.

### **Recommendation**

The current rate reimbursement structure limits the ability to reliably analyze, manage, or project service cost. These challenges paired with Recommendation B.1 (1915(c) Waiver Redesign) require the state to invest in the development of a new reimbursement rate methodology.

To promote systemic cost controls and expenditure stability, many states have moved away from individually negotiated IBAs to assessment-informed resource allocation. Under this structure, the state completes two primary functions: (1) utilize a standardized assessment tool

to develop levels of support applied to all services, and (2) apply a standard rate matrix keyed to the assessment levels.

- (1) **Standardized Assessment** – Assessing and determining the level of support an individual needs to maintain health, safety, and community engagement is a cornerstone to service delivery. Critical to this process is a standardized assessment with high validity which measures critical support domains correlated to service cost. The assessment tool plays an important role in “grouping” individuals with like needs to identify commonality in service cost assumptions (e.g., staffing ratios or support hours)

While there are many standardized assessments currently in use for this purpose, two commonly used tools are the Supports Intensity Scale (SIS) and the Inventory for Client and Agency Planning (ICAP). Both the SIS and the ICAP have been found to correlate assessed need to funding. However, BDS currently collects SIS assessments on active service participants, which would reducing the initial start up time and resources needed in assessment data collection. BDS currently utilizes the whole SIS to generate an aggregated score. Other states utilizing the SIS have identified that not all areas of the tool correlate to expenditures. States most commonly use sections:

- 1A – Home Living Activities
- 1B – Community Living Activities
- 1E – Health and Safety Activities
- 3a – Medical Support Needs
- 3b – Behavioral Support Needs

States have also leveraged “supplemental questions” available by SIS focused on enhanced medical and behavioral support needs to further identify high-cost service participants and better refine funding models. Through the SIS, BDS would be able to establish individual support needs based on standardized assessment to develop grouped levels of support ranging from low to high across services. This approach introduces rigor into determining the amount of support someone needs not currently available in BDS operations.

It is important to note the experiences of other states that have used the SIS for rate setting. In comparison to other assessment tools, the SIS tends to have higher costs than other assessment tools and requires significant training to ensure inter-rater reliability. While sections 1A, 1B, and 1E are normed and validated with strong inter-rater reliability, Sections 3a and 3b have not been normed and lack inter-rater reliability testing.

- (2) **Rate Development** –The rates paid for authorized units are the basis for system sustainability and sound policy decision-making. The antiquated rate methodology managed by BDS reduces the ability to pinpoint and adapt funding changes to (a) incentivize or disincentivize services or (b) modify funding based on appropriation amounts in a systematic way versus across the board. To combat these limitations, most states have modernized rate structures based on what is known as a rate build-up. Under the rate build-up, rates are based on key costs associated with service delivery

and built up from the direct labor cost to the final rate. Key factors included in a rate build up include:

- a. **Labor Wage (Direct Support)** – The highest cost of providing care is direct labor cost. Direct Labor cost is the wage paid to a Direct Support Professional (DSP) to provide the direct service to participants.
- b. **Employee Related Expenses (ERE)** – ERE is the percentage of total employee related benefits (i.e. health care, retirement contributions, etc.) paid on behalf of the provider to the DSP. Taken together, DSP wage and ERE comprises of the total cost of labor for direct care.
- c. **Productivity Factors** – A productivity factor is applied to the rate to capture time DSPs are completing service specific, but administrative functions (e.g. documentation, training, etc.). It captures the portion of a billing unit that is non-direct care but critical to service operations The productivity factor is calculated as a percentage of DSP wages.
- d. **Program Support** – Program support is a percentage of direct program-related support in program operations. Program support includes items such as supervisory wages, program specific building costs, and program supplies. Program support is calculated as a percentage of total DSP wages.
- e. **Transportation** – Transportation is inclusive of the total cost of transportation (i.e. mileage) to support an individual with accessing program services and is calculated as a percentage of total DSP wages.
- f. **Administrative Expense (AE)** - Administrative expenses, or organization overhead, constitute the time the executive leadership spends on program operations and the proportion of mailing, phones, or office supplies needed to support operations. AE is calculated as a percentage of DSP wages.

Taken together, the factors outlined above constitute the allowable costs under Medicaid reimbursement for service delivery. Importantly, while some functions of this process are set by policy decisions (e.g., DSP wage assumptions) others are driven by analyzing actual provider costs based on historical operations. To illustrate the rate build up method to rate development, the table below shows how these factors come together to build a rate for a single service. The example below is strictly for illustrative purposes of a rate build up and does not illustrate actual data from any service provider under BDS.

**Table/Figure 17. Illustration of Brick Methodology in Rate Setting**

Wage Component/DD Program (Average)	Assumptions	% Total Paid
Wage (Direct Support)	\$10.00	\$10.00
ERE (Schedule A – Personnel Expenses %)	22.5%	\$2.25
Productivity Factor %	5.0%	\$0.50
Program Support %	12.5%	\$1.25
Transportation/Mileage %	3.5%	\$0.35
Administration %	23.0%	\$2.30
<b>Total Per Unit Billing Rate</b>	--	<b>\$16.65</b>

As illustrated in the table above, the generation of a base rate using the brick method builds the rate up from the DSP wage (\$10.00 per hour) to the total billing rate (\$16.65 per unit) after

including all aspects of the service delivery cost. however, is an initial step in developing an assessment-informed resource allocation methodology. Using the base rate, the assessment levels (as described above) are added to the service to build out distinct increases to account for increased support needs within levels. Further, for services with multiple iterations (for example residential services with multiple service types and setting sizes) a matrix of rates is developed. Table/Figure 18 shows how the per unit rate developed above would be used to build and operationalize a rate matrix for 24/7 residential group home services.

**Table/Figure 18. Operationalization of Brick Methodology in Rate Setting**

LOS	Level Description	1 person	2 person	3 person	4 person	5 person
1	Low support needs	\$300.00	\$150.00	\$100.00	\$75.00	\$60.00
2	Moderate support needs	\$325.00	\$162.50	\$108.33	\$81.25	\$65.00
3	High support needs	\$350.00	\$175.00	\$116.67	\$87.50	\$70.00
4	Extraordinary behavioral support needs	\$375.00	\$187.50	\$125.00	\$93.75	\$75.00
5	Extraordinary medical support needs	\$400.00	\$200.00	\$133.33	\$100.00	\$80.00

\*Billing rates show per unit (daily) per person in the home  
 \* Daily residential rates assume 18 hours of service per day

The use of support level groups, paired with a rate build up and service specific iterations provides a pinpointed approach to service funding. While this approach does increase the number of rates managed by BDS, this degree of accuracy introduces significant benefits including:

- Improved funding stabilization
- Improved budgetary projections and planning
- Increased ability for targeted rate changes
- Increased opportunities for workforce stabilization through targeted wage increases for DSPs

**Cost-Benefit Estimate**

Cost-Benefit	Low	High	Justification
<b>Savings</b>	--	--	While no savings are currently projected, it is anticipated that BDS would realize savings during a rate setting process. However, due to the nature of rate setting and the policy and programmatic decisions to be made during the process, no estimate can be provided at this time. Savings may be identified by standardizing rates based on policy decisions made by BDS.
<b>Investments</b>			
Assessment Tool and Data	\$650,000 per year	\$850,000 per year	Cost estimates are based on the assumption that an assessment will be licensed by a third-party vendor and administered by a division of BDS staff trained by the

Cost-Benefit	Low	High	Justification
Collection (Annual)			assessment vendor. BDS may elect to utilize the current CSNI contract to continue SIS assessments which may reduce this cost estimate. Cost also assumes license of a data base structure to support input of assessment results.
Rate Setting Project	\$400,000	\$650,000	Estimated cost of proposals for third-party vendor to complete a rate development project
<b>Net Benefit</b>	<i>variable</i>		--

## Implementation

Area	Requirements
<b>People</b>	To successfully manage the reimbursement rate redesign, in addition to current staff, BDS will need a dedicated Waiver Manager as well as a standalone assessment unit (5 FTE) unless assessment processes are contracted through Community Support Network, Inc (CSNI) which currently completes the SIS for BDS.
<b>Process</b>	An in-depth stakeholder engagement and committee structure is critical to begin this process to develop stakeholder buy-in. Additionally, BDS will need to develop cost reporting template for service providers to report service delivery cost for model development. An RFP for a rate setting entity and an assessment licensing agreement will be needed.
<b>Technology</b>	Significantly increased IT infrastructure will be needed to manage the increased complexity of the proposed rate process. This is more fully addressed in Recommendation B.3.
<b>Preparation Work</b>	Stakeholder engagement should begin immediately upon project commencement to introduce the idea of new rates. Initial work to select an assessment should begin prior to rate setting activities to reduce the rate development process.
<b>Statute</b>	n/a

## Timeline

Target start time: During Year 2 of Waiver Redesign Process

	Year 1	Year 2	Year 3	Year 4
Stakeholder Engagement				
Data Collection				
Rate Development				
Implementation				

\* To promote efficiency and CMS compliance under the Direct Billing Corrective Action Plan, rate development should be completed by July 2023.

## Risks

Modifying rate methodology within the BDS service structure will be challenging and does introduce risk. While the majority of risk is associated to perceived outcomes by stakeholders, internal risk due to capacity issues and data quality are present. Risks associated with this recommendation are outlined below.

- Modifications to rate methodology may be concerning to stakeholders. There may be significant resistance to changing the rates all the way through rate implementation.
- Based on rate development and programmatic restrictions, the State may see a net increase in service costs. In such a case, the State may not have adequate funding to fully fund the new rate schedule delaying implementation. With a net increase, some providers will experience increased revenues, while others may have decreased revenue.
- Based on rate development and programmatic restrictions, the State may see a net decrease in service costs. Despite this overall decrease, some providers may experience increased revenues while others will have decreased revenue.
- The Corrective Action Plan related to direct billing may impact data availability.
- BDS lacks the staffing capacity and resources to commit to a rate setting project. If a waiver manager, at minimum, is not hired at BDS, it is unlikely that the project will be successful.
- Assessment data currently collected by BDS may be found to be outdated or unreliable for rate setting needs which may increase the cost and amount of time for project completion.
- Rate development requires accurate cost reporting by service providers to identify the cost to providing and operating services to individuals. Inadequate access or challenges accessing cost data from provider agencies may significantly slow rate development or increase the needs for BDS to make cost assumptions reducing accuracy and buy-in to a new rate structure.

### B.3 | Information Technology Systems Development

**Recommendation:** BDS should invest in and develop a comprehensive information technology system with capabilities of managing ISP development, case management record keeping, service authorization and service billing to improve system efficiencies, improve reliability in data, and increase access to data for decision-making.

<b>Timeframe</b>	4 years	<b>Complexity</b>	High
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#### Problem Statement

BDS operates complex Medicaid programs utilizing siloed data systems which significantly hinder the capacity to (a) ensure data reliability, (b) provide comprehensive, whole-person assessment and authorization data, (c) analyze service and system effectiveness and (d) utilize reliable data in decision-making.

#### Findings

The IT infrastructure managed by BDS hinders the ability to (a) have adequate access to reliable data for decision-making, (b) access standardized data to monitor and manage program operations, and (c) accurately collate information for critical authorization, quality and federally mandated analysis and reporting. BDS' IT structure is operated through four siloed data systems as illustrated in Table/Figure 19. While each system currently performs rudimentary requirements for basic system management, none of the current systems interface with the others. Under this structure, BDS staff are forced to export data into MS Excel workbooks to manually analyze and cross-reference data.

**Table/Figure 19. Disparate Systems used by BDS**

Legacy System	Platform	Used For	Interface	Maintained by	Started
NH Leads	<b>Web-based: older version database (PAWS) has PAs back to 1997</b>	Billing includes pending and denied, PAs, WL Registry, ESS, Dashboard reports, other misc.. reports	No	CSNI	1998
BTS (Budget Tracking System)	<b>Access Database</b>	Individual budgets by service by AA as well as other Medicaid and non-Medicaid funding that each region has access to bill (such as Respite, Part C, Room and Board, etc.). BTS tracks changes to individual budgets and other funding by funding type (including WL) for all waivers. These changes are reviewed and reconciled before moving from one contract to the next.	No	One individual who created the database, BDS must upload/download versions through MH Leads to keep information current	2007 current BTS (there were earlier versions)
HRST (Health Risk Screening Tool)	<b>Web-based</b>	HRST Assessment Tool; Service Agreement (SA); LOC tool	No	Nationwide; modules added for NH	2015
SIS Database (Supports Intensity Scale)	<b>Database</b>	SIS assessments	No	CSNI	2015



The current IT structure limits the ability to effectively and accurately manage the service system through increased potential for human error, long wait times for access to relevant data, and an inability to holistically analyze system effectiveness due to the lack of data interfacing capabilities. This issue is not new. In May 2019, PCG completed an analysis of the BDS IT modernization needs and found that the lack of access to reliable data significantly hinders the ability to monitor and manage the current system. As identified in PCG’s report of initial findings<sup>15</sup>:

“The lack of real-time data makes it difficult for BDS, Area Agencies and other stakeholders to have confidence that they are viewing and reporting on the same real-time (or near real-time) data from a trusted source (system of record). The lack of a real-time system and on-demand batch processing impedes BDS’ ability to view transactions (e.g., a client record change) as they occur. The lack of integration between the various systems used by BDS makes it difficult for users, providers, and oversight staff to obtain visibility throughout the BDS processes, particularly for data that exists on systems external to their organization. There is a defined need for the BDS staff to have a 360-degree view of each case; from a financial, demographic, and clinical perspective.”

While the lack of access to data is known throughout BDS and a distinct point of frustration among staff, the lack of access to and reliability of data served as a significant barrier into A&M’s ability to complete its analysis of the BDS systems. Completing the A&M data requests (many of which would be seen as basic in most modernized data systems) was extremely labor and time intensive. BDS has explored “piggybacking” onto components of IT modernization completed by DCYF primarily related to case management functions and potential integrations with NH Leads, but that work has not been fully planned or started.

### **COVID Impact**

The COVID-19 pandemic has shifted the way service providers and individuals provide and receive services. The movement away from congregate-based settings and toward a more decentralized service approach (e.g., more individuals living independently, day services being provided remotely, etc.) has created a greater need to have access to reliable data to track Service utilization. Further, through the State’s approved Appendix K, the Centers for Medicare and Medicaid Services (CMS) has provided significant flexibilities in how states render and fund services. However, these increased flexibilities and the additional federal funds to support them come with enhanced audit requirements pushing systems to reliably track and report to CMS utilization and spending data to avoid future penalties. A failure to have appropriate insights and access to this data may impact the State’s future Medicaid funding.

### **Recommendations**

Increasing the access to and reliability of data flowing through BDS would have significant impact on agency operations and management. By improving access to data, BDS would be better positioned to monitor service authorizations against provider billing in more real time and comprehensively evaluate systems operations holistically. Such actions are critical for ensuring

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<sup>15</sup> PCG. May 29, 2019. Preliminary Findings: NH BDS IT Modernization Project.

the right amount of service is provided to a participant, fraud is monitored and mitigated if detected, and the BDS' overall budget and expenditures are controlled and easy to project. Reliable IT structures also promote better management of: case management activities (i.e. service planning, case notes and outcomes), structures for collecting, tracking and mitigating allegations of abuse or neglect, and general trends in utilization to guide programmatic decision-making.

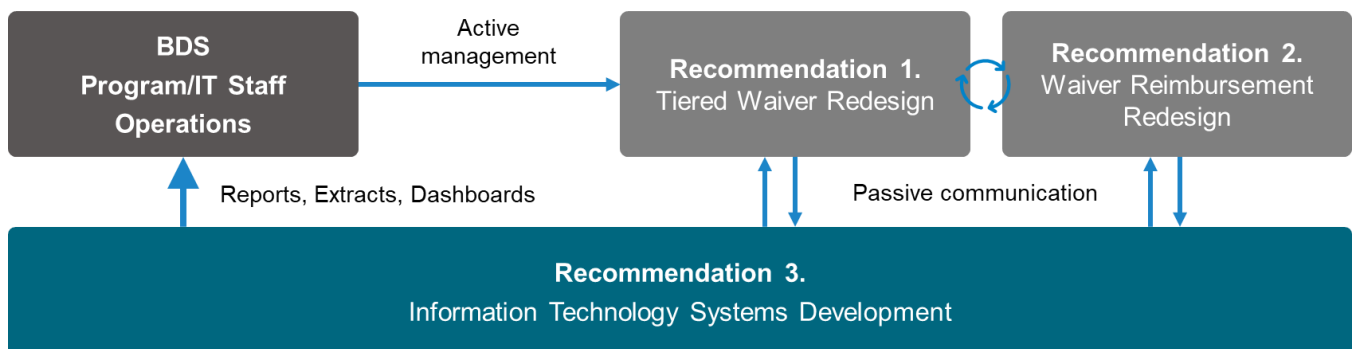
For BDS, an initial system development project should account for key functions of service operations, including:

- a. **Case Management:** a centralized structure for developing ISPs
- b. **Budget Approval and Authorizations:** a link between the ISP and the BDS authorized service amount
- c. **Medicaid Billing:** including direct bill capacity and interfacing capabilities with the MMIS
- d. **Waitlist Management:** a centralized, accessible registry of those waiting for services, including what services they are seeking access to
- e. **Participant Demographics:** inclusive of eligibility and assessment data

Taken together and centralized under one common database construct, access to such data and mechanisms for managing the service system would significantly increase the efficiency of BDS. Efficiencies would include: capacity for future planning and budgeting, system monitoring, and strategic policy development that is responsive to current and projected service needs.

Recommendations B.1 and B.2 above (Waiver and Rate Redesign) introduce critical system infrastructure components that are predicated on an IT infrastructure capable of handling and managing the additional data complexities both recommendations introduce. A&M anticipates that to maximize success for BDS, all three recommendations would be implemented in lockstep. Such an approach would have the most significant impact on BDS program savings while reducing the need to re-do any work to align with a staged implementation approach of the recommendations. Stated differently, the group of three recommendations are interdependent on one another to maximize success. While each could be addressed independently, doing so would likely increase duplicative work, increase cost estimates, and introduce an enhanced potential for the three components to not work well together diluting the overall impact of the proposed modernizations. Table/Figure 20 shows how these recommendations come together to improve system efficiency.

**Table/Figure 20. Interdependencies between A&M Recommendations 1-3.**



## Cost-Benefit Estimate

Cost-Benefit	Low	High	Justification
<b>Savings</b>	--	--	--
System Efficiencies		<i>variable</i>	Increases access to reliable data will significantly improve the operating structure of BDS staff. Currently staff spend a significant amount of time compiling data from multiple, unlinked sources as well as duplicative entry due to unreliable network capacity for managing data needs.
<b>Investments</b>	--	--	--
Initial Development	\$150,000*	\$300,000*	Depending on scope of IT development needs, it is expected that BDS will initially spend between \$150,000 and \$300,000.
Annual maintenance fee	\$75,000* per year	\$150,000* per year	System updates, changes and maintenance are expected to range between \$75,000 and \$150,000. Costs may increase if additional functionality is added.
<b>Net Benefit</b>		<i>variable</i>	--

\*represents state share of development costs at a 90-10 split for initial development and 70-30 split for annual maintenance

## Implementation

Area	Requirements
<b>People</b>	Given the complexity of building a ground up IT structure, BDS will require an IT Manager (1 FTE), a Waiver Manager (1 FTE), and an IT Project Manager (1 FTE – time limited).
<b>Process</b>	BDS will need to develop a RFP to select an IT vendor to assist in the planning and implementation of a new structure.
<b>Technology</b>	BDS should invest in a case management module with the capability to interface with MMIS. BDS should ensure technology outcomes include integration with provider system to avoid duplicity and data misalignment.
<b>Preparation Work</b>	To develop an IT RFP and develop initial build criteria, BDS should review and update the PCG recommendations and scoring based on current needs. BDS should also discuss experiences of other states in the selection, management and costs of similar recently implemented IT systems.
<b>Statute</b>	n/a

## Timeline

Target start time: Year 2 of waiver redesign

	Year 1	Year 2	Year 3	Year 4
RFP / Proposal Selection	■			
IT Development	■	■	■	
Systems Testing			■	
Implementation			■	■

## Risks

While the risk to BDS related to IT systems is highest under the current operating structures, implementing a new system does come with associated risks. Risks are primarily centered around overall cost and current staff capacity to manage this initiative. Specific risks associated with this recommendation include:

- IT development projects can increase exponentially in cost as additional functionality and needs are identified during the development process.
- Due to the length of time between development, implementation and perceived access to data, BDS would remain reliant on antiquate data systems unless a vendor could expedite development.
- BDS currently lacks the staffing capacity to manage a project of this magnitude. If additional staff are not hired, it is unlikely that BDS would be able to provide the staff resources needed to achieve success.

## B.4 | Reduction in FY22 Wait List Funding

<b>Recommendation:</b> Reduce the available funding for waitlist participants to more closely align allocated funding with trends in spending. Reduce appropriations request by \$8.2 million.			
<b>Timeframe</b>	<1 Month (savings to inform budget request for FY22)	<b>Complexity</b>	Low

### Problem Statement

DLTSS staff maintain an Excel-based forecast model which projects funding availabilities and expenditures for the Wait List each year. BDS' Wait List (WL) fluctuates on a yearly basis largely driven by external decisions or events (the closure of facilities, policy-driven increases to rates, etc.). For the past several years, BDS has consistently projected higher anticipated needs than actual expenditures, thus resulting in consecutive years of WL appropriations in excess of costs.

### Findings

There is a significant \$47,564,869 fund availability for the FY21 Wait List despite only \$14,664,476 in projected need. As a result, the FY21 net carryforward amount is projected to be \$32,900,393 to be used in FY22 assuming no change to funding requests and anticipated WL expenditures at historical levels.<sup>16</sup>

For FY21, however, BDS has indicated there are several factors which would elevate that year's expenditures above historical levels:

- A 3.1 percent service rate increase
- An expected increase to DSPs within the Area Agencies
- An expected increase to billed units post-COVID
- Anticipated funds needed to realize the change in the closure of a Designated Receiving Facility<sup>17</sup>

For these reasons, BDS anticipates the FY21 projected carryforward of \$32,900,393 will instead be drawn down to \$8,259,949 going into FY22.<sup>18</sup>

### COVID Impact

The COVID-19 pandemic has affected BDS' ability to more precisely project Wait List funding needs. In a given year, BDS categorizes WL entrants into three categories:

- **Group A:** Graduating or leaving the school system
- **Group B:** New resident to the state, or new entrant into the program, or
- **Group C:** Significant change in the individual's condition that requires additional services (medical change, change in caregiver capacity, etc.)

<sup>16</sup> WL expenditures have historically been 89% of the maintenance budget.

<sup>17</sup> Per the [2016 LBA audit of BDS](#), Area Agencies have historically been permitted to spend unused waitlist funds on one-time needs the following year.

<sup>18</sup> Based on 7-1-20 projection of FY22 anticipated budget request

The COVID-19 pandemic adds another layer of unpredictability to Groups B and C, as it is unclear how families are impacted by the coronavirus in relation to decisions around entering a DD waiver.

### Recommendation

After analyzing the historic Wait List (WL) data, A&M recommends reducing the FY22 appropriations request by 100 percent of the projected FY22 net carryforward. This would total \$8,259,949, with half being anticipated general fund savings after expenditures incurred by WL funds are reimbursed by the FMAP. In doing so, State would save General Funds at minimal impact to the DD waitlist, which has historically been generously funded. A reduction in appropriations would have limited impact on the WL, as the primary operational issue for Area Agencies has been the dearth of DSPs available to provide services to individuals on the waitlist, not the availability of funds itself.

### Cost-Benefit Estimate

Cost-Benefit	Low	High	Justification
Savings	\$4.1M*	\$4.1M*	--
Investments	\$0	\$0	--
Net Benefit	\$4.1M	\$4.1M	--

*\* Anticipated general fund savings after FMAP reimbursement*

### Implementation

Area	Requirements
People	N/A
Process	Due to the change in nature and structure of the funding request, continued collaboration and coordination between BDS program and fiscal staff and HHS fiscal staff will be required.
Technology	N/A
Preparation Work	N/A – analysis has already been completed.
Statute	N/A

### Timeline

Immediate, but savings are long-term and will be realized for FY22.

### Risks

Structurally changing the way in which BDS allocates funds to individuals on the waitlist introduces new risks to the current operations. Primarily, risks related to constant change in individual need and internal capacity limitations drive these risks. The risks associated with this recommendation are outlined below.

- Reducing appropriations during a year in which multiple events or factors may increase the cost or count of individuals entering BDS from the Waitlist may mean inadequate funding is available to meet all identified need.

## **B.5 | Develop In-State Intensive Treatment Service Options**

**Recommendation:** Develop in-state intensive care residential options to reduce or eliminate the need for out-of-state placement of individuals with complex care needs currently at an average cost per person of \$385,000.

<b>Timeframe</b>	4 years	<b>Complexity</b>	High
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### **Problem Statement**

BDS lacks the in-state capacity to support individuals with complex dual diagnosis (I/DD and mental health) conditions resulting in a high number of high-cost, out-of-state placements.

### **Findings**

BDS currently serves (primarily through the DD waiver) 38 individuals who require high-cost intensive care needs. However, BDS lacks access to adequate in-state residential placement options within the current provider network and contracts with out-of-state providers to support these individuals. These individuals have a primary diagnosis of I/DD but also tend to have complex medical or mental health diagnoses, thereby increasing the cost of care. Currently, twenty-nine individuals reside in Florida, seven individuals reside in Massachusetts, one person resides in Maine, and one person resides in Pennsylvania.

On average, individuals currently supported in out-of-state placements maintain an average cost per person of \$384,349. This ranges, however, from \$192,577 to \$488,566 for a total spend of \$14.6 million, of which \$13.8 million is funded through the DD Waiver<sup>19</sup>. Under this funding structure, 0.7 percent of the DD Waiver population accounts for 5 percent of the total DD Waiver budget. Currently, supports provided in out-of-state placements are put out through Request for Proposal (RFP) and contracted by BDS. Under this contracting structure, BDS has less control over the cost of care or additional costs or premiums placed on the cost of care by external bidders.

The current out-of-state service delivery system is an issue of both operational efficiency and service quality. As individuals are moved to out-of-home placements, they are displaced from their family, known community, and any established network of advocates best suited to support them in maintaining overall quality of life. In some cases, placement in out-of-state facilities has lasted upwards of 17 years with no current plans for transition back to New Hampshire. In 2020 alone, eight new individuals began treatment under the out-of-state placement system. Of the current individuals served in these facilities, the average length of placement is two years and three months.

### **COVID Impact**

During the COVID-19 pandemic, this group has been distanced from family and natural support networks. During public town hall meetings family members expressed concern and frustration at the inability to connect with and verify the health and well-being of family members supported in out-of-home facilities. Due to the heightened risk of exposure to the I/DD population during the pandemic, travel and visitation opportunities have been limited.

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<sup>19</sup> Remaining services are funded through the ABD Waiver for individuals with an acquired brain injury, not I/DD.



## Recommendation

BDS continues to support individuals with complex and high-cost support needs primarily because it lacks the provider network capacity to render these services in-state. The need for services to be contracted by out-of-state vendors increases the cost and decreases individuals' quality of life. In order to shift away from a high-cost model that takes residents out-of-state, A&M recommends BDS develops in-state capacity to support individuals with complex need within the current provider network.

Developing such capacity, however, requires an upfront investment by both BDS and the private provider organizations. There are both initial capital investment costs and long-term, annualized costs that must be considered. Initial startup costs include the capital investment needed for home purchase, Americans with Disabilities Act (ADA) compliance, security modifications, furnishing, fire suppression systems, and other facility improvements. Annualized costs account for the annual cost of care to support individuals, including direct support, clinical staff, transportation, and other costs. Given the complexity of support needs and the limitations in finding adequate and affordable housing of homes with more than four bedrooms, A&M estimates a total of ten four-bedroom homes will be needed to accommodate the full population currently supported out-of-state. Table/Figure 21 below provides a model of anticipated start-up costs<sup>20</sup>, annualized cost range (accounting for greater savings in per person costs when out-of-state premiums are eliminated and BDS has greater control over rate development and negotiation) and the time to realize Return on Investment (ROI). In the model, four scenarios are presented, including:

1. BDS, through grant funds made direct to service providers, shares 80 percent of the total anticipated initial capital investment cost per home at an average per person cost of \$250,000.
2. BDS, through grant funds made direct to service providers, shares 60 percent of the total anticipated initial capital investment cost per home at an average per person cost of \$250,000.
3. BDS, through grant funds made direct to service providers, shares 80 percent of the total anticipated initial capital investment cost per home at an average per person cost of \$350,000.
4. BDS, through grant funds made direct to service providers, shares 60 percent of the total anticipated initial capital investment cost per home at an average per person cost of \$350,000.

**Table/Figure 21. Anticipated Start-Up Costs**

<b>Initial Capital Investment Costs</b>	<b>Total Cost</b>	<b>State Share @ 80%</b>	<b>State Share @ 60%</b>
Property/Structural Updates	\$500,000	\$400,000	\$300,000
Architect	\$15,000	\$12,000	\$9,000

<sup>20</sup> Service development is centered around residential care services. Currently, all 38 participants served out of state receive residential care, only two receive any additional stand-alone services (i.e. day habilitation). This is primarily driven by the complexity of care needed for this specific population.

Construction Management	\$35,000	\$28,000	\$21,000
Fire Suppression System	\$40,000	\$32,000	\$24,000
Security System	\$35,000	\$28,000	\$21,000
Septic System	\$30,000	\$24,000	\$18,000
Electrical Updates	\$25,000	\$20,000	\$15,000
Generator	\$30,000	\$24,000	\$18,000
Windows (Tempered Glass)	\$40,000	\$32,000	\$24,000
ADA Accessible	\$20,000	\$16,000	\$12,000
Safety Measures	\$15,000	\$12,000	\$9,000
Appliance/Furniture	\$15,000	\$12,000	\$9,000
Maintenance Staff (10 hrs/week, 30 weeks)	\$9,000	\$7,200	\$5,400
Landscape	\$5,000	\$4,000	\$3,000
<b>Total</b>	<b>\$814,000</b>	<b>\$651,200</b>	<b>\$488,400</b>
<b>Total State Investment in Start Up Cost</b>		\$6,512,000	\$4,884,000
Annualized Per Person Service Costs		\$250,000	\$350,000
<b>Total Annualized Service Cost</b>		<b>\$9,500,000</b>	<b>\$13,300,000</b>
<b>Total Investment (Capital Share + Annualized Cost of Care)</b>			
Year 1 Cost (Total) @ 80% Share		\$16,012,000	\$19,812,000
Year 2 Cost (Total) @ 80% Share		\$9,500,000	\$13,300,000
Year 1 Cost (Total) @ 60% Share		\$14,384,000	\$18,184,000
Year 2 Cost (Total) @ 60% Share		\$9,500,000	\$13,300,000
		Per Person Cost \$250,000/year	Per Person Cost \$350,000/year
Annualized Savings After Capital Investment		<b>\$5,105,270</b>	<b>\$1,305,270</b>
<b>Number of Years for ROI<sup>21</sup></b>			
@ 80% Share		1.3	5.0
@ 60% Share		1.0	3.7

The model above is inclusive of federal funds and makes several assumptions, including:

1. Cost per person can be reduced by eliminating non-controllable costs such as family air travel or additional administrative fees for out-of-home placements.
2. Providers will find a cost share of 60-80 percent adequate to take on the risks associated with supporting this complex population.

<sup>21</sup> Low to high number of years for ROI for each State Share assumption based on the \$250k and \$350k per person per year scenarios

Under these assumptions, and as shown in Table/Figure 21, once the initial capital investment is made, it is anticipated that BDS would begin to realize ROI ranging from one to five years depending on the selected model. After reaching ROI, the state would see a state share net reduction in spending of \$0.7M-\$2.6M.

To reduce the state cost share portion of this development or increase the options for development, there may be opportunities to grant access to state owned land for residential development. The state should also look at opportunities to leverage Housing and Urban Development (HUD) funding to reduce home purchase costs.

### Cost-Benefit Estimate

Cost-Benefit	Low	High	Justification
<b>Savings</b>	\$0.7M	\$2.6M	Difference in funds already allocated per person and new per person cost structure
<b>Investments</b>	\$4.9M	\$6.5M	Initial Capital Investment Grant
<b>Net Benefit</b>	\$0.7M	\$2.6M	Realized annual savings after turning ROI

### Implementation

Area	Requirements
<b>People</b>	The complexity inherent with moving individuals with complex needs will require BDS to hire a Transition Coordinator (1FTE) responsible for planning, coordinating and tracking individuals transitioning back to NH.
<b>Process</b>	To ensure adequate capacity within in-state providers, BDS will need to focus efforts on provider development. Primarily, an RFP process for providers to access grant funds for new property development will be needed, as well as grant tracking capacity. Additionally, unique rate and reimbursement structures may be need to support the initial cost of service post-transition as well as annualized, ongoing care.
<b>Technology</b>	N/A
<b>Preparation Work</b>	Initial residential site development should begin one year prior to the first person transitions back in-state. Concurrent development may occur depending on the projected pace.
<b>Statute</b>	N/A

### Timeline

Planning for this initiative should begin immediately and will take time due to the complexity, but A&M estimates a full transition in three years after provider selection and contracting.

### Risks

Individuals currently supported in out-of-state settings have complex needs. The origination of the out-of-state service model was derived from the lack of capacity or willingness of local providers to serve these individuals locally. Given these and other environmental factors:

- If no current in-state providers identify as willing and able to partner in this effort, BDS may be unable to build adequate capacity.
- Some individuals currently residing in out-of-home placements may choose not to return to New Hampshire for various reasons, and the state may have to continue out-of-state placements for a portion of this group.
- A lack of adequate access to housing may delay infrastructure development and transition.

After initial transition, cost per person may rise to ensure full wrap-around support to support the major life change. While average costs should decrease over time, there may be recurring costs.

## C. DCYF

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### Executive Summary | Overview

#### **Scope**

The A&M team was tasked with performing a strategic assessment of areas in the Division for Children Youth and Families (DCYF). A&M focused on reviewing current business processes and workflows, understanding critical IT systems, and reviewing the impact of the COVID-19 pandemic on providing certain critical DCYF services. A&M was also tasked with analyzing the financial information, contracts, and other operational indicators of DCYF.

#### **Approach**

A&M began by developing an understanding of major services provided by DCYF, focusing on critical pain points outlined by stakeholders. In partnership with DCYF and the DHHS Fiscal Specialist Unit, A&M interviewed stakeholders, reviewed documents and financial information, and analyzed current processes. Working with leadership in DCYF and the Fiscal Specialist Unit, A&M's team of subject matter experts were able to identify a key recommendation for improvement, outlined below.

#### **Results**

As a result of the strategic assessment completed within DCYF, A&M recommends that DCYF and the DHHS Fiscal Specialist Unit address the current process-related problems with the aligned opportunities to ensure maximum IV-E funding. This recommendation addresses both system and process gaps that A&M identified alongside DHHS stakeholders. A&M worked with DCYF and the Fiscal Specialist Unit to identify gaps and develop potential opportunities to improve upon each gap identified. It should be noted, that lack of data and access to data is a significant issue that was identified across all A&M areas of review.

A&M has identified other opportunities for improvement but is continuing to vet these opportunities at a deeper level of detail. As such, these opportunities will not be presented in this October 2020 report.

### Executive Summary | Recommendations (Short-term)

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
C.1	Maximizing Federal IV-E Funding – Foster Care	In order to maximize federal IV-E revenue, DCYF will need to evaluate policies/procedures to identify current process-related problems and develop new procedures to ensure that all eligible youth are identified, and appropriate documentation is established to maximize IV-E funding.	\$.05M	\$.05M	\$1.1M	\$4.5M

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## Other Areas Reviewed

Opportunity	Determination
<b>Kinship Licensing</b>	The A&M team reviewed an opportunity to maximize IV-E Revenue through licensing kinship families. The cost to license and maintain licensure for kinship families was greater than the revenue maximization opportunity.
<b>Foster Care Matching/Licensing Utilization</b>	The A&M team reviewed the opportunity to use CARES Act funding to support implementing a Foster Care Matching software. The current vendor would be unable to meet the CARES Act deadline (12/30/2020).

### C.1 | Maximizing Federal IV-E Funding - Foster Care

<b>Recommendation:</b> In order to maximize federal IV-E revenue, DCYF will need to evaluate policies/procedures to identify current process-related problems and develop new procedures to ensure that all eligible youth are identified, and appropriate documentation is established to maximize IV-E funding.			
<b>Timeframe</b>	6 to 12 months	<b>Complexity</b>	Medium

#### Problem Statement

New Hampshire is leaving federal IV-E funds on the table, largely due to process and technology gaps. Federal IV-E funding drawdown is dependent on collecting accurate financial information from families, documenting appropriate legal/court findings, and ensuring DCYF foster care placements/homes are licensed.

#### Findings

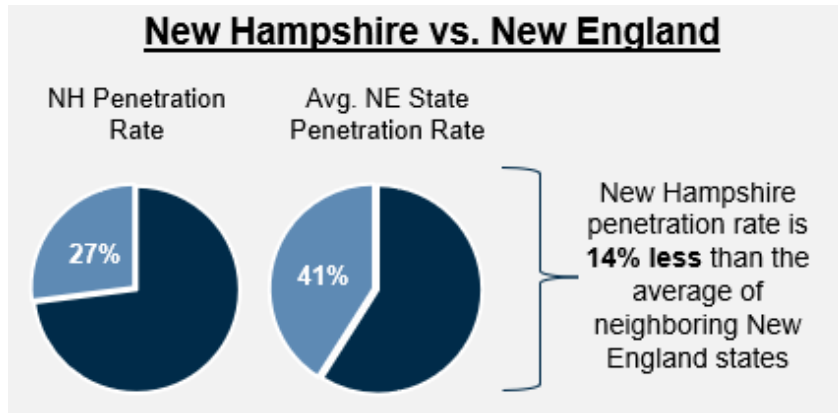
Under Title IV-E of the Social Security Act, states are entitled to claim partial federal reimbursement for the cost of providing foster care, adoption assistance, and kinship guardianship assistance to children who meet federal eligibility criteria.

Children eligible for the IV-E foster care program are:

- In court-ordered out-of-home placements;
- considered financially “needy” in the homes from which they were removed based on 1996 AFDC guidelines; and
- are in a licensed or approved foster care placement.

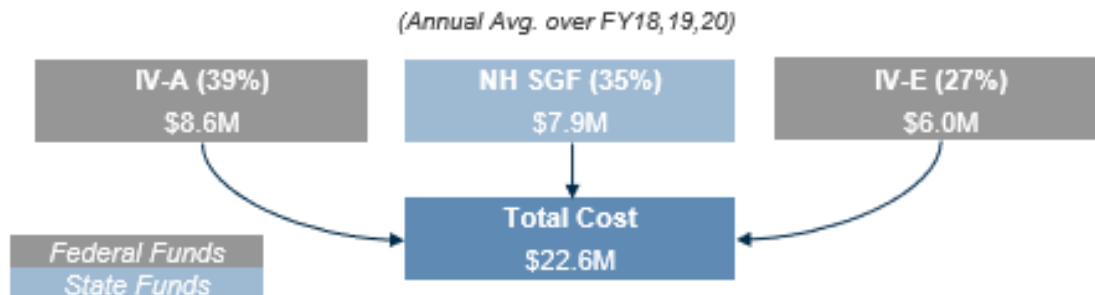
Over the past three fiscal years, only 27 percent of eligible IV-E foster care placements were collecting IV-E funds, compared to the average 41 percent of neighboring New England states as shown below in Table/Figure 22.

**Table/Figure 22. NH IV-E Penetration Rate vs. New England Average IV-E Penetration Rate<sup>22</sup>**



Annually, New Hampshire spends on average \$22.6 million on Foster Care Maintenance Payments. 35 percent (\$7.9 million) comes from State General Funds, while 27 percent (\$6.0 million) comes from Title IV-E.

**Table/Figure 23. Foster Care Maintenance Payment Funding**



The A&M team reviewed the current process followed by the Fiscal Specialist Unit (FSU) to determine IV-E eligibility and identified that out of the top five reasons for ineligibility four were related to a process gap or inefficiency and one was related to a systems gap between BRIDGES and New Heights. Table/Figure 24 highlights the current process the FSU follows to manage a youth placement and identify federal funding sources.

Table/Figure 25 corresponds to Table/Figure 24 by describing the process gap that leads to IV-E ineligibility.

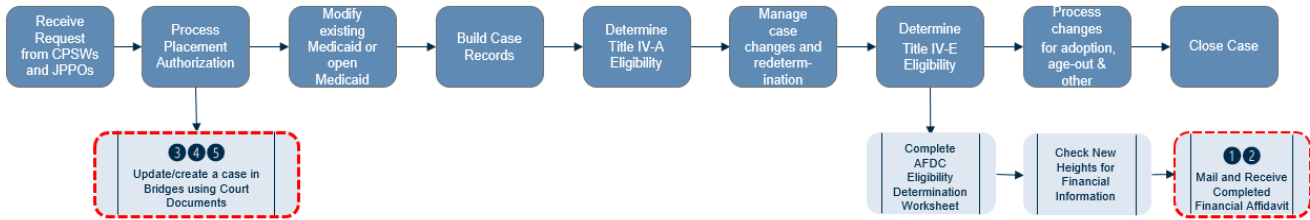
It should be noted that the reasons listed below for IV-E ineligibility are anecdotal and drawn comments made by DCYF and FSU staff. The current systems (Bridges/New Heights) do not track reasons for IV-E ineligibility. To determine the magnitude of each reason for ineligibility a sample size of 300 cases would need to be manually reviewed. The current process of determining IV-E eligibility primarily falls onto the FSU staff, who have no personal relationship

<sup>22</sup> Rosinsky, Kristina, and Sarah Catherine Williams. "Child Welfare Financing.", Child Trends, 2016, [www.childtrends.org/research/research-by-topic/child-welfare-financing-sfy-2016](http://www.childtrends.org/research/research-by-topic/child-welfare-financing-sfy-2016).



with the families. There is little collaboration between CSPWs/JPOs and FSU staff after FSU staff receive a placement request from the CPSWs/JPOs.

**Table/Figure 24. FSU Process to Identify Funding Sources for Children in Care**



**Table/Figure 25. Process and System Related Gaps That Lead to IV-E Ineligibility**

#	Reason for IV-E Ineligibility	Process Related?	Systems Related?
1	Failure to Provide Financial Data	X	
2	Unable to Capture Wage Data	X	
3	Bridges/New Heights Did Not Interface		X
4	Reasonable Effort	X	
5	Contrary to the Welfare	X	

**Failure to Provide Financial Data**

To be eligible for IV-E, financial information must be collected from families whose children have been removed from care. If this information is not available in New Heights, the FSU is responsible for following up with the family to obtain the financial data to determine IV-E Eligibility. The current process involves sending out a financial form to the families and asking them to complete and return the form to DCYF. While the rate of return of these documents is not formally tracked, anecdotal evidence from FSU is that the rate of return is “not high at all.” To increase IV-E eligibility, DCYF should focus on implementing agency process changes to enhance the capacity to capture and document financial data. Currently, the following opportunities exist to increase the availability of financial data provided to FSU staff:

- Many of these families are required to fill out a Financial Affidavit for Court Appointed counsel similar to the Financial Affidavit FSU utilizes. DCYF should partner with courts to create a consolidated Financial Affidavit inclusive of information that can be used by both the courts and DCYF. This would require families to complete one financial form, and the form would be completed by the family while they are present for the court hearing. This coordinated effort would increase the likelihood that the financial data could be obtained timely for IV-E eligibility determination and reduce the need for FSU workers to follow up with families for financial information.

- The collection of financial information currently falls to the responsibility of the FSU worker who usually has no established relationship with the family. DCYF should have CPSW/JPPO staff share responsibility with FSU workers in obtaining financial data from the families during their contacts/visits and case planning meetings.

#### *Unable to Capture Wage Data*

If a parent lives in New Hampshire but works in another state (e.g., Vermont, Massachusetts, Maine) FSU workers have few opportunities to capture parent wage data if it is not provided by the parent. Currently, FSU workers utilize The Work Number to try and identify wage data, but this data is often old or does not provide all of the necessary pieces of information required. To better capture out-of-state wage data, a Memorandum of Agreement (MOA) or other data sharing mechanism should be implemented to allow for New Hampshire to receive and supply other states with critical information such as wage data, to help increase I-VE revenue.

#### *Bridges/New Heights Did Not Interface*

When identifying IV-E eligibility, the two systems that are utilized are Bridges and New Heights. Bridges is used by DCYF for case management and documentation. New Heights is the integrated eligibility system used by DCYF for determining and tracking eligibility. DCYF staff highlighted inconsistencies in the reliability of the two systems accurately reporting data to one another. During the A&M team review, the FSU team had recently discovered two placements with placement start dates dating back to 2017. Both placements were IV-E eligible, but because Bridges and New Heights did not interface correctly, DCYF was unable to claim IV-E funding and instead fully funded these placements with State General Funds. The error was identified only after a manual review of select placements. Ensuring that eligibility data is shared correctly between the two systems is imperative to maximizing IV-E revenue.

#### *Contrary to the Welfare/Reasonable Effort*

I-VE eligibility requires documentation both that a child has been placed outside of the home and that a reasonable effort has been made to prevent the child's removal from the home. This documentation is completed as part of the paperwork provided to the courts by DCYF. The judge is responsible for confirming this to be accurate and checks the appropriate boxes on the court order. In some cases, a child is IV-E eligible but the courts and/or CPSWs/JPPOs worker does not ensure that documentation is complete and appropriate boxes are not checked on the court order. In these following instances, DCYF is unable to claim IV-E eligibility.

- Contrary to the Welfare – Increase training for CPSWs/JPPOs on “Contrary to Welfare” and insert checks and balances into the process to ensure this checkbox is marked (if applicable) before it reaches the FSU desk.
- Reasonable Effort – Increase training and collaboration regarding reasonable efforts standards to ensure courts understand the importance of this documentation and the impact to the agency for IV-E eligibility when documentation is not present. Include checks and balances in the process to ensure this checkbox is completed (if applicable) before the order leaves the courts.

#### *DCYF/FSU IT Integration*

The current Bridges system does not include functionality to track and report IV-E funding data to inform the FSU staff regarding trends. The A&M Team identified areas previously

established by an Internal Process Improvement Committee that would bring the most benefit to DCYF units and the FSU to provide greater efficiency, accuracy, and timeliness within the FSU. The following opportunities in Table/Figure 26 should be included in the current development of the DCYF Comprehensive Child Welfare Information System (CCWIS):

**Table/Figure 26. FSU IT Integration Opportunities in Future CCWIS System**

#	Bridges System Issue	Current Manual Workaround	Fix in CCWIS	Benefit
1	Placement Notifications	Placement Notifications from CPSWs and JPPOs regarding placement of a youth do not automatically come through BRIDGES, they are made via Microsoft Outlook.	Automate Intake Requests in the CCWIS system to send an alert to the correct fiscal specialist based on the district office that both the field worker and Fiscal Specialist are assigned to.	Reduce the current need for FSU Supervisor to redirect emails. Remove the need for intake requests to be made via Microsoft Outlook Provide ability to more accurately track case status
2	"Blue File" Case Files	DCYF FSU maintains paper based "Blue Files" for everyone receiving DCYF services. "Blue Files" are often duplicated information between DCYF Units and FSU.	Share CCWIS capabilities with FSU to access the electronic case files and allow scanned documents to be attached to the case.	Having documents and case status in one place with controlled access by all DCYF units will lead to greater efficiency, accuracy & timeliness.
3	"Manila File" Case Files	DCYF FSU maintains paper based "Manila Files" for everyone receiving IV-A funding. There is no current functionality to manage IV-A funds.	Build functionality in the CCWIS system to open and manage IV-A funds. Provide a screen-by-screen design in the new system that tracks to the current paper IV-A checklist.	Having documents and case status in one place with controlled access by all DCYF units will lead to greater efficiency, accuracy & timeliness.
4	Reporting	FSU uses over 20 reports to prioritize work and identify missing items. Forms are currently not auto populated, manually created.	Replicate current reports into the CCWIS system with the ability to provide real-time reporting. Auto-populate on-line forms and letters from "known" data.	Access to real time reporting leads to greater efficiency accuracy and timeliness. Auto-populating forms limits the time FSU staff spend manually creating forms and letters.

### Benefits

By increasing the penetration rate by 5 percent to 20 percent, DCYF can expect an annual increase in IV-E federal funding from \$1.1 million to \$4.5 million. This revenue maximization opportunity would reduce the amount of State General Funds necessary to cover foster care maintenance payments. Using the most recent placement data (FY20 Q2), New Hampshire can realize the following annual cost savings by increasing their current penetration rate:

- 5 percent penetration rate increase → \$1.1 million annual cost savings
- 15 percent penetration rate increase\* → \$3.4 million annual cost savings
- 20 percent penetration rate increase → \$4.5 million annual cost savings

*\*increasing penetration by 15 percent will put New Hampshire at the New England State Average penetration rate.*

Increasing IV-E revenue has no impact on the quality of service provided to the children and families of New Hampshire.

**Table/Figure 27. Potential Revenue Maximzation Opportunities by Increasing IV-E Eligibility Penetration Rate**

	FY20 Q2 Total Placements	FY20 Q3 IV-E Penetration Rate	IV-E Ineligible Placements	IV-E Eligible Placements	Quarterly Rev. Max Opportunity	Yearly Rev. Max Opportunity
Current	1,624	27%	1,207	417		
5% Increase	1,624	32%	1,110	514	\$ .3M	\$1.1M
10% Increase	1,624	37%	1,029	595	\$ .6M	\$2.3M
*NE Avg. 15% Increase	1,624	42%	947	677	\$ .8M	\$3.4M
20% Increase	1,624	47%	866	758	\$1.1M	\$4.5M

**Cost-Benefit Estimate**

Cost-Benefit	Low	High	Justification
<b>Savings</b>	\$1.1M	\$4.5	Total general fund savings realized by increasing the current penetration rate by 5 percent (low) to 20 percent (high).
<b>Investments</b>	\$.05M	\$.05M	\$.05M costs were calculated assuming initial manual review of ineligible children requires one FTE reviewing 25 cases a day 68 days x 8 hours/day x \$100/hour.
<b>Net Benefit</b>	\$1.1M	\$4.5M	

**Implementation**

Area	Requirements
<b>People</b>	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.
<b>Process</b>	DCYF will need to make changes and modifications to the current processes FSU staff follows to identify IV-E funding.
<b>Technology</b>	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.
<b>Preparation Work</b>	Manually review 300 cases to identify the magnitude of each of the reasons for ineligibility
<b>Statute</b>	N/A

## Timeline

	Week 1-6	Week 6-7	Week 7-10	Week 10-30
Manual Data Review	■	■		
Prioritize Data Findings	■	■		
Identify Process Changes		■	■	
Implementation				■

## Risks

The following risks regarding addressing current process gaps are identified as:

- Manually reviewing 1,700 cases is a time-consuming process that will require dedicated time from the Fiscal Specialist Unit
- Buy-in from outside stakeholders (courts) is necessary for some process opportunities

## D. DEHS

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### Executive Summary | Overview

#### **Scope**

The A&M team was tasked with performing a strategic assessment of areas in the Division of Economic and Housing Stability (DEHS). A&M focused on reviewing and observing current business processes and workflows, understanding critical IT systems, and the determining impact of COVID-19 on DEHS' ability to provide certain critical services, such as processing eligibility. A&M was also tasked with analyzing the financial information and other operational indicators of DEHS.

#### **Approach**

A&M began by developing an understanding of major services provided by DEHS, focusing on critical pain points outlined by stakeholders. In partnerships with the division, A&M interviewed stakeholders, reviewed a significant number of documents, financial information, and current processes. Working with leadership in DEHS, A&M's team of subject matter experts were able to identify key areas in need of improvement that can bring both cost savings and efficiencies to the state.

#### **Results**

The Bureau of Family Assistance (BFA) is responsible for determining eligibility resides within the Division of Economic Housing Stability (DEHS) and is staffed statewide across thirteen district offices. The BFA shows a high number of vacancies, primarily in the Family Service Specialist (FSS) position with a total of 32 budgeted vacancies. The FSS position is responsible for determining both initial and continuing eligibility for economic service supports. As a result of high vacancies, FSS workers manage a correspondingly high caseload per staff person (588 cases/month), resulting in increased processing times. Additionally, FSS workers are responsible for managing the approximately 50,000 calls received by the BFA call center per month. The lack of self-service technology and a case-based eligibility process is impacting BFA's ability to manage eligibility processing workload. The A&M team has outlined four recommendations to address the findings described above; A&M recommends that DEHS: Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies. Maximize technology projects to reduce manual functions and improve processing times. Review current business processes including organization of the call center staffing to reduce call volume and FSS workload; and case-based model and consider opportunity to move to a task-based model.

**The above recommendations have the capacity to reduce processing time, reduce call volume, improve accuracy rate and enhance constituent service delivery without requiring a significant net increase in expenditures.**

A&M has identified other opportunities for improvement but is continuing to vet these opportunities at a deeper level of detail. As such, these opportunities will not be presented in this October 2020 report.

**Executive Summary | Recommendations (Short-term)**

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
D.1	Increase Workforce Capacity	Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies to improve caseload metrics and application timeliness.	\$.10M	\$.16M	Variable	Variable
D.2	Implement Technology Projects using COVID Dollars	Implement technology improvements to DEHS systems and other areas to alleviate increased workload due to COVID-19 and improve client experience.			\$2.1M	\$2.1M
<b>Total</b>			<b>\$.10M</b>	<b>\$.16M</b>	<b>\$2.1M</b>	<b>\$2.1M</b>

**Executive Summary | Recommendations (Long-term)**

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
D.3	Redesigning Call Center Processes	Conduct further analysis into current business processes including call center operations, and case-based eligibility model. Consider implementing enhanced Interactive Voice Technology (IVR) and a triage process within the call center and shifting case-based model to a task-based model.				
<b>Total</b>			<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>



## D.1 | Increase Workforce Capacity

<b>Recommendation:</b> Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies to improve caseload metrics and application timeliness.			
<b>Timeframe</b>	3 to 6 months	<b>Complexity</b>	Medium

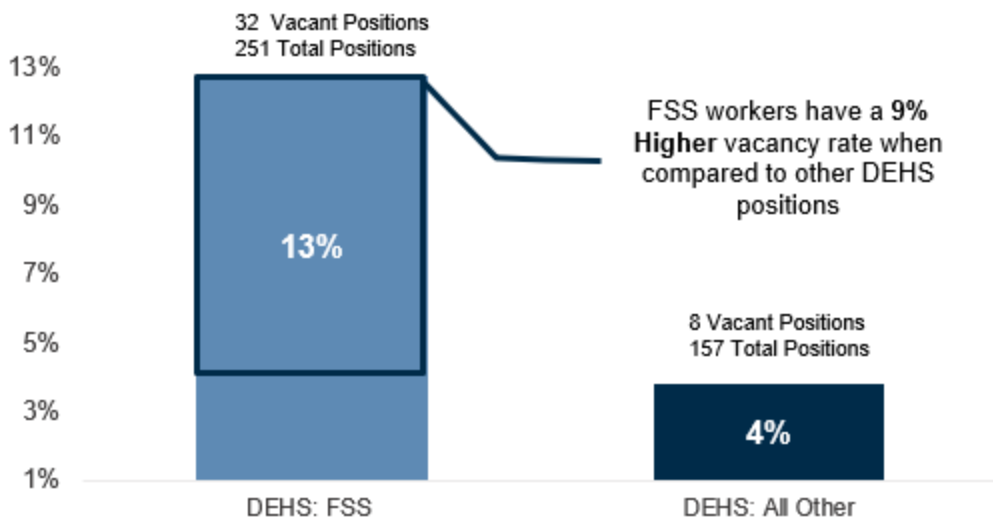
### Problem Statement

FSS positions are currently at a 13 percent vacancy rate for budgeted positions (32 positions). Increased workload associated with current vacancies has led to a delay in application processing time and is contributing to staff burnout.

### Findings

FSS workers are primarily responsible for determining and certifying the eligibility of constituents for programs of assistance, vacant positions are all currently budgeted for. As of September 2020, DEHS FSS workers had a **9 percent higher** vacancy rate compared to other direct care<sup>23</sup> DEHS positions, highlighted in Table/Figure 28. All of the current vacant FSS positions are already budgeted for. Additionally, FSS workers are responsible for staffing the call center, which removes them from being able to process applications one to two days a week.

**Table/Figure 28. Vacancy Comparisons of FSS I/II vs. All Other Direct Care DEHS positions**



DEHS has internal caseload benchmarks for each FSS worker to have a caseload of 400-500 cases per month. Based on total eligibility applications received over the past year, FSS workers average a total of 588 cases per month. High vacancy rates and high caseloads have contributed to the decline in applications processed in a timely manner over the last twelve months. Table/Figure 29 highlights the percentage of applications that have been processed in a timely manner within federal requirements. Federal guidelines require applications that are

<sup>23</sup> Using NH DHHS's classifications for direct care

reviewed within 30 or 45 days depending on application type. The following applications were reviewed in Table/Figure 29:

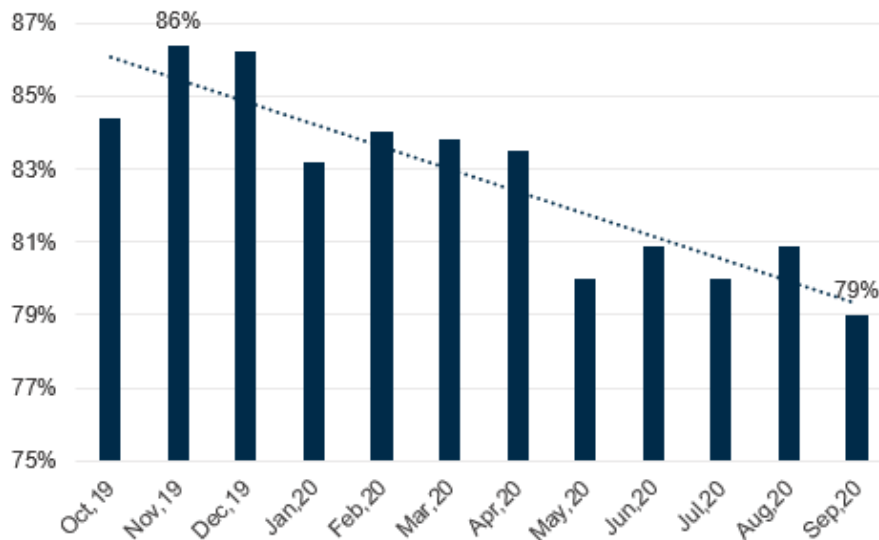
*Applications with a Federal Requirement of 30 Days:*

- Supplemental Nutritional Assistance Program (SNAP)
- Child Care

*Applications with a Federal Requirement of 45 Days:*

- Older Americans Act Nutrition Programs
- Financial Assistance for Needy Families
- MAGI/Family Planning
- Aid to the Needy Blind
- Qualified Medicare Beneficiary/Specified Low-Income Medicare Beneficiary/Qualified Disabled Working Individual

**Table/Figure 29. Applications<sup>24</sup> Processed In a Timely Manner Over the Last Twelve Months**



The percent of applications processed in a timely manner has dropped seven percent when comparing November 2019 data to September 2020 data. The decrease in the percent of applications is due to:

- Increase in applications due to COVID-19
- Current FSS vacancies/High FSS caseload
- Cases that have remained open past the requirement due to the current public health emergency

**COVID Impact**

The current workload is anticipated to increase due to COVID-19 benefits disenrollment.

*Analysis that provides a range of potential savings related to the COVID-19 benefits disenrollment is provided under a separate recommendation in this report.*

<sup>24</sup> Applications Include FANF, MAGI, OAA, ANB, APDT, QMBs, Food Stamps, Child Care

## Benefits

Benefits of prioritizing hiring FSS vacancies include increases in:

- Opportunity to improve the timeliness of application processing
- Clients receive benefits more timely
- Positive contribution to staff morale
- Improve capacity for DEHS staff to manage the anticipated increase in workload due to post-COVID benefits disenrollment

## Cost-Benefit Estimate

All costs outlined below are one-time costs.

Cost-Benefit	Low	High	Justification
<b>Savings</b>	Variable	Variable	
<b>Investments</b>	\$ .1 M	\$ .16 M	Investment was calculated assuming that a team of three (low) to five (high) full time employees were necessary to conduct a surge hire effort for four months at \$50 an hour. DEHS does not currently have any other external recruitment costs that are tracked .
<b>Net Benefit</b>	--	--	

The above recommendation has the capacity to improve caseload ratios, reduce processing time, and enhance constituent service delivery without requiring a significant net increase in expenditures.

## Implementation

Area	Requirements
<b>People</b>	Team of 3-5 people within HR/DEHS dedicated to implementing a surge hire effort for FSS positions.
<b>Process</b>	Hiring process will need to be streamlined to allow for a quick onboarding of FSS positions.
<b>Technology</b>	N/A
<b>Preparation Work</b>	Identify current barriers to hiring FSS workers timely.
<b>Statute</b>	N/A

## Timeline

	Week 1-3	Week 4-8	Week 8-12	Week 12-14
Identify Recruitment Plan	█			
Identify Surge Hire Team	█			
Identify Roles and Process	█	█		
Interview and Hire			█	
Onboard				█

## Risks

The time to train an FSS worker is approximately 9-12 months, during which they have the capacity of .5 FTE.

## D.2 | Implement Technology Projects Using COVID Dollars

**Recommendation:** Implement technology improvements to DEHS systems and other areas to alleviate increased workload due to COVID-19 and improve client experience.

<b>Timeframe</b>	3 months	<b>Complexity</b>	Medium
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### Problem Statement

The increase in family assistance applications due to COVID-19 has highlighted the need for the implementation of certain technology projects to reduce the current eligibility processing workload.

### Findings

There are very few avenues for clients to find answers online to simple inquires such as case status. The lack of self-service opportunities has led to an increase in clients calling in with simple inquires. The A&M team, in partnership with DEHS and the current systems vendor (Deloitte), identified current system pain points and improvement opportunities. The projects and opportunities outlined below are projects that could be funded with CARES Act funding and could be completed by 12/30/20 based on available data Deloitte is deferring current projects including existing M&O enhancement work and other DDI projects. In total, there are 14 identified projects. The projects identified fall under two categories:

1. Funds that have already been incurred or that will be incurred by DHHS related to COVID-19
2. Technology investments that are necessary to maintain pre-pandemic level of services, driven by increased demand caused by COVID-19

The implementation of these projects would eventually be a cost incurred by DHHS. The COVID-19 pandemic has expedited the need for implementation.

**Table/Figure 30. DEHS Projects to be Supported by CARES Act Funding**

Type of Project	Project Description	#	Project Detail	Cost (in millions)
A) COVID-19 Direct Support	Funds that have already been incurred or that will be incurred by DHHS related to COVID-19	1	Ongoing COVID Support due to extended emergency	\$ .31
		2	COVID Unwind	\$ .25
			<b>Subtotal A</b>	<b>\$ .56</b>
B) Necessary Technology Investments related to COVID-19	Technology investments that are necessary to maintain pre-pandemic level of services, driven by increased demand caused by COVID-19	3	Automate scheduling and checklist generation for SNAP cases	\$ .14
		4	Verification Tracking	\$ .32
		5	FAQ Chat Bot	\$ .24
		6	E-Notices/Paper Notices	\$ .02
		7	Client Self-Service Document Indexing	\$ .14
		8	Pre-Application for Phone Interviews	\$ .08
		9	Individualized Adhoc Noticing Client Voicemail Follow-up post to NH Easy	\$ .10
		10	Enhanced Mobile Document Upload	\$ .07
		11	Self-Service Marketing Notice	\$ .02
		12	Call Center Voice to Text	\$ .14
		13	Phone Application – Video Interview	\$ .14
		14	Self-Service Online Scheduling	\$ .16
			<b>Subtotal B</b>	<b>\$ 1.6</b>
			<b>Total (A + B)</b>	<b>\$ 2.1</b>

All identified projects Table/Figure 30 are designed to reduce FSS worker caseload by allowing the client to be able to do as much as possible without needing to call or reach out to an FSS worker; reducing manual processes and maximizing automation.

## **COVID Impact**

All of the identified projects can be funded using COVID-10 dollars, which is 100 percent federal funds.

## **Benefits**

The benefits to DEHS and constituents are:

- An increase in self-service opportunities can reduce the number of client calls.
- The implementation of these projects have long-term benefits and will continue to improve client and staff experience post COVID-19.
- Using 100 percent COVID-19 dollars to implement these projects will yield savings to DHHS (as these projects would have eventually needed to be completed in future years).

The following detailed COVID benefits and long-term benefits were enumerated in conjunction with DEHS and Deloitte.

Funds that have already been incurred or that will be incurred by DHHS related to COVID-19:

### **1. Ongoing COVID Support due to Extended Emergency**

- a. *COVID Benefit:* This effort directly supports ongoing execution of COVID service delivery to DHHS clients. The duration of COVID operations support is greater than previously forecasted and is required to maintain continuity of COVID-related activities such as COVID-19 Testing, SNAP Max-Allotment, Medicaid Continuous Coverage, Weekly Reports and Adhoc requests, Monthly Redetermination Changes.
- b. *Long-Term Benefit:* Absent the investment in COVID coverage, DHHS will need to forgo planned New Heights maintenance and enhancement activities which will create a significant backlog in time sensitive project delivery and will disrupt ongoing operations dependent on New Heights.

### **2. COVID Unwind**

- a. *COVID Benefit:* The "unwind" activities are required to return to pre-COVID eligibility rules and processes and to manage the backlog of work which will result from COVID catch-up such as Medicaid renewals which have been suspended.
- b. *Long-Term Benefit:* Absent the investment in COVID coverage, DHHS will need to forgo planned New Heights maintenance and enhancement activities which will create a significant backlog in time sensitive project delivery and will disrupt ongoing operations dependent on New Heights.

Technology investments necessary to maintain pre-pandemic level of services, driven by increased demand caused by COVID-19

### **3. Automate scheduling and checklist generation for SNAP cases**

- a. *COVID Benefit:* The volume of redeterminations directly resulting from the deferral of renewals due to COVID will create a "cliff effect." As a result, DHHS staff will be required to support a dramatic increase in workload compared the COVID or Pre-COVID renewal volume. This effort will offset that surge by reducing the effort of processing applications. The resources that process applications and schedule appointments are the same resources that will need to manage the renewal surge.
- b. *Long-Term Benefit:* The value of this investment will persist after the COVID unwind is completed providing for improved timeliness and reduced human intervention for application processing in perpetuity. In addition, customer service is improved with clients having near to immediate access to required verifications.

#### **4. Verification Tracking**

- a. *COVID Benefit:* COVID workload and client inquiries have resulted in an unprecedented call center backlog with wait times running at 40-60 minutes. The largest driver of call volume is questions surrounding verifications. Did you receive my document, what do I still owe? Reducing call volume associated with verifications, including COVID verifications, by providing verification tracking through NH EASY will reduce call volume. Providing DHHS staff access to current verifications pending will also reduce the duration per call for clients that do still elect to call. This aid in the management of the COVID related staff overload and normalization of call wait time. It will also aid in resource availability to support the Medicaid redetermination surge staffing need.
- b. *Long-Term Benefit:* The value of this investment will persist after the COVID unwind is completed by reducing call volume and through more efficient call processing in perpetuity.

#### **5. FAQ Chat Bot**

- a. *COVID Benefit:* The call volume including COVID related benefit questions and questions around supporting services from families suffering from the economic effect of COVID has driven substantial call volume increases at the same time staff has been dispersed to work from home. The FAQ chatbot will provide another channel to answer questions, including questions after hours.
- b. *Long-Term Benefit:* The value of this investment will persist after the COVID unwind is completed by reducing call volume and through more efficient call processing in perpetuity.

#### **6. E-Notices/Paper Notices**

- a. *COVID Benefit:* With limited on premise staffing due to COVID, this enhancement reduces the dependency on physical mailroom processing for notice issuance and returned mail processing by incentivizing clients to "Go green" decreasing paper notice handling and postage.
- b. *Long-Term Benefit:* The value of this investment will persist after the COVID unwind is completed with reduced mailing and return mail volume and the associated cost savings.

#### **7. Client Self-Service Document Indexing**

- a. *COVID Benefit:* This project provides a digital vehicle for clients seeking to limit physical COVID exposure associated with documents submission. It also speeds



processing time reducing the volume of closures due to failure to provide while simultaneously reducing the volume of work at the central scanning unit as indexing by DHHS is not required. This will be especially important with the COVID Medicaid renewal surge and required verifications.

- b. *Long-Term Benefit:* The value of this investment will persist after the COVID unwind is completed with reduced cost and improved timeliness for verification processing. It is also consistent with the DEHS aspiration of enhanced customer self-service and improved timeliness.

#### **8. Pre-Application for Phone Interviews**

- a. *COVID Benefit:* COVID has driven increased application volume while eliminating the ability to support in person interviews which had previously been the norm. The in person interviews have been replaced with phone interviews due to COVID. Pre-application client submission will reduce State staff time keying data through the New HEIGHTS driver reducing the effort and duration per phone application interview.
- b. *Long-Term Benefit:* The value of this investment will persist after the COVID unwind is completed with ongoing improved efficiency for call interviews, which are likely to be used more extensively in the future even after the COVID unwind.

#### **9. Individualized Ad Hoc Noticing Client Voicemail Follow-up post to NH Easy**

- a. *COVID Benefit:* COVID specific activities have driven increased client inquiries and follow up actions to support P-EBT, COVID Medicaid, and an overall expansion of services. The result is a massive increase in call volume. Improve client communication in leu of office help and to reduce call volume overload and these client specific notices can be distributed using e-mail and text messaging leveraging existing NH EASY multi-channel capabilities.
- b. *Long-Term Benefit:* The value of this investment will persist after the COVID unwind is completed with ongoing improved efficiencies for phone or video interviews.

#### **10. Enhanced Mobile Document Upload**

- a. *COVID Benefit:* COVID is limiting client access to paper forms, public mail services (particularly for clients without their own residence mailbox). In addition, COVID marketing of NH EASY has expanded adoption. This enables clients to submit more efficiently in a virtual model. Providing enhanced mobile photo capture for documents captured as pictures such as drivers licenses will improve clients ability to engage digitally with DHHS in leu of office traffic with District Offices closed or restricted.
- b. *Long-Term Benefit:* The value of increased mobile document submission and greater digital engagement provides residual benefits to both clients and DHHS with improved efficiency and reduced rework.

#### **11. Self-Service Marketing Notice**

- a. *COVID Benefit:* Client usage of NH EASY has expanded during the COVID era and NH EASY clients are generally extremely positive regarding the capabilities and user friendly features in NH EASY. With targeting communication we can improve client awareness of NH EASY as an alternative resources in leu of physical offices increasing the number of NH EASY account holders.

- b. *Long-Term Benefit:* The value of increased NH EASY adoption as well as re-use of periodic marketing strategies will improve digital adoption for the benefit of clients and reduced service delivery cost in perpetuity. This is particularly true given that many clients return with multiple spells over time and NH EASY expedites that transition.

## **12. Call Center Voice to Text**

- a. *COVID Benefit:* Call volume has increased dramatically with COVID related service delivery driving volume of 40-60 minute hold times. With each call case workers record case notes which is an intensive aspect of managing call volume. This feature offsets increased call volume associated with COVID community needs and associated increased case work.
- b. *Long-Term Benefit:* Voice to text would aid DHHS staff with call center efficiency in perpetuity.

## **13. Phone Application – Video Interview**

- a. *COVID Benefit:* The usage of in person interviews has been dramatically reduced due to COVID with staff working and clients minimizing contact in the community. Although phone interviews are now being utilized, it does not allow for visual identify proof of the clients. It is also less interactive making it more difficult to engage with clients to provide a stronger human centric service and to use body language and other visual cues to help manage the interview more successfully to achieve an accurate result.
- b. *Long-Term Benefit:* A percentage of interviews were completed by phone prior to COVID. It is anticipated that virtual interviewing will be considerably more common, even after the COVID era has passed. Video interviewing will support digital engagement which will benefit clients and DHHS as the State looks to serve clients where they are in the community. This will make it easier to serve clients, many who are challenged on transportation and time will be in a much strong position to collaborate with DHHS via video conference.

## **14. Self-Service Online Scheduling**

- a. *COVID Benefit:* Clients and case worker schedules and schedule volatility have both been directly impacted by COVID-19, including the mechanism and hours for conducting interviews. Allowing clients to have direct influence over scheduling vs using a system assigned schedule will result in fewer missed appointments, reduced worker scheduling effort, and improved client satisfaction at time when COVID is stretching the Departments ability to maintain call volumes, interviews and other competing COVID centric demand.
- b. *Long-Term Benefit:* Client initiated phone interview scheduling for virtual interview and more dynamic schedule management will provide benefits post COVID, particularly as DEHS shift towards increased digital client engagement with the continued transition from the brick and mortar pre-COVID model.

## Cost-Benefit Estimate

All savings, costs and net benefits outlined below are a one time cost.

Cost-Benefit	Low	High	Justification
Savings	\$2.1M	\$2.1M	The cost of the projects is recognized as a savings to DHHS, as all projects will be 100 percent federally funded by COVID dollars, rather than DHHS incurring them as a State General Fund expense
Investments	--	--	
Net Benefit	\$2.1M	\$2.1M	

## Implementation

Area	Requirements
People	Current vendor (Deloitte) will need to increase current team resources in order to complete projects by 12/30.
Process	N/A
Technology	Improve self-service applications and backend automation within New Heights and NH Easy
Preparation Work	Implementation of identified projects have already begun in order to meet the 12/30/20 deadline outlined in the CARES Act.
Statute	N/A

## Timeline

	Week 1-4	Week 4-8	Week 9-12
Identify Requirements			
Development			
Implementation			

## Risks

- Technology projects are required to inform and get approval from CMS, ACF, FNS for changes to HEIGHTS.
- Technology projects need to be completed by 12/30/20.
- M&O enhancement work and DDI projects (currently being completed by Deloitte) will need to be deferred until the COVID-19 projects are complete.

### D.3 | Redesigning Business Processes

**Recommendation:** Conduct further analysis into current business processes including call center operations, and case-based eligibility model. Consider implementing enhanced Interactive Voice Technology (IVR) and a triage process within the call center and shifting case-based model to a task-based model.

<b>Timeframe</b>	12 to 24 months	<b>Complexity</b>	High
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#### Problem Statement

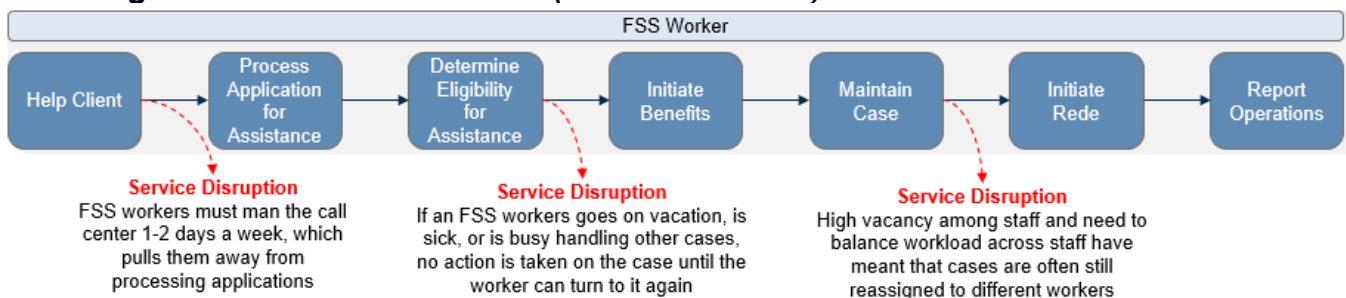
Family Service Specialists (FSS) currently operate on a case-based model to process eligibility applications. The current process also removes FSS workers one to two days per week from processing applications to staff the call center.

#### Findings

FSS workers spend on average two days per week processing eligibility for clients. One day per week is dedicated to administration and processing. Two days per week are dedicated to staffing the call center.

The current case-based model New Hampshire follows is highlighted in Table/Figure 31. In the case-based model an individual caseworker works one-on-one with a family over time to handle all aspects of service delivery, from the initial application to periodic updates on their eligibility status. While a case-based approach theoretically allows for more personal connections between FSS workers and families, recurring high caseloads and high vacancy rates impact FSS workers capacity to complete timely processing of eligibility benefit applications. The case-based approach also opens itself to multiple types of service disruption highlighted in Table/Figure 31. All service disruptions negatively impact the FSS workers ability to process applications timely.

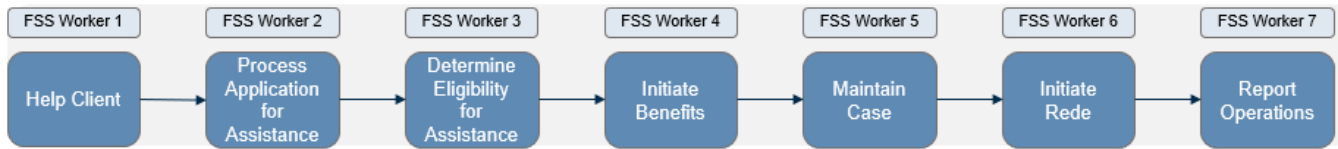
**Table/Figure 31. Case-Based Model (Current NH Model)**



In a task-based approach, FSS workers would handle specific functions of case processing (e.g., accepting applications or processing renewals or changes) rather than all functions as with the traditional case-based approach. The task-based approach, which requires electronic files, increases efficiency and lets FSS workers concentrate on completing a specific function or action needed to reach an eligibility decision. This model, highlighted in Table/Figure 32 has the capacity to alleviate some of the pressure on overburdened workers with a large numbers of clients and will ensure that cases move to the next available worker rather than waiting for an assigned caseworker who may be occupied.

In calls conducted with other two other states (CT,KY) on the shift to a task-based process, both states reported improved performance metrics and increased productivity. In Connecticut, one of the states A&M and DEHS leadership spoke with, they reported a processed timely percent of 98 percent over the last twelve months compared to New Hampshire’s average 82 percent timeliness rate.

**Table/Figure 32. Task-Based Model (Current CT and KY Model)**



Currently, the Bureau of Family Assistance (BFA) has a decentralized call center. Statewide, the call center receives approximately 50,000 client calls per month regarding all aspects of the application, eligibility, benefits, case maintenance, and the redetermination processes. A review based on available data highlighted that approximately 75 percent of the calls received are calls that do not need a FSS worker to answer. In the current call center process, FSS workers are responsible for managing all call types:

1. **General Information (12.5 percent of calls)** - General information and case specific self-serve information
2. **Simple Inquires (50 percent of calls)** - Rescheduling, case status, have my documents been received, eligibility questions, reporting changes
3. **Unrelated Calls (12.5 percent of calls)** - Calls that BFA cannot assist in, such as desktop support, Medicaid, referrals to community services out of area, etc.
4. **Calls that Require FSS I/II (25 percent of calls)**

Table/Figure 33 illustrates a high-level view of the current call center process.

**Table/Figure 33. Current State Call Center Process**



As highlighted above, approximately 75 percent of the calls could be handled by IVR, a third-party vendor, or a Family Service Assistant (FSA) worker rather than an FSS worker. By triaging calls and directing them to the correct person, FSS workers can limit the amount of time spent on the phone and more time spent processing eligibility. A high-level future state process for the call center redesign is highlighted in Table/Figure 34.

**Table/Figure 34. Potential Future State Call Center Process**



By utilizing IVR and/or a third party vendor to triage calls, and allowing FSA workers to address simple inquiries, FSS call volume has the potential to drop significantly. A decrease in the volumes of calls will help place FSS focus back on service delivery and meeting the needs of vulnerable populations as quickly and efficiently as possible.

### Benefits

States who have shifted from a case-based model to a task-based model have been able to streamline and substantially improve access of benefits in the following areas<sup>25</sup>:

- Staff productivity
- Improved error rate
- Throughput of applications
- Net improvement in average days needed to process applications

By implementing enhanced IVR and a triage process to the current call center process, the following benefits can be recognized:

- No wait time by using IVR/NH Easy for simple inquiries
- Accurate and timely actions being taken on client cases
- More productivity for FSS by covering less phone lines

### Cost-Benefit Estimate

Cost-Benefit	Low	High	Justification
Savings	<i>Implementing a business process redesign will require further analysis to determine necessary costs and benefits. A well-executed business process redesign will improve eligibility application processing times.</i>		
Investments			
Net Benefit			

### Implementation

Area	Requirements
<b>People</b>	Team of 3-5 people within BFA to work part time during the suggested timeline to assist in reviewing current case-based processes and design a plan to potentially move it to task based.
<b>Process</b>	A complete shift of the current eligibility case-based process to a task-based process.
<b>Technology</b>	A more in-depth review of current technology utilized in the current case-based process is necessary. Enhanced IVR would need to be developed within the call center.
<b>Preparation Work</b>	A more in-depth review of the current call center operations and case-based process is necessary. Both a business processing analysis and a cost-benefits analysis should be conducted to inform the decision of shifting business processes
<b>Statute</b>	N/A

<sup>25</sup> Julia Isaacs, Michael Katz, and Ria Amin, "Improving the Efficiency of Benefit Delivery "(Urban Institute , 2016), <https://www.urban.org/>.

## Timeline

	Month 1	Month 2-4	Month 5-10	Month 10-24
Conduct Analysis	█			
Business Process Review	█	█		
Identify Future State		█	█	
Prepare Change Management Plan		█	█	█
Implementation				█

## Risks

- This would be a lengthy process and require a through communication plan and training plan for DEHS staff.
- This endeavor requires significant preparation for business processing change management.
- External stakeholders have previously disagreed on the use of a third-party vendor to triage calls.
- Requires agreement from multiple external and internal stakeholders.



## E. MEDICAID CARE MANAGEMENT

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### Executive Summary | Overview

#### **Background**

The A&M team conducted analysis on the following areas of the Medicaid Care Management program, focusing on the COVID-related increased FMAP and enrollment growth, as well as reviewing health plan contract terms to identify opportunities for performance improvement:

1. The Families First Coronavirus Response Act (FFCRA) provides a temporary 6.2 percentage point increase to each qualifying state's Federal Medical Assistance Percentage (FMAP) effective January 1, 2020 through the last day of the calendar quarter in which the PHE ends.
2. State Medicaid programs hold contracted health plans accountable for their performance using a variety of levers, including: a withhold of monthly capitation payments, shared savings, bonus payments, monetary penalties, capitation rate adjustments, reporting and publicizing performance on quality, and auto-assignment of Medicaid members to higher-performing health plans, among others. NH DHHS currently relies primarily on two of these levers: a withhold of monthly capitation payments and monetary penalties.

#### **Findings**

While additional supporting analysis and detail are provided within this report, the following two findings highlight the rationale for our two recommendations in this area:

1. For at least five years prior to the COVID pandemic, Medicaid enrollment in New Hampshire was effectively flat. With the passage of FFCRA, enrollment immediately increased due to FMAP-related restrictions on disenrollment during the PHE. The State is at financial risk for the ongoing costs of COVID-related enrollment growth after the PHE and increased FMAP end.
2. NH DHHS currently relies primarily on two of the various mechanisms listed above for holding health plans accountable: a withhold of monthly capitation payments and monetary penalties. However, these levers are currently unavailable to the State, due primarily to COVID-related business disruptions.

#### **Recommendations**

The A&M team has outlined two recommendations to address the findings described above, including:

1. Develop a robust implementation plan for promptly disenrolling Medicaid recipients who no longer meet eligibility requirements when the COVID PHE and increased FMAP end.
2. Shift NH DHHS's approach to performance incentives for health plans from monetary penalties and a withhold of capitation payments to an auto-assignment algorithm that rewards higher-performing plans with increased membership.

### Executive Summary | Recommendations (Short-term)

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
E.1	Eligibility Determination	Develop a robust implementation plan for promptly disenrolling Medicaid recipients who no longer meet eligibility requirements when the COVID Public Health Emergency ends.				<i>Variable</i>

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### Executive Summary | Recommendations (Long-term)

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
E.2	Health Plan Performance Incentives	Shift NH DHHS's approach to performance incentives for health plans from monetary penalties and a withhold of capitation payments to an auto-assignment algorithm that rewards higher-performing plans with increased membership.				<i>Variable</i>

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## E.1 | Eligibility Determination

<b>Recommendation:</b> Develop a robust implementation plan for promptly disenrolling Medicaid recipients who no longer meet eligibility requirements when the COVID Public Health Emergency ends.			
<b>Timeframe</b>	2 to 3 months	<b>Complexity</b>	Medium

### Problem Statement

As a condition of accepting the increased Federal Medical Assistance Percentage (FMAP) for COVID-19, with few exceptions, state Medicaid programs are prohibited from terminating coverage for anyone enrolled as of March 18, 2020. The eligibility restrictions of the funding has resulted in significant increases in Medicaid enrollment and expenditures since March. If the PHE ends on January 23, 2021 as currently declared, states will have suspended disenrollments for several months. The increased FMAP will expire at the end of the calendar quarter in which the PHE ends, presently March 31, 2021. This timeline gives states two months to redetermine eligibility and disenroll those who is no longer eligible without incurring the ongoing cost of COVID-related enrollment growth after the increased federal funding ends. The longer this process takes, the greater the financial risk a state faces.

### Findings

On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was enacted into law. FFCRA provides a temporary 6.2 percentage point increase to each qualifying state's Federal Medical Assistance Percentage (FMAP) effective January 1, 2020 and extends through the last day of the calendar quarter in which the PHE ends. On October 2, 2020, the PHE was extended through January 23, 2021 and the increased FMAP was extended through March 31, 2021.

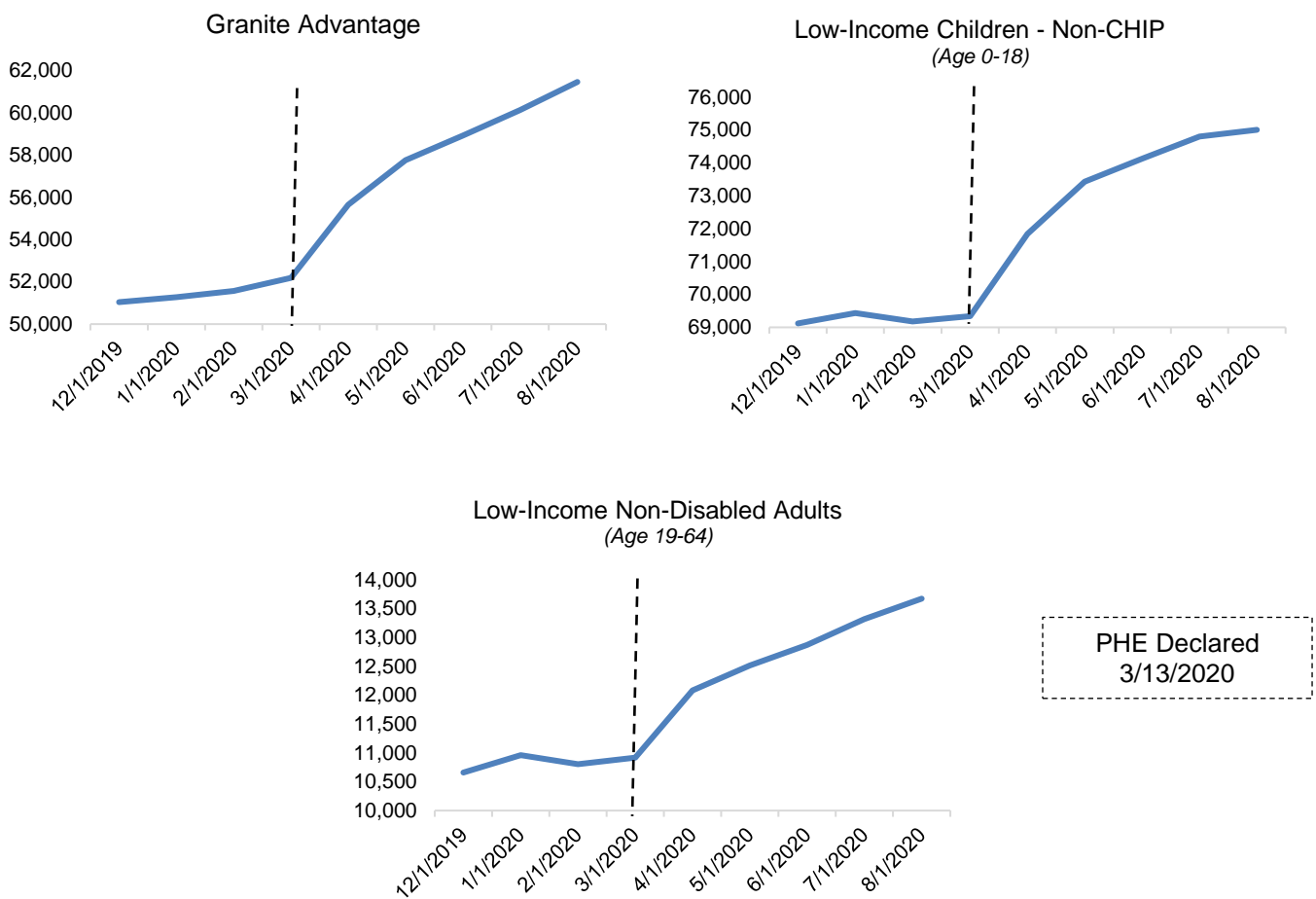
To qualify for the temporary FMAP increase, states must comply with certain requirements through the end of the month when the PHE ends. States must:

- Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (the maintenance of effort requirement);
- Not charge premiums that exceed those that were in place as of January 1, 2020;
- Not end coverage for individuals from Medicaid if such individuals were enrolled in the program as of the date of the beginning of the PHE period, or became enrolled during the period, unless the individual voluntarily ends eligibility or no longer lives in the state (the continuous coverage requirement).

Further, states are expected to identify and reenroll individuals whose coverage ended on or after the date of enactment for reasons other than a voluntary request or ineligibility due to residency. At a minimum, states are expected to inform individuals whose coverage ended after March 18, 2020 of their continued eligibility and encourage them to contact the state to reenroll. Where feasible, states are to automatically reenroll individuals whose coverage ended after March 18, 2020 and suspend any disenrollments otherwise scheduled to occur. Coverage is to be reinstated back to the date of termination.

The impact of these maintenance of effort and continuous eligibility requirements has been increased Medicaid enrollment nationwide. In New Hampshire, prior to the COVID-19 pandemic, Medicaid enrollment over the past five years was effectively flat. Following the passage of FFCRA, enrollment immediately increased by 4.2 percent. During March and April 2020, New Hampshire's Medicaid enrollment grew across all eligibility categories. The most notable increases were among Non-Disabled Adults (10.7 percent), Low-Income Children Non-CHIP (3.7 percent), and Granite Advantage (7.4 percent) recipients. Between May and August 2020, enrollment in these groups continued to grow at a rate of between one and three percent per month.

**Table/Figure 35. Enrollment Numbers by Eligibility Type (12/2019 to 8/2020)**



**Table/Figure 36. Enrollment Numbers by Eligibility Type Percent Increase by Month (2020)**

	March % Increase	April % Increase	May % Increase	June % Increase	July % Increase	August % Increase
Granite Advantage - Medicaid Expansion	1.2%	6.2%	3.6%	2.0%	2.0%	2.2%
Low-Income Children - Non-CHIP (Age 0-18)	0.2%	3.5%	2.2%	0.9%	0.9%	0.3%
Low-Income Non-Disabled Adults (Age 19-64)	1.1%	9.6%	3.5%	2.8%	3.4%	2.6%

## COVID Impact

While some have theorized that the rise in the number of unemployed workers due to COVID-19 would be a key driver of recent Medicaid enrollment growth, recent research finds that the growth is not systemically related to job losses.<sup>26</sup> This finding leaves the enhanced FMAP's eligibility requirements as the leading explanation for the increase in Medicaid enrollment and expenditures. Specifically, in New Hampshire, the expenditure impact of enrollment growth since March 2020 has been \$29.5 million in the Granite Advantage program and \$4.8 million in the Standard Medicaid program through September 30, 2020.

**Table/Figure 37. Expenditure Increase Impact Due to Increased Enrollment<sup>27</sup>**

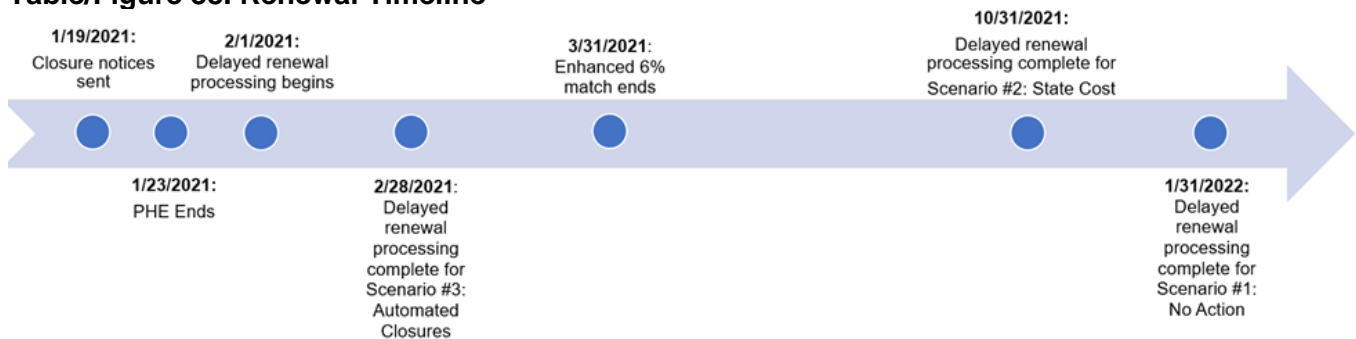
(\$ millions)	FMAP	FY20			FY21			TOTAL Est. Impact through Sep 30, '20		
		Total	Fed	State	Total	Fed	State	Total	Fed	State
Standard Medicaid + 6.2%	0.5620	\$0.1	\$0.1	\$0.0	\$4.8	\$2.7	\$2.1	\$4.8	\$2.7	\$2.1
Granite Advantage	0.9000	\$11.1	\$10.0	\$1.1	\$18.5	\$16.6	\$1.8	\$29.5	\$26.6	\$3.0
<b>Total</b>		<b>\$11.2</b>	<b>\$10.0</b>	<b>\$1.1</b>	<b>\$23.2</b>	<b>\$19.3</b>	<b>\$3.9</b>	<b>\$34.4</b>	<b>\$29.3</b>	<b>\$5.1</b>

## Benefits

The temporary FMAP increase is intended to help states pay for the extraordinary costs of the COVID-19 pandemic. However, this funding is time-limited, and states are at risk of paying the higher state share of ongoing enrollment costs after the increased FMAP ends.

If the PHE ends on January 23, 2021, states will have suspended eligibility redetermination (renewals) and related disenrollment for more than a year. The earliest date states could begin renewing and disenrolling ineligible individuals would be February 1, 2021, and the increased FMAP would end just two months later. It will be a challenge for NH DHHS to catch up on the volume of deferred renewals before the increased FMAP ends. The longer it takes NH DHHS to redetermine eligibility and end coverage for those who no longer qualify, the higher the expenditure exposure will be.

**Table/Figure 38. Renewal Timeline**



<sup>26</sup> <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00900>

<sup>27</sup> Date of payment estimate based on enrollment times PMPM for Low Income Children, Low Income Adult, and Granite Advantage members; actual enrollment received through August 2020 so September 2020 enrollment impact for Granite Advantage is an estimate

Advance readiness for the eligibility actions required at the end of the PHE will be a primary determinant of how quickly NH DHHS recovers from the FMAP-driven expenditure growth. Robust implementation planning can increase the speed and efficiency of the effort. A data-driven understanding of the number of people impacted, both by eligibility category and total cost, can inform strategic thinking. An end-to-end view of tasks and timelines is also critical for the success of the effort. Collaboration among all involved in the renewal process can help identify areas of opportunity for streamlining and facilitate creative thinking and innovation.

### Enrollment Redetermination Strategies

A multitude of factors will determine the rate at which New Hampshire reaches a post-COVID enrollment and expenditure baseline. Described in Table/Figure 39 below are three examples of how NH DHHS could recover from the PHE FMAP-driven expenditure growth. All scenarios are based on a PHE end date of 1/23/21 and increased PHE FMAP end date of 3/30/21.

All scenarios focus on the child and family and non-disabled adult (expansion) eligibility groups driving enrollment growth since the increased FMAP requirements went into effect. The scenarios focus exclusively on health plan expenditures, as the eligibility groups driving enrollment growth are mandatory managed care enrollees. Aged and disabled recipients are included in the enrollment projections to account for overall renewal workload but they are excluded from the fiscal portion of the models as they are not the main drivers of COVID-19 enrollment and spending growth.

**Table/Figure 39. Enrollment Redetermination Strategies**

Scenario	Operational Tactic
<b>1) Pre-COVID Renewal Process</b>	NH DHHS resumes disenrollment of ineligible individuals on the pre-COVID timeline of annual redetermination. For example, an enrollee whose redetermination was due in March 2020 but who was continuously enrolled through January 23, 2021 when PHE is set to end would be redetermined in March 2021 and, if ineligible, disenrolled that month. This routine monthly process would continue through January 2022, when disenrollment from the PHE FMAP-related enrollment increases would be complete. This scenario assumes historic workload volume and current workforce capacity.
<b>2) Reorganize Workload by State Cost</b>	NH DHHS stages the renewal workload by eligibility group, expediting the disenrollment of groups with the highest per member per month costs considering the state share only. This scenario assumes higher workload volume over a shorter time period, ending in October 2021.
<b>3) Use Automated Closure Functionality</b>	NH DHHS auto-closes ineligible members of eligibility groups driving the PHE FMAP-related enrollment increases, specifically non-CHIP children, expansion and non-disabled adults. More vulnerable populations, such as long-term care recipients and Medicaid-Medicare dual enrollees would be exempt from auto-closure. The scenario assumes a single batch job in March 2021, a short-term workload spike from the minority of cases that do not auto-close, and all redeterminations and PHE FMAP-related disenrollment completed in the first calendar quarter of 2021.

None of the scenarios address the workforce requirements of the workload staging. An assessment of NH DHHS’s workforce capacity is ongoing, and workforce needs will be dependent on policy, procedure, process, and systems tactics chosen.

**Cost-Benefit Estimate**

The below estimates of possible costs and cost avoidance illustrate the budgetary opportunities presented by a data-driven, tactical approach to implementation planning for the renewal and disenrollment effort.

Scenario	Total Funds Cost	Federal Funds Cost	State Funds Cost	Operational Tactic
Pre-COVID Renewal Process	\$274.5M	\$228.2M	\$46.3M	Resume Pre-COVID renewal process, no change in annual timeline
Reorganize Workload by State Cost	\$216.9M	\$182.8M	\$34.0M	Prioritize disenrollment based on state share of per member per month cost
Use Automated Closure Functionality	\$93.4M	\$74.6M	\$18.8M	Maximize automation, minimize timeline

Scenario 1 estimates the "worst case" cost of no change from Pre-COVID renewal 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 from the worst case by \$12.3M in state funds, and Scenario 3 is estimated to potentially lower the state cost 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.

**Implementation**

Area	Requirements
<b>People</b>	Sufficient workforce capacity (e.g., eligibility workers, call centers, mail rooms, etc.) and short-term staff augmentation (such as temp workers for less complex tasks) to prevent or reduce backlog from catch up workload
<b>Process</b>	Targeted policy, procedure and process changes to streamline work, economize administrative effort, and manage catch-up workload within workforce constraints.
<b>Technology</b>	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 necessary for the effort
<b>Preparation Work</b>	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.
<b>Statute</b>	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.



The development of a robust implementation plan for promptly disenrolling Medicaid recipients who no longer meet eligibility requirements when the PHE ends will require action in multiple areas. Most importantly, NH DHHS will need to ensure that sufficient workforce is dedicated to the effort. Policy experts are needed to understand applicable regulatory requirements and flexibilities, particularly guidance forthcoming from CMS. Data analysts and researchers are needed to provide information for decision making towards a renewal strategy that balances concerns with administrative capacity, cost, and the well-being of vulnerable populations. Technologists are needed to design, develop and test eligibility system changes that streamline the work with more automation and less manual effort.

Seasoned managers of eligibility field operations are needed to simplify procedures and work processes to economize administrative effort and manage temporary increases in workload within workforce constraints. Temporary workers may be needed to prevent work processing delays or reduce backlog by taking less complex work off the plates of the fixed number of seasoned eligibility workers whose expertise is necessary for more complex tasks. Call center staffing and Interactive Voice Response technology changes, which can maximize incoming callers' ability to navigate a phone system before talking to a human operator, will also need to be addressed.

**Timeline**

	Month 1	Month 2	Month 3
<b>Gather Requirements</b>			
<b>Data Analysis</b>			
<b>Develop Policy</b>			
<b>Develop Systems Changes</b>			
<b>Implementation</b>			

Initial planning efforts hinge on understanding the regulatory requirements surrounding eligibility redetermination and disenrollment in general, as well as specific to the COVID PHE and FMAP. As such, time ranges presented here begin with the date CMS issues COVID disenrollment guidance.

Prior to release of the CMS guidance, however, NH DHHS can identify variables that will be important to their renewal strategy considerations, including but not limited to: knowledge of current regulatory requirements and flexibilities; current policy, procedures and processes, including COVID-specific modifications; current system functions, including COVID-specific programming and resulting error or exception patterns and manual workarounds; and all pieces of the Medicaid enterprise impacted by the eligibility requirements of the COVID FMAP, both internal and external to NH DHHS. A certain amount of planning for the reversal of COVID-specific changes could be accomplished in advance of CMS guidance.

NH DHHS can also begin to build models that simulate the impact of different policy, procedure, process or system change options for the renewals catch up. Preparation would include the organization of key data points, such as:

- Pre- and post-COVID enrollment trends;
- Renewal volume by month;
- Renewal outcomes, including the manual and streamlined renewal counts as well as disenrollment by closure code reason;
- Timelines for renewal packet and advance notice of adverse action mailings and related expiration dates;
- Eligibility worker counts;
- Caseload and productivity statistics; and,
- Options for the use of automated closure functionality.

As much as possible, the data would be provided by eligibility category and capitation rate cell, to inform both eligibility field operations and financial planning. The establishment of standing forums with stakeholders across the Medicaid enterprise is especially important in fostering innovation and collaboration around the renewal effort.

### **Risks**

The greatest risks to NH DHHS' advance planning efforts are: insufficient resources dedicated to preparedness efforts and dependency on the timing of federal guidance on operational considerations in ending federal maintenance of effort and continuous coverage requirements.

States need CMS answers to key questions on what will be permissible from an operations perspective. CMS advises that guidance will be forthcoming soon, but until then, NH DHHS cannot complete implementation planning. Without needed information, NH DHHS faces delays in essential inputs, including: data analysis to inform strategic decision making; development of policy, procedure, and process changes; design, development and testing of system changes; and communications for implementation, such as eligibility worker training.

Sufficient resources for planning and implementation are also critical. NH DHHS staff will need to prioritize planning activities and arrange for resources to handle any temporary workload increase, for eligibility workers, call centers, mail rooms and more. Short-term staff augmentation, such as temporary workers for less complex tasks, can help prevent or reduce backlog from the catch-up work.

In short, if NH DHHS applies itself to advance planning, then NH DHHS will increase its ability to mitigate the financial risks of ongoing enrollment resulting from the COVID-19 FMAP restrictions.

## E.2 | Auto-Assignment

<b>Recommendation:</b> Shift NH DHHS's approach to performance incentives for health plans from monetary penalties and a withhold of capitation payments to an auto-assignment algorithm that rewards higher-performing plans with increased membership.			
<b>Timeframe</b>	24 months	<b>Complexity</b>	Medium to High

### Problem Statement

NH DHHS relies on monetary penalties and a withhold of capitation payments to hold health plans accountable for their performance but cannot use these financial incentives at this time. An alternative approach is needed to keep health plans focused on advancing state aims and meeting contract requirements.

### Findings

Across the country, state Medicaid programs hold contracted health plans accountable for their performance using a variety of levers, including: a withhold of monthly capitation payments, shared savings, bonus payments, monetary penalties, capitation rate adjustments, reporting and publicizing performance on quality, and auto-assignment of Medicaid members to higher-performing health plans, among others. NH DHHS currently relies primarily on two of these levers: a withhold of monthly capitation payments and monetary penalties.

NH DHHS-contracted plans can earn back a withhold of two percent of the monthly capitation payments by meeting performance targets on six measures in the categories of quality improvement, care management and behavioral health. Additionally, plans that perform exceptionally well on these measures can qualify for bonus payments of up to five percent more than the monthly capitation rate from an incentive pool funded with withhold dollars not earned back by other plans.

NH DHHS-contracted plans can be fined for non-compliance with specific contract terms. A table of liquidated damages details fines generally applicable to failure to meet minimum operational requirements, such as timely, complete, and accurate encounter data submission or failure to meet minimum care management participation. Fines range from \$500 per day to \$100,000 per violation. Between March and September 2020, NH DHHS catalogued over one hundred instances of health plan non-compliance, with total monetary penalties estimated at more than \$6.6 million across the three plans. Of the total, penalties for failure to meet care management targets accounted for \$1.5 million and encounter data submissions deficiencies accounted for \$1.2 million.

Currently, NH DHHS is unable to leverage either of these performance incentives. It waived the contract's withhold provisions for the September 2019 to June 2020 contract year due to the impact of the COVID-19 pandemic. It has also elected not to assess the estimated penalties, because certain contract requirements are proving aspirational or temporarily unattainable and some fines in the liquidated damages table are found to be overly aggressive.

Additionally, the state fiscal impact of COVID-19 necessitates budgetary reductions, and downward adjustments to the aspirational or temporarily unattainable contract requirements enable the state’s actuary to reduce monthly capitation rates. For example, for the September 2019 to June 2020 period, the per member per month administrative allowance for all rate cells was reduced by 1.5 percent to recognize that significantly fewer health plan members are enrolled in care management programs than the 15 percent expectation in the contract.

While helpful in generating budgetary savings, an adverse consequence of these adjustments is weaker financial incentives to focus health plan investments and attention on advancing state aims and complying with contract requirements.

**COVID Impact**

NH DHHS waived the contract’s withhold provisions for the September 2019 to June 2020 contract year and reduced the administrative allowance for care management in the capitation rates specifically due to the impact of the COVID-19 pandemic. These changes, though detrimental to incentives for health plan performance, were preferable to other means of reducing Medicaid expenditures, such as reductions to eligibility, covered services or reimbursement rates that would be harmful to Medicaid recipients and providers.

**Benefits**

The benefit of implementing a value-based auto-assignment algorithm is the ability to maintain health plans’ focus on contract compliance and achieving state aims, particularly when other financial incentives are unavailable. Specifically, NH DHHS’s health plan contract allows the state to reward higher-performing plans with additional membership through the use of an auto-assignment algorithm. The department has not used this provision to date because of a commitment from the recent procurement which added a third health plan to the program. Until the new entrant has sufficient enrollment for financial viability, all random auto-assignments are being enrolled in this health plan. NH DHHS anticipates reaching the plan’s minimum enrollment target by the end of CY21, at which point it will be possible to implement a value-based auto-assignment algorithm. A benefit of the auto-assignment option in particular is its potential to further engage health plans in improving health and containing costs because of its direct impact on a health plan’s opportunity for financial profit.

**Cost-Benefit Estimate**

<b>Cost-Benefit</b>	<b>Low</b>	<b>High</b>	<b>Justification</b>
<b>Savings</b>	NA	NA	The shift in membership among plans is cost-neutral to the state
<b>Investments</b>	NA	NA	Assumes state staff time

Although the actual impact of an auto-assignment algorithm will depend on its specifications, provided herein is a hypothetical model of the potential impact of value-based auto-assignment. It begins in CY22 when the new entrant’s minimum enrollment target is anticipated to have been met. For simplicity’s sake, the model assumes that random auto-assignments are directed solely to the single highest performing plan. It does not attempt to address the methodological details that would be required to implement. Nor does it pre-suppose which plan would be the highest performer. Instead, it shows the potential outcome

for each of the three contracted health plans, assuming that in each case one “winner takes all” for the duration of the model’s two-year period. The model estimates the enrollment and revenue impact to each health plan. There are no state savings, as the shift in membership is cost-neutral from the payer side of the equation. The model’s outcomes demonstrate the power of this lever to shift market share among the competitors and increase or decrease plan revenues. The scale of the changes can be seen as a proxy for the scale of motivation, as the greater the market share, the greater the earnings, and the greater the earnings, the greater the potential for profits.

## Implementation

Area	Requirements
<b>People</b>	Adequate resources to research and develop a value-based auto-assignment algorithm.
<b>Process</b>	Health plan contract amendments to implement the change, including updates to the appendix that outlines auto-assignment methods.
<b>Technology</b>	Program changes to the existing auto-assignment algorithm in the member enrollment system.
<b>Preparation Work</b>	Understand other states’ experience with value-based auto-assignment. Strategic planning to establish the performance objectives of the algorithm, or the values on which its detailed design will be based.
<b>Statute</b>	Identify state or federal law or rule impacting financial performance incentives for NH DHHS-contracted health plans (i.e., SB 313)

A shift in health plan performance incentives from reliance on a withhold and monetary penalties to value-based auto-assignment will require adequate resources for research, development and implementation. The effort will require an understanding of other states’ experience and awareness of state or federal law or rule impacting financial performance incentives for NH DHHS-contracted health plans, such as SB 313. It will require strategic planning to establish the performance objectives for the algorithm, or the values on which its detailed design will be based. Careful attention must be paid to crafting the specifications such that methodological challenges from health plans’ legal departments can be averted. Finally, contract amendments will be needed. including updates to the appendix that outlines auto-assignment methods; and, changes must be programmed into the member enrollment system.

## Timeline

	Year 1	Year 2
Background Research		
Strategic Planning		
Design System Changes		
Program System Changes		
Implementation		

Based on NH DHSS assumptions as of mid-October 2020, the timeline proposed for development of value-based auto-assignment is CY21 through CY22 Q1, with implementation to take place in CY22 Q2. Key NH DHSS assumptions include:

1. the new entrant must meet its minimum enrollment target before value-based auto-assignment can begin, and
2. this enrollment target will be reached at the end of CY21.

Background research, including other states' experience and legal constraints, would be conducted in CY21 Q1. Strategic planning on auto-assignment objectives would be completed in CY21 Q2. Activities in CY21 Q3 and Q4 would center on auto-assignment algorithm design. Contract amendments and programming for member enrollment system changes would take place in CY22 Q1, for a go-live date in CY22 Q2.

### **Risks**

Risks to a shift in NH DHHS's approach to its health plan performance incentive strategy include:

1. Insufficient resources for the tasks for planning and implementation;
2. Ongoing COVID-related disruptions to health plan operations, further delaying implementation of financial performance incentives;
3. Extended duration of commitment to auto-assignment algorithm to achieve financial viability of new entrant

### **Early Adoption Update**

Building on discussions with the A&M team about the auto-assignment recommendation as it was being drafted, by early November 2020, NH DHHS had taken the initiative to outline an approach to begin rewarding higher-performing plans with additional membership beginning in January 2021, concurrent a right-sizing of liquidated damages.

The Medicaid agency dedicated scarce staff resources to creative thinking that enabled the introduction of value-based auto-assignment a year earlier than initially thought possible. It took an incremental approach that allows the state to concurrently continue to direct most auto-assigned lives to the new entrant and honor its commitment to reach the plan's minimum enrollment target with no change in timing.

Agency leadership took advantage of current contract negotiations to effect the early implementation, including the development of detailed programmatic guidance during CY20. The agency reviewed MCO performance challenges to date and chose a limited set of high priority objectives for a small scale test of the effect of value-based auto-assignment in focusing health plan investments and attention. The lump sum method it chose to award lives obviates the need for changes to the existing auto-assignment algorithm in the member enrollment system, simplifying and expediting implementation. This "toe in the water" approach offers a concrete path forward on the broad-brush direction provided in SB 313.

The agency is currently finalizing an amendment to health plan contracts to begin implementation of value-based auto-assignment effective January 1, 2021. The performance measurement period for value-based auto-assignment awards will begin in FY21 Q3.

Additional lives will be awarded in three categories of performance, including: health risk assessment (1,000 lives), encounter data submission (1,000 lives), and psychiatric boarding service use (3,000 lives). Award dates for each of the three will be staggered throughout FY21. The benefit of the agency's initiative is a much shorter implementation timeline to course correct on health plan performance incentives even as the challenges of COVID remain.



## F. MEDICAID MANAGEMENT INFORMATION SYSTEM

### Executive Summary | Overview

#### Scope

A state's Medicaid Management Information System (MMIS) is the critical claims processing and data storage system that all states are required to operate to be eligible for federal funding. The MMIS is thus the centerpiece of a state's Medicaid information technology infrastructure. A&M's team conducted an in-depth review of NH DHHS's MMIS contract, architecture, and costs to review the strategy and operations of the current MMIS implementation, compare DHHS's spend on its MMIS versus peer states, characterize the value and functionality derived from the current MMIS, and identify opportunities to increase MMIS value and functionality while minimizing cost.

#### Approach

The A&M team, in partnership with BIS and DMS staff, gathered and reviewed a significant number of documents and financial information to conduct an analysis of the MMIS. In addition to its document review, A&M also conducted numerous discussions with members of the BIS and DMS teams, collected and analyzed data from authoritative third-party sources (e.g., CMS), and consulted MMIS industry experts.

#### Results

Several key findings emerged from the A&M team's discussions with stakeholders, document review, and data analysis: (1) DHHS has not adopted a consistent strategy for its MMIS, and is instead maintaining an aging system in an ad hoc fashion; (2) DHHS spends more on its MMIS than peer states (other states in New England and other states with similar Medicaid enrollment); and (3) the current MMIS uses obsolete software and requires extensive manual workarounds to function.

Based on these findings, A&M recommends that DHHS (1) adopt a long-term strategy and vision for the State's MMIS; (2) explore a "modular" procurement and implementation approach for a new MMIS system (a possibility previously reviewed by DHHS); and (3) pursue an improvement to contract terms around DDI spend and product upgrades during procurement.

This recommendation offers an emerging and directional view of planning for a new MMIS, as well as its potential costs and savings. The State's MMIS is an expensive component of its Medicaid program, but a necessary one. A&M's recommendation aims to ensure DHHS has the capacity to operate a future MMIS in a more cost-effective manner than its current system.

### Executive Summary | Recommendations (Long-term)

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
F.1	New MMIS Strategy Adoption	Develop a comprehensive, long-term MMIS strategy and vision to maximize MMIS value and minimize cost over time.	Variable	Variable	\$5.5M	\$21.6M

**F.1 | MMIS Strategy**

<b>Recommendation:</b> Develop a comprehensive, long-term MMIS strategy and vision to maximize MMIS value and minimize cost over time, including a modular approach to procurement and implementation; new, competitive contract terms; and a business case for MMIS re-procurement.			
<b>Timeframe</b>	5 years	<b>Complexity</b>	High

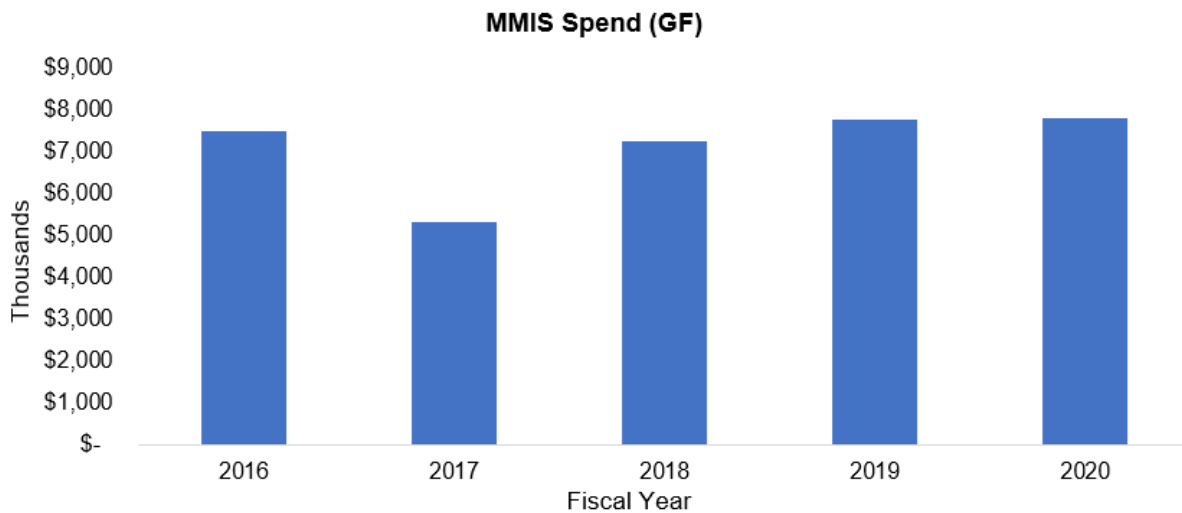
**Problem Statement**

Lack of adopted strategy inhibits effective development and deployment of current technology and system transformation opportunities. Reporting capabilities in the MMIS are inadequate and prevent proper data collection and analysis. Incomplete license and application inventories prevent line of sight into capability gaps, priorities and transparency on technology and software spend. MMIS expenditures are high in comparison to key benchmarks.

**Findings**

NH DHHS spent \$7.8 million in General Fund (GF) dollars on its MMIS system in FY20 and an annual average of \$7.1 million in GF dollars between FY16 and FY20 (as seen in Table/Figure 40). NH DHHS is not realizing the full value of its MMIS, as new capabilities required to support new CMS requirements or State waiver programs require functionality not available in the MMIS today and require manual workarounds to implement. Reporting capabilities in the MMIS are also inadequate and prevent proper data collection and analysis. When the MMIS was implemented in 2013, the solution had already been in development for six years, making it obsolete upon implementation. Additionally, the shift from Fee For Service (FFS) Medicaid to Managed Care required significant changes in how to manage the State’s Medicaid needs.

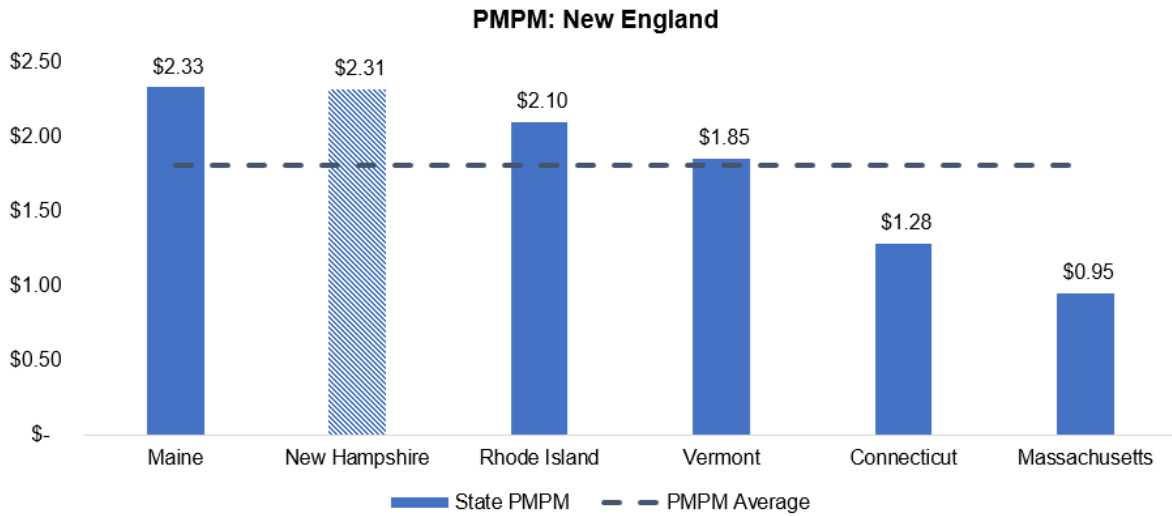
**Table/Figure 40. FY16 - FY20 MMIS Spend**



Source: New Hampshire CMS 64 Activity Reports, FY16-FY20

Based on CMS comparison data, A&M identified New Hampshire’s average MMIS PMPM (i.e., per member, per month cost) between CY08 and CY18 (note that the CMS data is based on calendar year). Looking at just the State share of MMIS expenditures, New Hampshire’s MMIS PMPM was nearly 30 percent higher than all other New England states except Maine: \$2.31 vs. \$1.80 on average (Table/Figure 41).

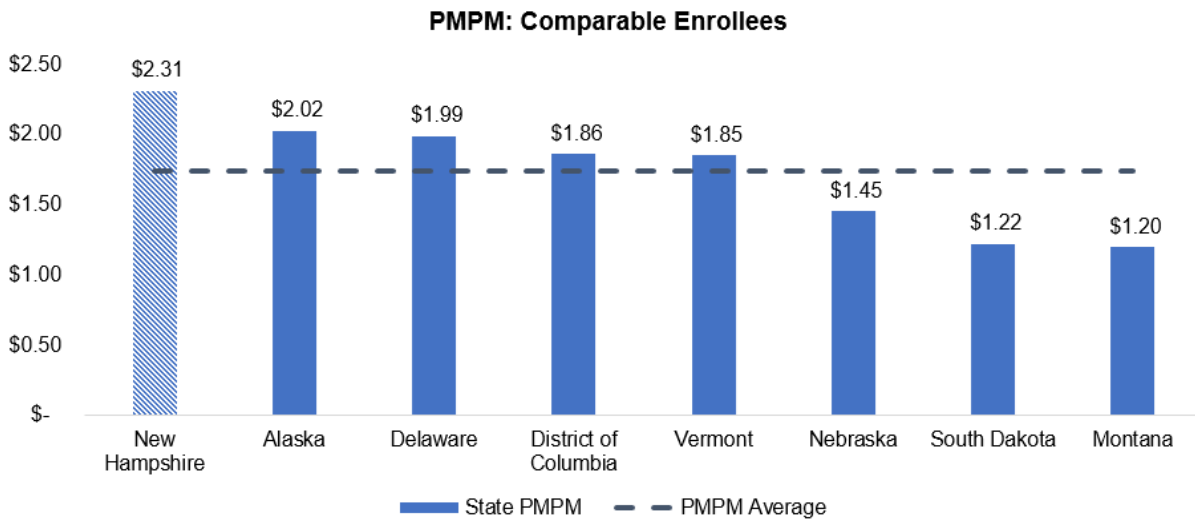
**Table/Figure 41. MMIS PMPM Comparison to New England States, CY08 – CY18**



Sources: New Hampshire CMS 64 Activity Reports; GAO Medicaid Information Technology Report

When compared to states with similar Medicaid enrollment over that same timeframe, New Hampshire had a 33 percent higher average MMIS PMPM: \$2.31 vs. \$1.74 (Table/Figure 42). In addition, A&M’s analysis of NH DHHS’s CMS 64 reports indicated that the State’s MMIS spend for FY20 was tracking to \$3.47 PMPM – a 35 percent increase over its average from available CMS data.

**Table/Figure 42. MMIS PMPM Comparison to States with Similar Enrollment, CY08 – CY18**

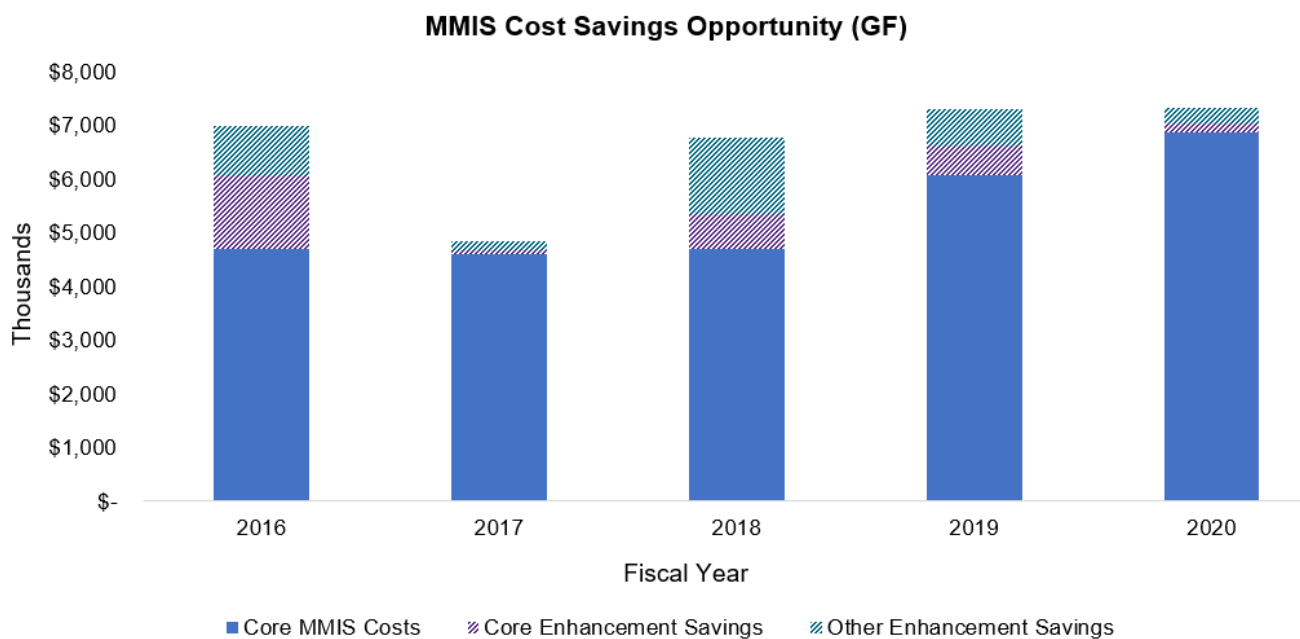


Sources: New Hampshire CMS 64 Activity Reports; GAO Medicaid Information Technology Report

NH DHHS’s existing contract with its MMIS vendor does not include adequate support for enhancement of base product capabilities or annual allocation of design, development and implementation (DDI) dollars. New Hampshire currently bears the cost of updates to a monolithic system could instead be shared across a vendor’s clients.

As a result, between FY16 and FY20 NH DHHS spent \$6.3 million on upgrades related to HIPAA and ICD-10, among other enhancements. These costs accounted for nearly 18 percent of all MMIS GF expenditures between FY16 and FY20, and these costs should have been absorbed by the vendor (Table/Figure 43). A&M anticipates these costs, as a standard practice, would be borne by alternative MMIS vendors as part of a modular approach.

**Table/Figure 43. FY16 – FY20 NH DHHS Spend on Enhancements to Core MMIS Functionality**



*Source: New Hampshire CMS 64 Activity Reports, FY16-FY20*

In 2016, Congress enacted the Cures Act, stipulating that states will be subject to a reduction in Federal Medical Assistance Percentages (FMAP) if they fail to implement Electronic Visit Verification (EVV) for personal care services by January 1, 2020 and for home health care services by January 1, 2023 absent a one-year extension based on CMS approval of a state’s Good Faith Effort application. NH DHHS anticipates that the cost of these penalties will exceed the costs of implementing an EVV system that automates billing and detects fraud, waste, and abuse. This illustrates the financial implications of lacking an MMIS strategic plan.

Manual workarounds, obsolete software, reporting and data difficulties, regulatory compliance challenges, and comparably high spend all indicate a lack of adopted MMIS strategy. A comprehensive long-term strategy and vision are necessary to meet changing program needs and to determine how the MMIS and/or any integrated systems must be developed and deployed. The lack of this strategy limits NH DHHS’s ability to understand what is required for future development of its MMIS and prevents its ability to control or avoid costs.

Additional and supportive findings include:

- MMIS software dates back to 2007 and uncertainty exists as to whether ongoing vendor support will exist for operations, putting NH DHHS in a high-risk position.
- Manual workarounds are used to satisfy reporting requirements for waiver and other State programs, creating difficulties in accessing and producing reports and causing data quality concerns. For example, reporting is so manual that three staff members are required to produce core CMS 64 reports.
- The Bureau of Information Services (BIS) builds manual workarounds for many required enhancements, as the time required to implement and be compliant for programs is frequently not achievable by the State's current vendor.
- Limited design, development, and implementation (DDI) capabilities and understanding of underlying technology and business rules exist in-house at NH DHHS.

NH DHHS received approval to delay EVV implementation until January 1, 2021. NH DHHS hired Mercer to support development of EVV business and system requirements. It was also stated during stakeholder interviews that NH DHHS has decided to begin absorbing the penalties on 1/1/2021, rather than implementing an EVV solution before the deadline. This will lead to a quarterly penalty against the state's FMAP of .25 percent per quarter in 2021.

### **COVID Impact**

A properly functioning MMIS is essential for tracking Medicaid beneficiary health metrics and claims. If data or reporting is unreliable, the state will be unable to capture the true cost of COVID's impact on citizens' health and on the State's health care system.

Applying a modular MMIS solution could enable NH DHHS to focus future COVID enhancements on the relevant MMIS modules, rather than undertaking a large and complex impact analysis and implementation across its current monolithic system. A modular MMIS would be more nimble, allow for an iterative development approach, and align with the CMS's Medicaid Information Technology Architecture (MITA) framework, which emphasizes the promotion of "reusable components through standard interfaces and modularity" and "interoperability, integration, and an open architecture."<sup>28</sup>

### **Benefits**

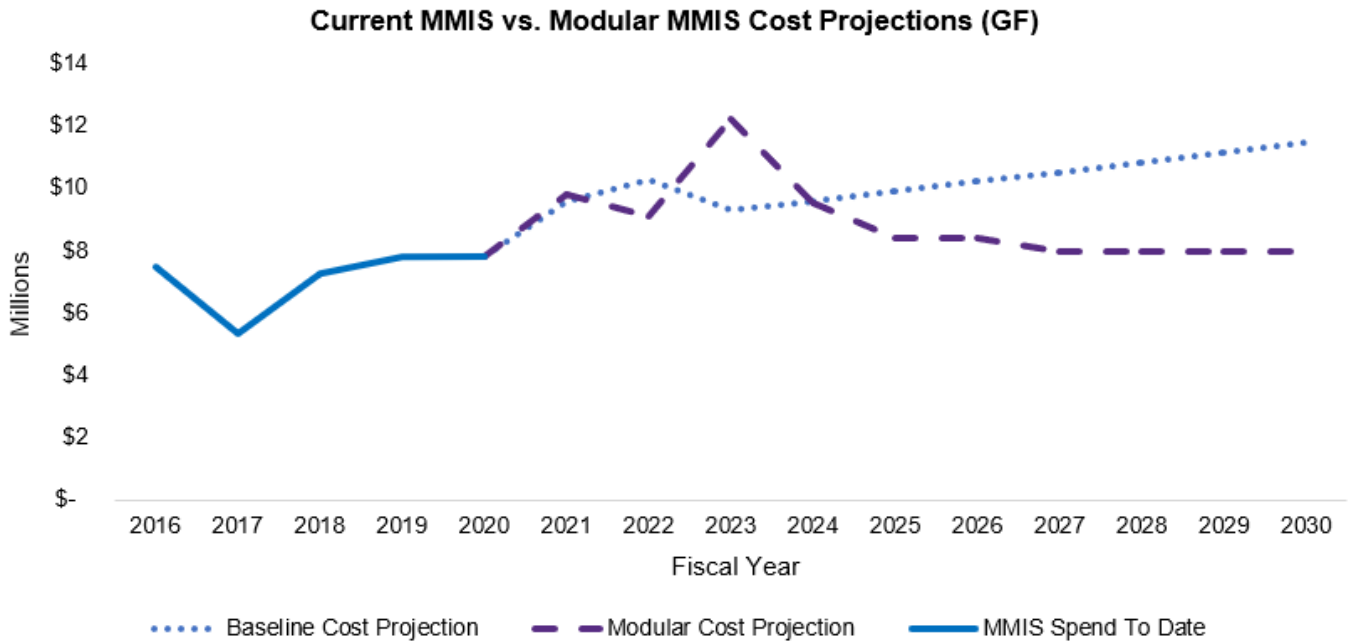
A modular MMIS approach could potentially save NH DHHS approximately \$13.5M in General Fund expenditures over a nine-year period between FY22 and FY30, or an average of \$1.5M per year. Per Table/Figure 44 and Table/Figure 45 below, a hypothetical modular approach ("Modular Cost Projections") yields higher near-term DDI costs but lower long-term O&M costs versus a forecast of current MMIS spend ("Baseline Cost Projection").<sup>29</sup> A linear regression forecast of NH DHHS's current MMIS spend suggests rising costs (over \$10M annually) unless alternative action is taken. The cost of adopting a modular MMIS approach is significant, but continuing with the current MMIS is likely to prove costly and technically challenging.

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<sup>28</sup> CMS MITA Framework.

<sup>29</sup> Modular cost projections are based on "DDI Mid" and "O&M Mid" projections in Table 2.

**Table/Figure 44. FY21 – FY30 Current MMIS vs. Modular MMIS Cost Projections\**



Sources: NHDHHS CMS 64 Activity Reports; Montana DPHHS Modularity Project Summary Costs; Proprietary Research on MMIS Vendors; GAO Medicaid Information Technology Report

**Table/Figure 45. FY21 – FY30 Current MMIS vs. Modular MMIS Cost Projections<sup>30</sup>**

Cost Comparison	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total
Baseline Cost Projection	\$9.6	\$10.3	\$9.3	\$9.6	\$9.9	\$10.2	\$10.5	\$10.9	\$11.2	\$11.5	\$103.0
Modular Cost Projection	\$0.3	\$9.1	\$12.2	\$9.6	\$8.4	\$8.4	\$8.0	\$8.0	\$8.0	\$8.0	\$79.9
<b>Savings / (Investment)</b>	<b>(\$0.3)</b>	<b>\$1.2</b>	<b>(\$2.9)</b>	<b>\$0.0</b>	<b>\$1.5</b>	<b>\$1.8</b>	<b>\$2.6</b>	<b>\$2.9</b>	<b>\$3.2</b>	<b>\$3.5</b>	<b>\$13.5</b>

(Totals in M)

Sources: *Ibid*

The other benefits of a modular MMIS approach include consistency and accuracy of data across MMIS. Additionally, NH DHHS would be able to leverage competitive bidding for various MMIS capabilities. The use of multiple vendors would also allocate risk across vendors: if one vendor struggles to implement, their failure does not jeopardize the entire modular MMIS system, as would be the case in a more monolithic contract. The modular system would also reduce or eliminate the manual workarounds that exist today, and it would also increase innovation and specialization among MMIS vendors due to competition for different modular components.

Deploying a modular approach would also enable NH DHHS to utilize more competitive contract terms. DDI spend could be apportioned in the contract; it presently is not included. Additionally, NH DHHS could include certain base product upgrades, such as federal

<sup>30</sup> Assumes that 2021 is final year of existing Conduent contract; runs in parallel with procurement of new modular approach for that year, and then has ongoing transition costs through 2026. “Modular Cost Projection” line item also includes vendor management, program management, and legacy integration costs.



compliance requirements, at the vendor's cost. NH DHHS could also use advantageous contracting vehicles (e.g., NASPO) to minimize MMIS spend and provide more consistent and competitive pricing.

### *Key Considerations*

A modular approach to the State's MMIS has both benefits and risks that require significant further analysis. The strongest benefit is the ability to procure the strongest solution at the best price for each component. The modular approach also enables NH DHHS to structure and modify the implementation and migration process to ensure limited risk and funding challenges for the solution. However, embracing a modular approach will require NH DHHS to build strong internal capabilities to ensure critical oversight for development and implementation of the overall MMIS program. These stronger internal capabilities will serve as a key integration role to ensure the overall solution is effectively implemented across vendors.

Proposed modules, needed capabilities, and queuing of deployment are dependent on a broader NH DHHS Medicaid strategy. NH DHHS will need to proactively define its approach to MMIS implementation. CMS does not currently have a pre-defined set of modules for an MMIS. NH DHHS will thus need to tailor its MMIS modular procurements to meet the needs of its Medicaid program. The more unique the needs and business processes of the State, the more customized the modules, with a corresponding increase in associated costs. A consistent, long-term strategy – and consistent funding to execute that strategy – will facilitate the success of a modular implementation.

NASPO ValuePoint provides a cooperative purchasing program that facilitates public procurement solicitations and agreements using a lead-state model. As part of this program, NASPO has initiated procurements for MMIS modules and created a more competitive bidding environment for critical MMIS vendors (CNSI, DXC, Optum, WiPro, and Conduent). NH DHHS should evaluate the opportunity of using NASPO for its MSA negotiations and for pricing procurement of future MMIS modules. NASPO currently has an executed MSA for the provider enrollment module and anticipates having MSAs executed for the core claims module by end of 2020.

A modular approach requires development of a system integrator service to integrate MMIS modules and other NH DHHS systems (e.g. New Heights, Salesforce, etc.). Proposed modules are dependent on MCOs remaining in their current operational state in New Hampshire.

A straw model timeline was developed (see "Timeline" below) and provides a starting point for evaluation of a modular implementation. Numerous alternative approaches may be taken; other states such as Georgia are replacing all modules in a sandbox environment and converting all modules at once upon completion. NH DHHS will need to determine the best go-forward option as it develops its MMIS strategy.

Cost projections are highly subjective and may be higher than current MMIS expenditures due to extensive module implementation, integration, or rework. The cost projections included in this report are preliminary and illustrative.



BIS staff vacancies are the highest among DHHS divisions, particularly within the MMIS team. Proper staffing levels will be crucial to the successful implementation of a new MMIS.

The success of any future state, modular or otherwise, will hinge to some degree on the engagement and capabilities of the State’s current MMIS vendor.

**Cost-Benefit Estimate**

All figures represent General Funds, and assume Federal match of 90/10 for DDI costs and 75/25 for O&M costs. DDI costs are one-time implementation costs while O&M costs are calculated for a ten-year period.

<b>Cost-Benefit</b>	<b>Low</b>	<b>High</b>	<b>Justification</b>
<b>Savings</b>			
Modular MMIS	\$5.5M	\$21.6M	Total savings (2022 – 2030) based on DDI High + O&M High spend and DDI Low + O&M Low spend, respectively
<b>Investments</b>			
Modular MMIS	\$81.5M	\$97.4M	9-year state spend (2022 - 2030) – DDI and O&M cost projections for proposed “best of breed” MMIS modules (see Table 2 below); costs include total costs for Implementation Program Mgmt (\$.9M - \$1.1M) and ongoing Vendor Oversight (\$1.2M to \$1.5M)
<b>Total Costs<sup>31</sup></b>	<b>\$81.5M</b>	<b>\$97.4M</b>	<b>9-year all-in state spend (2022-2030), inclusive of DDI and O&amp;M costs</b>
<b>Net Benefit</b>	Modular approach may allow NH DHHS to avoid \$103M in 9-year GF spend associated with maintaining current MMIS, yielding savings of \$5.5M - \$21.6M		

**Table/Figure 46. Proposed MMIS Modules with Mid, High, and Low Cost Estimates**

<b>Module</b>	<b>DDI Costs (GF) in M</b>			<b>O&amp;M Costs (GF) in M</b>		
	<b>Mid</b>	<b>High</b>	<b>Low</b>	<b>Mid</b>	<b>High</b>	<b>Low</b>
Provider Management	\$0.7	\$0.8	\$0.7	\$6.4	\$7.0	\$5.7
Systems Integration	\$3.5	\$3.8	\$3.1	\$29.8	\$32.7	\$26.8
EVV	\$0.7	\$0.8	\$0.6	\$6.0	\$6.6	\$5.4
Data Management	\$0.9	\$1.0	\$0.8	\$7.9	\$8.7	\$7.1
Accounting	\$0.3	\$0.3	\$0.3	\$2.1	\$2.3	\$1.9
Claims Management	\$1.7	\$1.9	\$1.6	\$13.3	\$14.6	\$12.0
Pharmacy Management	\$0.1	\$0.1	\$0.1	\$0.7	\$0.7	\$0.6
Contacts Management	\$0.2	\$0.2	\$0.2	\$1.2	\$1.3	\$1.1
Implementation Program Management	\$1.0	\$1.1	\$0.9	n/a	n/a	n/a
Ongoing Vendor Management	n/a	n/a	n/a	\$1.4	\$1.5	\$1.2
Modular Transition Services	n/a	n/a	n/a	\$2.1	\$2.3	\$1.8
<b>Totals</b>	<b>\$9.1</b>	<b>\$10.1</b>	<b>\$8.2</b>	<b>\$70.7</b>	<b>\$77.8</b>	<b>\$63.7</b>

*Sources: NHDHHS CMS 64 Activity Reports; Montana DPHHS Modularity Project Summary Costs; Proprietary Research on MMIS Vendors; GAO Medicaid Information Technology Report*

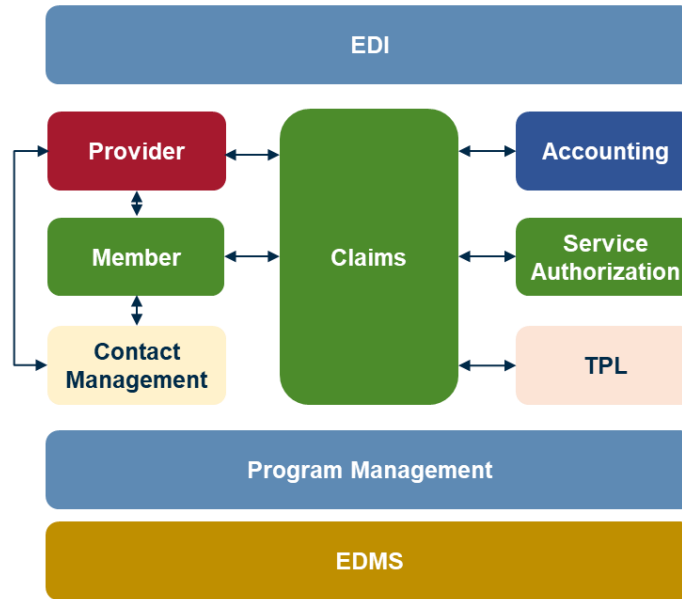
<sup>31</sup> Total costs do not include costs for IV&V vendor.

## Implementation

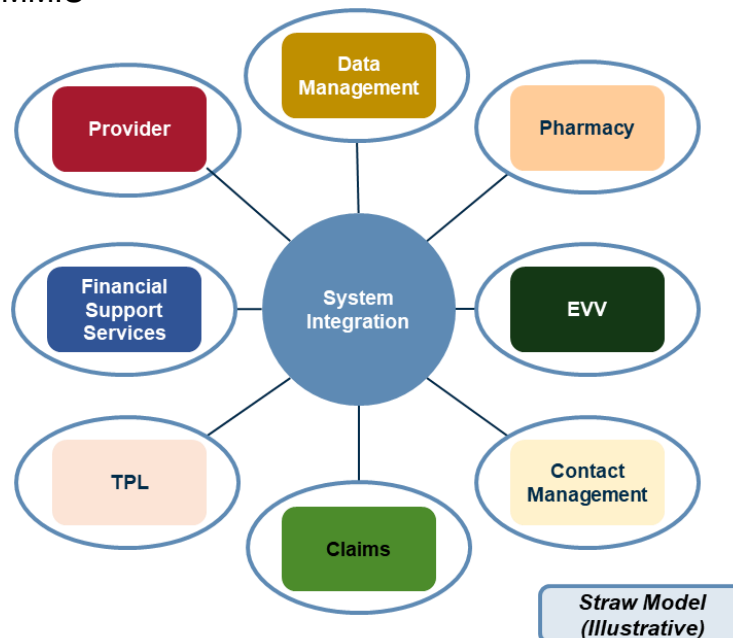
A modular MMIS approach would enable the State to procure best-of-breed functionality from multiple vendors. This modular approach also may enable competitive bidding from multiple vendors and allow a phased procurement and implementation timeframe. Figure 6 below depicts the NH DHHS current state versus a hypothetical future state MMIS architecture. The future state architecture will need to be rigorously defined as part of the development of the future state MMIS strategy.

### Table/Figure 47. Current State Versus Future State MMIS Architecture

Current State: Monolithic MMIS



Future State: Modular MMIS



The table below summarizes the people, process, technology, preparation work, and statutes necessary for MMIS strategy development and modular implementation.

Area	Requirements
<b>People</b>	<ul style="list-style-type: none"> <li>• Communication plan to inform key stakeholders of future state MMIS strategy and to ensure buy-in from DHHS and State leadership.</li> <li>• Internal IT/other staff selected to drive strategy and business case development for modular approach.</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Development of implementation roadmap to provide insights on when modules and capabilities are made available and what dependencies exist across various modules.</li> <li>• Creation of updated IAPD/APD submissions to CMS for reconciliation with new modular development and procurement strategy.</li> <li>• Procurement and implementation.</li> </ul>
<b>Technology</b>	<ul style="list-style-type: none"> <li>• Definition of modular DDI and O&amp;M requirements as DHHS procures various modules.</li> <li>• Identification of access to and clarity around current MMIS and surrounding applications and functionality (e.g., DoIT, Conduent, etc.).</li> <li>• Current state inventory to assess modules, applications, licenses/access.</li> </ul>
<b>Preparation Work</b>	<ul style="list-style-type: none"> <li>• Determination of program expectations for service delivery transformation.</li> <li>• Modular development will require ongoing integration of systems.</li> <li>• Current system may need to coexist as new modules are implemented.</li> </ul>
<b>Statute</b>	<ul style="list-style-type: none"> <li>• DHHS must determine whether procurement is allowed through the NASPO vehicle.</li> <li>• DHHS must require EVV use for all Medicaid-funded PCS by 1/1/2020 and HHCS by 1/1/2023.</li> </ul>

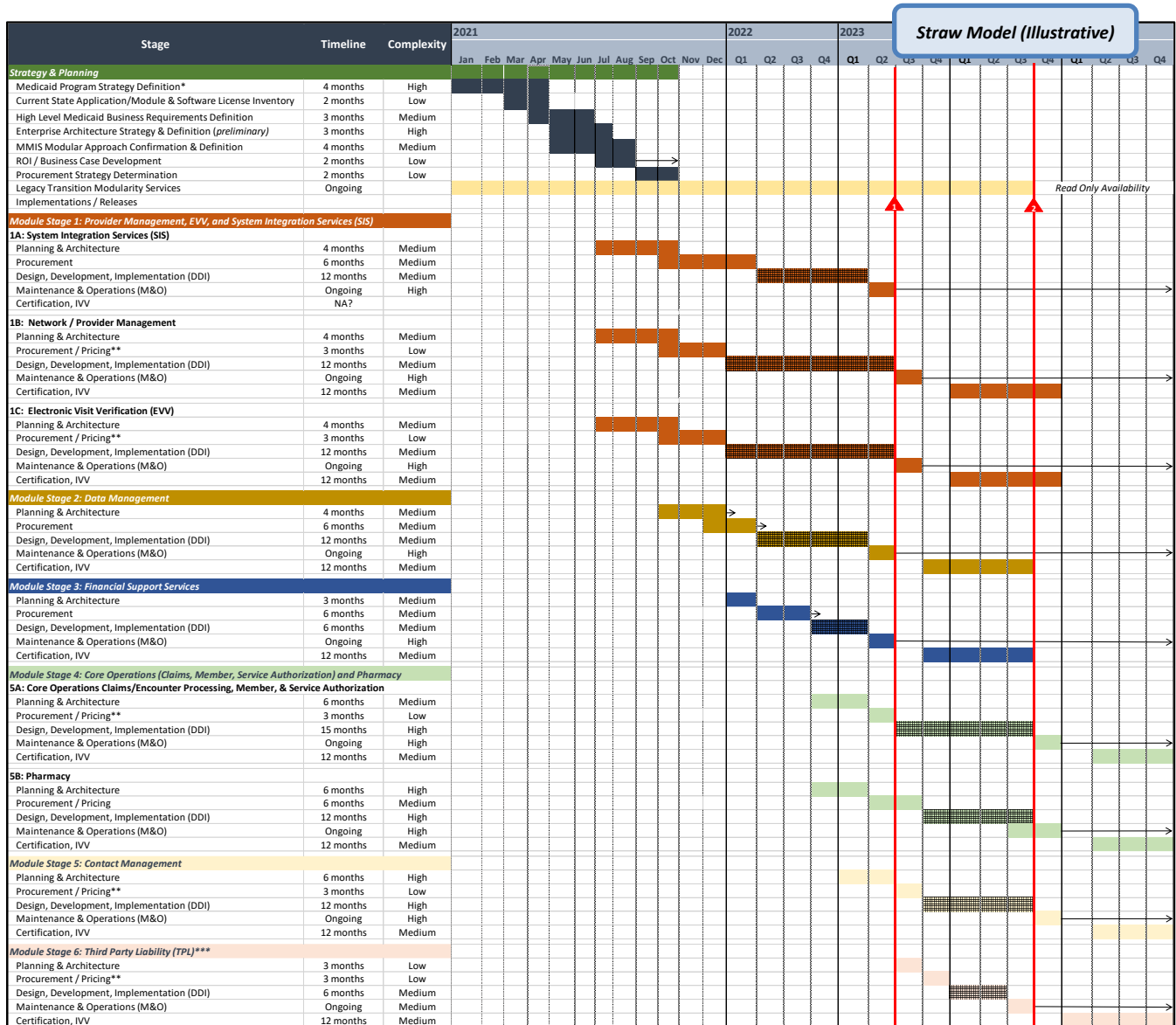
### Timeline

NH DHHS faces a critical timeline associated with the re-procurement and implementation of its MMIS. In addition to the capabilities of its current MMIS not meeting the changing needs of the State and doing so at significant cost, the existing software is at risk of not being supported in the coming years given its 13-year life span.

A straw model timeline provides NH DHHS with insights and a starting point for understanding the complexity and dependencies of implementing various modules for a new MMIS system. It reflects preliminary evaluation of the benefits and risks associated with a re-procurement initiative and the respective timelines that might result from a modular implementation. The timeline below was developed based on several criteria, including information from other State Medicaid departments, conversations with MMIS vendors, illustrative MMIS modular implementation timelines, key dependencies of functionality, and an understanding of critical functions required by the State balanced with overall implementation risk. An initial risk/complexity review was based on anticipated stakeholders required to sign off, policy required for decision making, the number of integrations, and funding requirements.

The timeline outlined in Table/Figure 48 reflects this preliminary thinking and serves as the foundation for building the illustrative cost analysis of this recommendation.

**Table/Figure 48. Modular MMIS Implementation Straw Model Timeline for NH DHHS**



**Footnotes:**  
 \* Substantive shift in role and capabilities required by MCOs will impact requirements and overall approach and pricing to MMIS roadmap  
 \*\* Procurement phases are anticipated to leverage NASPO timelines (or NHDHHS specific timelines) that reflect accelerated procurement / pricing cycles  
 \*\*\* Timeline includes integration with existing systems, e.g., New Heights, COTS, etc., but does not include any "additional COTS" package development, build, or implementation

**Complexity Level Assumptions:**  
**High:** Significant number of critical stakeholders required to sign off, policy required for decision making, multiple integration - department or system, funding determination required  
**Medium:** Critical stakeholders are varied by primarily within the Medicaid Department; decision making does not require significant policy changes or modifications; funding source is identified by request  
**Low:** Limited number of critical stakeholders involved or decision makers required to move initiative forward; funding source within budget and/or source is known

**Risks**

Review of the potential for a new modular MMIS procurement and implementation identified potential risks that require mitigation. Chief among these risks is the possibility that insufficient funding will be allocated to support the re-procurement and ongoing MMIS implementation.

Securing the funding for an anticipated 10-year investment will require continued refinement of the MMIS business case, and regular communication with stakeholders. Other risks include:

- **Lack of strong program management capabilities.** For NH DHHS to effectively implement the identified timelines and integration dependencies across a modular solution, strong program management oversight will be necessary to monitor achievement of timelines, budgets, and architecture decision making. The MMIS implementation will need to be effectively managed and monitored to minimize risk to current operations.
- **Lack of a clear definition of future Medicaid strategy and vision, including delivery system and care management modalities.** As NH DHHS evaluates how to best act on its care management strategy, it will need to understand how that strategy impacts the functionality required in a modular MMIS. The timeline outlined above reflects the build-out of core capabilities, e.g., provider management, system integration services, and EVV, as initial functionality. This provides additional time to finalize a care management strategy that will influence the requirements of the NH DHHS MMIS system. Proposed modules are dependent on a larger NH DHHS Medicaid strategy.
- **Inability to manage “transitional state” for 5 years.** NH DHHS will need to prepare to be in a “state of transition” for at least 5 years during a modular implementation approach. Alternatives exist to a staggered implementation (e.g., develop and build all components prior to any implementation, etc.) however, the approach outlined enables implementation and building of capabilities at least partially over a 5-year implementation. Additionally, as existing capabilities become more cumbersome to support, this enables a phased approach to limit the impact.
- **Complex data sources and relationships may need to be configured manually during implementation.** Given Conduent has not provided NH DHHS with comprehensive documentation surrounding its MMIS solution, it is anticipated that understanding critical data relationships and building true data “sources of truth” will require additional support and critical subject matter experts that may not be available in the areas and at the levels necessary in NH DHHS today.

## G. STAFFING REVIEW

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### Overview

#### **Background**

This review was conducted in tandem with other A&M workstreams that focused solely on different divisions and functions. The content of this staffing review should be read within the context of the aforementioned recommendations, and the findings from this review will, at times, reference certain recommendations directly. A&M's entering hypothesis at the outset of this review was that DHHS is lean relative to the functions it performs, informed in part by the vacancy rate of 20.6 percent across all funded positions as of September 2020 and qualitative accounts of large workloads. Vacancy rates alone do not determine the staffing and operational state of an organization, so A&M reviewed DHHS staffing indicators from multiple angles to determine the state of operations.

#### **Scope**

This review provides both an analysis of the current state of DHHS operations and supporting information to other recommendations. This review was not intended to produce granular recommendations in isolation from the other workstreams. The primary objectives of this review are threefold:

1. To determine whether DHHS is adequately staffed and structured in order to fulfill its mission to provide opportunities for citizens to achieve health and independence
2. To inform the work of the division-focused and function-focused workstreams
3. To provide analysis on the level of efficiency within the organization

As with other aspects of DHHS operations, the COVID-19 pandemic significantly affected the human resources of DHHS. In this analysis, A&M studied the impact of the COVID-19 pandemic on select areas, which this report will highlight when appropriate. To that end, to pinpoint the exact effect of the pandemic, A&M used four points in time when looking at the effect of time on select staffing areas like vacancies: the end of June 2018 and 2019 (FY18 and FY19), March 2020 (FY20, pre-pandemic), and September 2020 (FY21, post-pandemic).

To meet the three objectives mentioned above, A&M performed the following analyses:

1. **Benchmark Review:** Reviewed benchmarks of certain key DHHS & division indicators
2. **Vacancy Review:** Analyzed vacancy rates of different divisions
3. **Span of Control Review:** Reviewed the average span and organizational structure

#### **Conclusion**

Through these benchmarking analyses, A&M identified that DHHS is not overstaffed relative to its peers. A&M identified through a review of vacancies that significant transactional and operational vacancies impede DHHS from achieving transformational change. A&M determined through the span of control review that while the near-term efficiency of the organization would be unlikely to change through an overhaul of the organizational structure, DHHS could use span data to identify divisions for further study. As stated previously, this analysis was completed in the context of the recommendations made elsewhere in this report and should be read through that lens.

## G.1 | Benchmarking

### **Approach**

Evaluating the staffing operations in a state agency against benchmarks is useful to determine if an agency is overstaffed or understaffed. Benchmarking can be organized into two general categories: absolute benchmarking and relative benchmarking. Due to the limitations inherent to state government outlined below, A&M performed a relative benchmarking exercise for DHHS. Limitations persist, however, in relative benchmarking due to certain key factors, and those limitations must be accounted for when findings are used in decision-making.

#### *Absolute Benchmarks: Availability and Limitations*

The purpose of an absolute benchmarking exercise is to evaluate the difference between the current state of an organization against a universal metric. The end result of an absolute benchmark informs organizational leadership whether they are meeting a standard. Absolute benchmarks may be set into statute by a governing body (like a federal agency) or suggested by an organization (like an association). Absolute benchmarks and best practices are available and useful in certain functions within state governments. For example, leadership within a child and family services agency would do well to examine established metrics and indicators to measure performance, like the wait time of a call center or the number of child welfare cases per caseworker.

In state government department-wide staffing, absolute benchmarks are often either not available or not useful. Availability is limited because the inputs to absolute benchmarks must be somewhat static to draw utility from comparison. The structure of health and human services agencies vary widely depending on factors like the types of services offered, the number of contracted services versus services performed in-house, or the number of state-run healthcare institutions. The differing structures of state health and human services agencies that lead to this variance preclude many absolute benchmarks from existing. Due to this limited availability and utility, A&M did not evaluate DHHS against absolute benchmarks.

#### *A&M's Approach and Limitations*

A&M utilized relative benchmarks for this analysis, comparing DHHS staffing levels to peer states to evaluate the starting hypothesis that DHHS was relatively lean. To engage in this relative benchmarking exercise, A&M collected publicly available data from states similar in size to New Hampshire. A&M examined data from select New England states (Vermont, Maine, and Rhode Island) to illustrate New Hampshire's position against neighbors with similar geography and select Mountain West states (Wyoming and Montana) for comparisons with similar states with a variety of political governance histories. The availability of public headcount data limited comparisons of NH DHHS against peer states.

For the same reasons that absolute benchmarks at the state agency level often do not exist, the usefulness of relative benchmarks at the department level is limited. For appropriate comparison between two states' health and human services agencies, the agencies must be functionally equal in types of services performed, types of facilities operated, and types of programmatic decisions made. That being said, department-level aggregate indicators can provide enough information for decision-makers to determine whether an agency is widely outside a normal range.



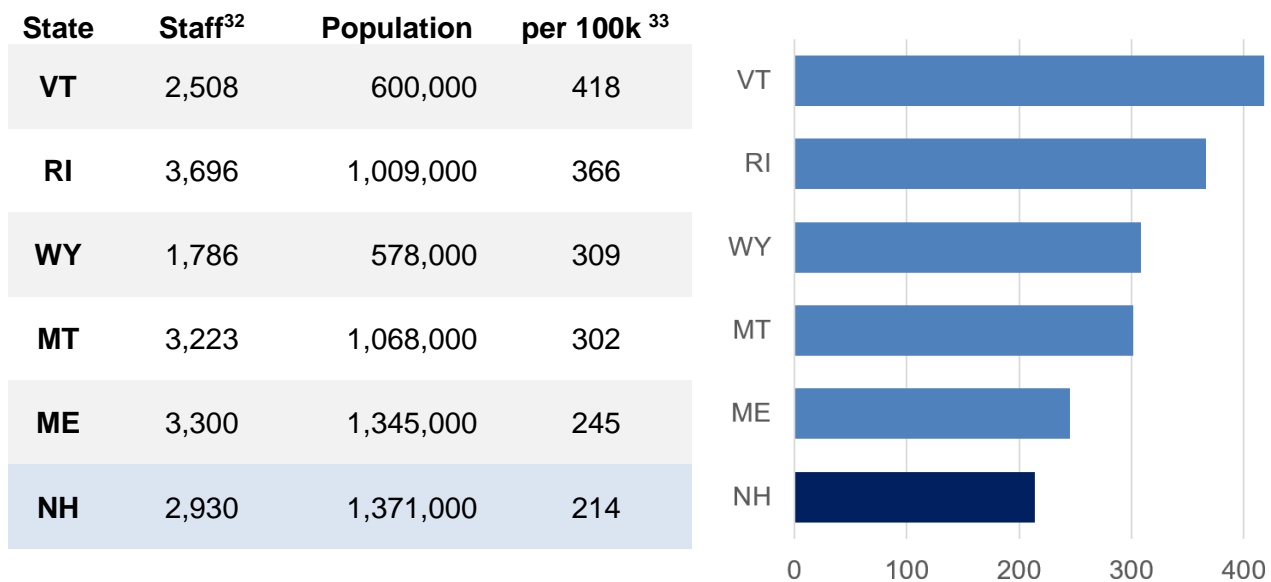
## Findings

A&M engaged in this benchmarking exercise to evaluate the hypothesis that DHHS is understaffed (or, at the very least, is not overstaffed). With the understanding that the precise magnitude of the level of understaffing should not be imputed solely on these department-level metrics, A&M examined two key indicators for this analysis: (1) the DHHS staff count relative to the state population and (2) the DHHS staff count relative to the number of Medicaid and CHIP beneficiaries served. A&M also examined certain division-level indicators relative to peer states.

### (1) Staff Relative to the State Population

A&M compared the relative size of each HHS agency per resident in the state (rounded to the nearest 100) to other HHS agencies. This metric identifies how many total New Hampshire residents are served by each state government staffer because the population served by DHHS is the totality of the population of New Hampshire. As each state government organizes these functions differently, in some cases multiple departments were combined to provide a closer comparison to New Hampshire DHHS.

**Table/Figure 49. Staff Count Per 100,000 Residents**



Comparing this indicator shows that New Hampshire DHHS has fewer staff members for the total population served than all of the peer states examined. As before, this indicator provides one example of evidence that DHHS is not overstaffed, but it does not, in isolation, indicate the magnitude to which the department is understaffed. Using this metric does not suggest that these contemporary agencies are overstaffed, as it is entirely plausible that *all* of these agencies are understaffed for some reason or another. This approach can, however, show that NH DHHS is not overstaffed relative to peers based on the total state population served.

<sup>32</sup> Includes full-time and part-time staff; state data references can be found in the appendix

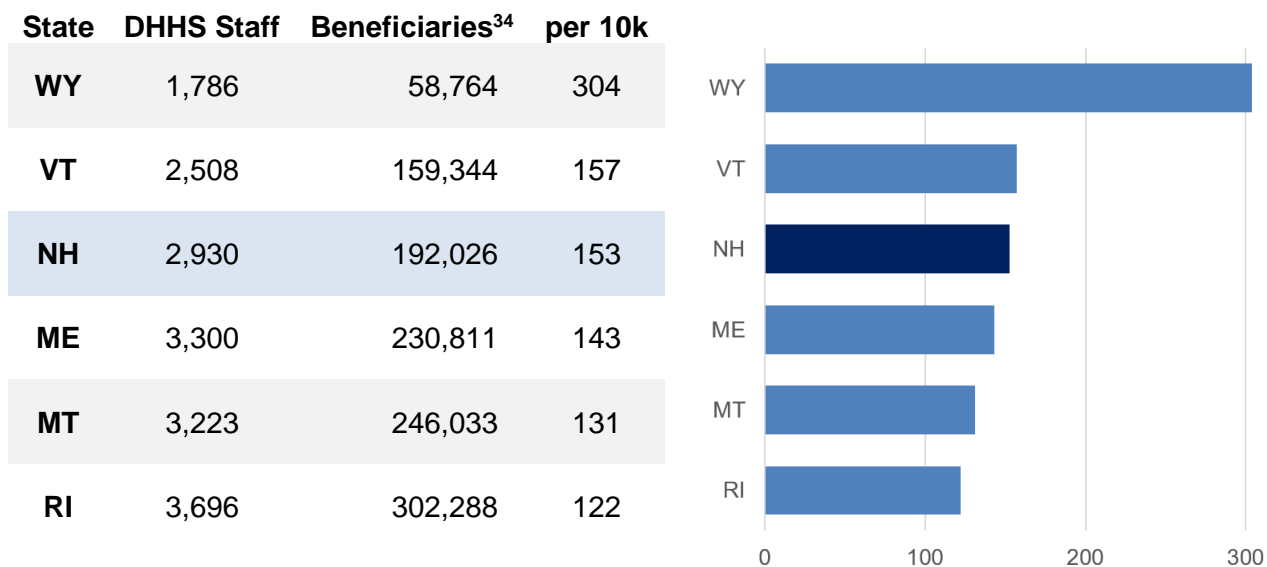
<sup>33</sup> Total Staff/population\*100,000 = Staff per 100,000 residents

A&M has hypothesized numerous reasons for discrepancies, like the fact that each agency has a certain level of fixed costs that it must cover. A complete root cause analysis, however, was outside the scope of this review. As it is, each state may have a myriad of reasons why their staffing levels should be adjusted up or down to account for different drivers; while these should not be discounted, using multiple state examples alleviates some of the issues with making one-off comparisons. In conclusion, comparing the total number of staff per total population suggests that DHHS is not overstaffed.

**(2) Staff Count Relative to Beneficiary Count**

A&M also compared the total staff count to the number of beneficiaries served (Medicaid & CHIP beneficiaries as of May 1, 2020, the most recent completed data available). The figures below are presented as the number of HHS staffers per 10,000 beneficiaries serves.

**Table/Figure 50. Staff Count Per 10,000 Beneficiaries**



On this indicator, New Hampshire rests in the middle of the distribution of states and within the narrow range of its geographical neighbors. In contrast to the previous indicator examined in which only staff was an adjustable variable, the two variables in this calculation (staff and beneficiaries) are *both* influenced by policymakers. This metric, specifically, is influenced in part by the percentage of the population receiving Medicaid and CHIP benefits, as presented in Table/Figure 51.

**Table/Figure 51. Percentage of Population Receiving Medicaid or CHIP Benefits**

NH	VT	RI	ME	MT	WY
14.0%	26.5%	29.9%	17.2%	23.0%	10.2%

As mentioned when examining the staff count compared to total population, the discrepancy in the number of staffers per beneficiary also can be affected by other drivers not apparent in this

<sup>34</sup> Based on CMS Data from May 2020, the last date for which complete data was available at the time of this report. Beneficiaries include Medicaid and CHIP beneficiaries.

top-line data. Wyoming and New Hampshire have the lowest and second-lowest percentage of beneficiaries while having the highest and third-highest number of staffers per beneficiary. As with other indicators, it is important to understand the context of these peer states. For instance, Wyoming is one of the few states in which Medicaid is primarily Fee-For-Service as opposed to Managed Care, and states that deliver Medicaid through Managed Care shift much of the administrative burden MCOs (and thus decrease the overall staff count per beneficiary). Increased staff count per beneficiary is associated with decreased beneficiary percentage, but this data does not provide enough information to be conclusive (e.g. Vermont is the only exception to this association of the group of six). As such, this indicator neither proves nor refutes the hypothesis that DHHS is not overstaffed.

*Division Analysis*

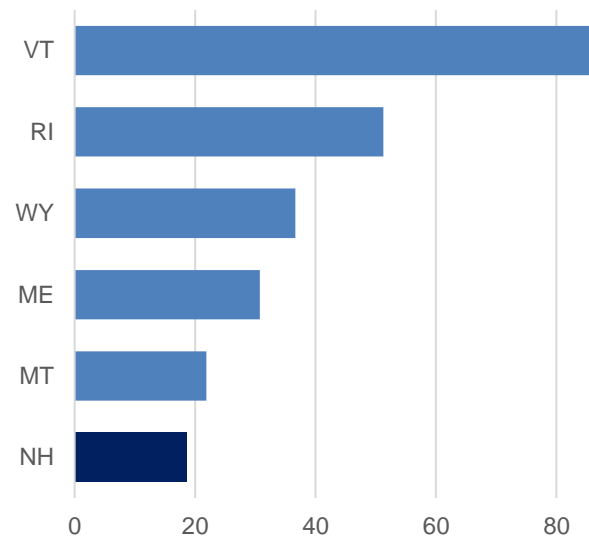
Some of the reasons for the discrepancies in department-level views could be explained by differences in what functions agencies perform. To better understand both if DHHS is understaffed and to what magnitude, the functions of the divisions must be compared, rather than the department in total.

**Public Health**

Less risk of inappropriate comparison exists when the mandates of the contemporary divisions are functionally equal, like state Public Health (PH) departments. In all PH departments, the population served is simply the population of the state. During the COVID-19 pandemic, the state PH departments are under high scrutiny, and staffing the appropriate capacity in these departments is important for states to respond to the public health emergency. In Table/Figure 52 the relative size and of New England states is presented.

**Table/Figure 52. Public Health Staff Count Per 100,000 Residents**

State	PH Staff	Staff /100k Residents	PH Spend per Staffer (\$)
VT	523	87	\$298,000
RI	518	51	\$363,000
WY	212	37	\$312,000
ME	414	31	\$318,000
MT	234	22	\$267,000
NH	255	19	\$438,000



Compared to other New England states, DPH<sup>35</sup> has 58 percent of Maine’s PH staff per resident, 35 percent of that of Rhode Island, and 21 percent of that of Vermont. This relatively lean position is borne out in the budgeted division spend managed per staffer (note: this number should be read as “the amount of DHHS budget that each staff member is responsible for handling” and not as an indicator that NH is spending more on each staff member’s compensation). DPH employees are responsible for managing 37 percent more budgeted spend than the next closest state of Rhode Island. In interviews with stakeholders, A&M has developed some theory as to *why* DPH is so dramatically lower in staff per resident than peers; namely, DPH contracts out a significant number of services. However, these contracts, vendors, and grants must be managed, which also requires human resources. This explanation, however, does not completely explain the root causes which was outside the scope of this study. Based on these two high-level indicators, A&M can project that it is likely that DPH is understaffed relative to its peers.

## **Conclusion**

An appropriate use for the department-wide benchmarks presented is to identify whether DHHS is overstaffed. Based on the comparison of DHHS to peer institutions on these indicators, A&M can conclude that DHHS is not disproportionately overstaffed relative to the population served (both in total and in beneficiaries). With the data available and with the appropriate inherent difficulties in engaging in this exercise, A&M cannot conclusively decide the magnitude of the understaffed nature of DHHS based on these department-wide indicators alone.

Examining these types of comparison on the functional level, as shown here with the Division of Public Health and the Division of Medicaid Services, has provided indications that these divisions are likely understaffed relative to peers. Further analysis to determine the magnitude of understaffing must be evaluated relative to other operational indicators (not just peer institution staff counts), which is discussed in the following section.

## **G.2 | Vacancy Review**

A&M also examined the vacancy rates and the administrative functions of DHHS to understand how DHHS’ operations current state compare to the previous periods, with special focus on the effects of the COVID-19 pandemic. While many areas were included in this analysis, a particular division’s omission from this report should not be read as an affirmation that the staffing level or vacancy level is appropriate. Rather, this report elevates certain divisions and functions that illustrate the effects of high vacancy rates.

Larger divisions not studied at length include, among others, New Hampshire Hospital, Glenclyff Home, Long-Term Supports and Services, and Legal; some of these divisions may be studied further in future engagements or staffing reviews.

## **Approach**

A&M used a framework as a heuristic to evaluate DHHS’ effectiveness in various functions and identify areas where vacancy rates impede its ability to progress along with the framework.

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<sup>35</sup> Includes the Emergency Services Unit

The framework includes three categories, and analysis checks the ability of an organization to fulfill the objectives of the category. The categories of this T-O-T framework are as follows:

1. **Transactional:** Does the organization complete the transactions in a timely and accurate manner?
2. **Operational:** Does the organization evaluate and continuously refine processes, protocols and systems to maintain and improve operational efficiency?
3. **Transformational:** Does the organization have the capacity to transform programs and services to achieve better outcomes and prepare for future conditions?

Effective organizations complete transactions, continuously evaluate and refine operations, and regularly initiate transformational projects. These three categories build upon each other. For a state agency to improve operations, it must first be able to handle the day-to-day transactions. For a state agency to achieve transformational change, it must first have intact, functioning operations.

### Findings

Understanding the levels of vacancies within DHHS provides a roadmap to identify the areas where DHHS is most acutely experiencing organizational stress. A&M examined vacancy rates in DHHS with different approaches: within each division and across organizational function. Examining the vacancy rates at the division level helps point to the most acute needs of an organization. At DHHS, the overall full-time vacancy rate is 15.6 percent and the part-time vacancy rate is 54.8 percent. When blended, the vacancy rate is 20.6 percent

**Table/Figure 53. Vacancy Rates in Full-Time Positions in DHHS Divisions<sup>36</sup>**

Division	FY20 Pre-COVID	FY21 Post-COVID	% Change
Information Services	26.3%	26.3%	0.0%
Medicaid Services	22.2%	22.2%	0.0%
Office of Finance	12.0%	20.8%	73.1%
NH Hospital	13.0%	20.8%	59.4%
Division of Behavioral Health	27.1%	19.0%	-30.1%
Glenclyff Home	14.7%	17.8%	20.8%
Division of Program Quality & Integrity	14.9%	17.0%	14.3%
DCYF	21.0%	16.0%	-23.9%
Division of Public Health Services	13.1%	13.9%	5.6%
Legal and Regulatory Services	16.9%	13.1%	-22.0%
OCOM	13.3%	12.5%	-6.3%
Economic and Housing Stability	9.9%	10.0%	0.5%
Long Term Supports and Services	8.0%	9.5%	18.2%
Bureau of Human Resources	3.6%	7.1%	100.0%
Facilities Maintenance and Office Services	3.6%	6.9%	93.1%
<b>Department-Wide</b>	<b>14.7%</b>	<b>15.6%</b>	<b>5.5%</b>

<sup>36</sup> OCOM includes the Office of the Commissioner, the Office of Health Equity (OHE), and the Employee Assistance Program (EAP)

The vacancy rates shown here and the COVID-driven change point to the impediments DHHS faces as it aims to both react to the COVID-19 pandemic and forge forward to become a transformational organization. Many of the highest vacancy rate divisions and functions are the most critical divisions and functions for managing transactions, running operations, and facilitating transformations. If these divisions and functions remain understaffed, DHHS will face deepening transactional and operational issues that preclude transformation.

**a) Information Technology**

The Bureau of Information Services and the Division of Medicaid Services are experiencing the highest and second-highest vacancy rates (at 26.3 percent and 22.2 percent), respectively, among all DHHS divisions. That these divisions are understaffed aligns with other findings referenced in this report. Namely, information technology functions are experiencing the most acute vacancy rates, leading to some of the MMIS and IT systems issues more broadly, as outlined in the DD and MMIS sections of this report. Recognizing that, A&M also grouped each staff category into functional groups to provide insight into the IT staffing levels (as seen in Table/Figure 53<sup>37</sup>). The vacancy rate at the IT functional level seen here is high, has been growing, and getting worse through the COVID-19 Pandemic.

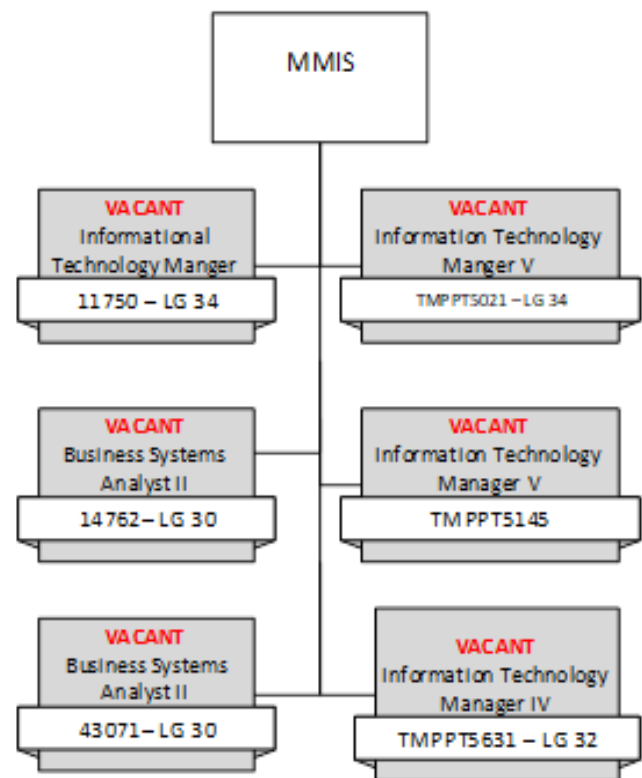
This IT functional vacancy rate of 23.8 percent also understates the magnitude of the staffing issues faced by the Division of Medicaid Services. As seen in Table/Figure 55. MMIS Vacancies, the totality of the MMIS department is vacant. Not only must this minimum staffing capacity be addressed for DHHS to mitigate risk of transactional and operational issues, but also these vacancies preclude DHHS leadership from using timely and accurate data necessary for strategic decision-making and planning.

This vacancy issue arose firsthand within A&M’s engagement at NH DHHS, as certain data pulls were difficult or impossible and the backlog of requests on the existing staff led to delays in data receipt. These issues highlight the way IT vacancy rates hampers the effectiveness of the whole organization. Meeting the transactional and operational needs at present will enable DHHS to chart a path forward toward transformational changes.

**Table/Figure 54. IT Functional Vacancy Rate**

FY	FY18	FY19	FY20 (Mar.)	FY21 (Sep.)
<b>Vacancy Rate</b>	5.7%	11.8%	18.0%	23.8%

**Table/Figure 55. MMIS Vacancies**



<sup>37</sup> Includes part-time staff vacancy for completeness

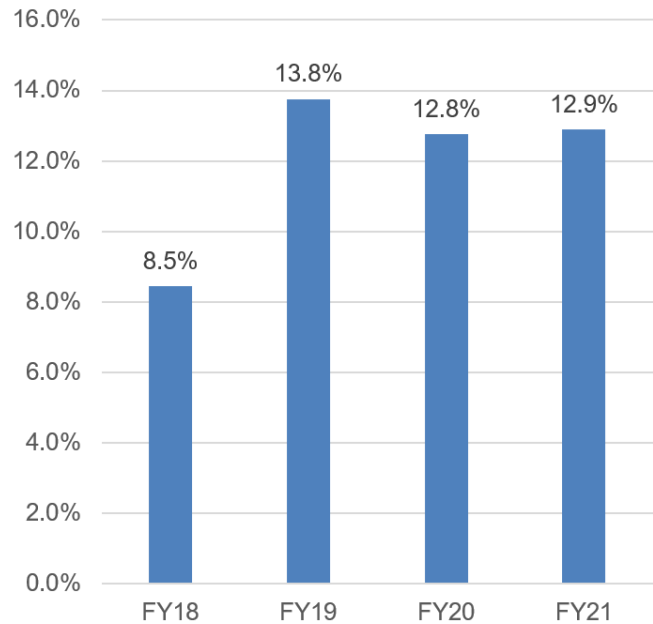


In the world of the COVID-19 pandemic, these transactional and operational issues created by IT vacancies are further exacerbated as all IT functions are critical to maintaining a virtual work environment. The staffing vacancy rate increase within the IT functions from March 2020 to September 2020 risks impeding DHHS’s ability to respond to the PHE.

**b) Eligibility**

The eligibility functions are a critical piece of DHHS operations, operating as the gateway for the citizens of New Hampshire to access services provided by DHHS. The eligibility functions also play a critical role in multiple other recommendations outlined in this report, namely, E.1 Eligibility Redetermination. As outlined in that recommendation and the accompanying recommendation D.1 Increase Workforce Capacity, The transactional capacity of the eligibility function directly affects the general fund expenditures of New Hampshire following the expiration of the PHE and the ensuing end to the enhanced FMAP. The quicker that the transactional aspects of the eligibility functions can operate and handle the increased volume at the end of the PHE, the more expenditure avoidance NH will realize.

**Table/Figure 56. Vacancy Rate in Eligibility Functions**



The staffing levels at present in the eligibility functions of DEHS show a current vacancy rate of 12.9 percent, which is relatively flat as compared to the end of F19 but also nearly a 50 percent increase in the vacancy rate compared to the end of FY18. These vacancy rates, alongside the data collected through interviews with DEHS stakeholders and analysis of operational data such as call wait times, indicate that DEHS has room for improvement to meet its transactional requirements (see recommendation E.1 for more information on the effects of staffing shortage). For DHHS to successfully implement major operational projects within the area of eligibility determination, the transactional gaps created by staff shortages must be tackled.

**c) Other Areas**

The vacancy rates presented previously also highlight some of the key areas where DHHS remains in the operational portion of the T-O-T framework. While these areas will not be examined in-depth, they are brief highlights of other pressing vacancy issues in DHHS.

**i. Division of Program Quality and Integrity and Office of Finance**

Beyond the Bureau of Information Services and the Division of Medicaid Services, other divisions with high vacancy rates include the Office of Finance and the Division of Program Quality and Integrity. The functions completed by these offices, while not direct care, have downstream effects on the ability of DHHS to fulfill its transactional needs, operate smoothly,



and initiate transformational projects. For example, the full staffing of the Office of Finance functions within divisions would help enable for improved capacity to execute cost control, manage contracts, and perform forecasting or other tasks (which realize increased value for DHHS). Likewise, a fully staffed Division of Program Quality and Integrity could provide DHHS more resources to proactively solve issues and mitigate risk of single audit findings. High vacancy rates in these offices, therefore, has negative downstream effects on DHHS' ability to do transformational work. Further analysis of the vacancy rate and the downstream effects of low staffing in these areas is required to determine the magnitude of these effects.

ii. Trade Services

To further highlight how vacancies in certain functions affect the department as a whole, consider the trade services functions as seen in Table/Figure 57. Trade Services is a basic operational function that DHHS must meet for facilities. For reference, trade services include food service, groundskeeping and maintenance, semi-skilled labor, and other such services. Trade services have seen a spike in vacancies in this category, nearly double the rate since FYE19 and a significant jump owing to the COVID-19 pandemic. (Note that due to the nature of trade services being more heavily part-time positions, those have been included in this vacancy rate to provide an accurate picture). Increased vacancy rates in trade services have several key downstream effects, both of which have a negative fiscal or operational impact:

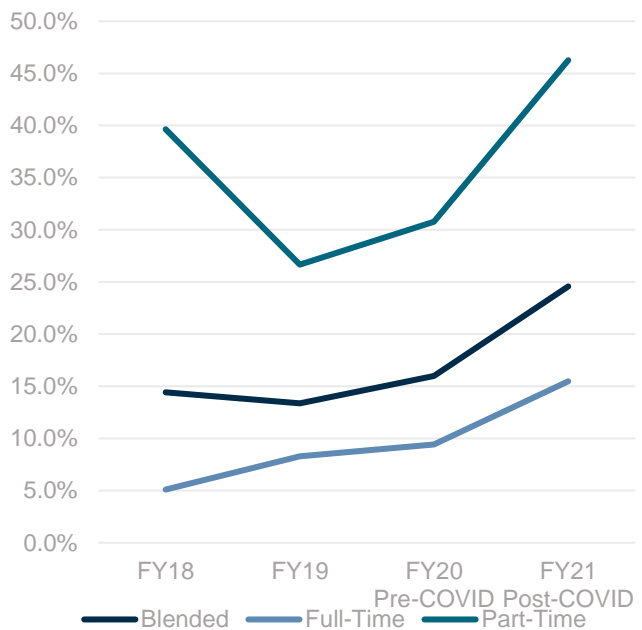
- (1) increased overtime expenditures to make up for lost capacity,
- (2) increased contracting for services previously done in house (and extra time needed to manage the bid process), or
- (3) the affected division goes without service.

Fully staffing a function like trade services alleviates management time and effort on these transactional services and frees up time to perform transformational work.

**Conclusion**

These highlights provide a brief snapshot into other issues arising from high vacancy rates. With regards to information technology, eligibility, and other staff functions, vacancies are limiting leadership to focus on the transactional functions and operational processes of their positions, leaving little time or effort available to engage in transformational work.

**Table/Figure 57. Trade Services Vacancy Rate**



**Table/Figure 58. Trade Services Vacancy Rates**

	FY18	FY19	FY20	FY21
			Pre-COVID	Post-COVID
<b>Blended</b>	<b>14.4%</b>	<b>13.4%</b>	<b>16.0%</b>	<b>24.6%</b>
<i>Full-Time</i>	<i>5.1%</i>	<i>8.3%</i>	<i>9.4%</i>	<i>15.5%</i>
<i>Part-Time</i>	<i>39.7%</i>	<i>26.7%</i>	<i>30.8%</i>	<i>46.3%</i>

### G.3 | Span of Control

#### **Background**

As a part of our regular staffing review, A&M examined the average span of control within DHHS to determine if any management functions or divisions should be studied for further organizational redesign. The “span of control” (ratio of supervisors to direct reports) is an indicator commonly used to assess distribution of human resources between management and frontline personnel. The optimum span of control for a given public sector department will vary based on the complexity of its functions and other factors. There is consensus, however, among organizational design experts that the number of employees most efficiently managed by one supervisor has increased (and may continue to) as communication technology improves and organizational structures flatten.

The traditional approach span of control identifies middle management with low spans and uses those divisions as an opportunity for consolidation, which is neither what A&M recommends nor is the approach taken in this analysis. The goal of increasing span of control within DHHS should be to shift roles from supervisors to outcome-influencing front-line staff through the natural process of attrition. As supervisors leave employment with DHHS, efforts could be made to backfill their vacancies with front line staff level positions. Increasing the number of front-line staff not only generates compensation savings but also streamlines the organizational structure and increases the level of service to citizens.

#### **Findings**

A&M used human resources data to quantify the total number of direct reports per person, shown below in Table/Figure 59. For this exercise, A&M included part-time positions within the ratio, though the difference when excluding part-time positions was immaterial.

**Table/Figure 59. Span of Control by Division**

Division	Occupied Positions	Vacant Positions	Total Positions	Average SOC (Current State)	Average SOC (No Vacancy)	Increase in SOC at Full Capacity
<i>NH Hospital</i>	649	291	940	10.14	14.24	40.4%
<i>Glenclyff Home</i>	154	49	203	9.06	11.94	31.8%
<i>DEHS</i>	549	85	634	5.78	6.34	9.7%
<i>Legal and Regulatory</i>	163	32	195	4.66	5.27	13.2%
<i>LTSS</i>	131	22	153	4.23	4.50	6.5%
<i>DPQI</i>	85	26	111	4.05	4.63	14.3%
<i>DPH</i>	265	61	326	3.35	3.66	9.2%
<i>Office of Finance</i>	109	48	157	2.87	3.34	16.5%
<i>DBH</i>	47	13	60	2.61	3.16	20.9%
<i>Medicaid</i>	23	13	36	2.09	2.77	32.4%

On a department-wide basis, DHHS’ Span of Control ratio of direct reports to managers is a median of 1:4 and an average of 1:5. As a percent of a whole, the direct report data indicates that approximately 19.8 percent of total DHHS staff have at least some supervisory responsibilities. This span is lower than a commonly-used heuristic of 1:6, but, rather than

using the 1:6 as an absolute indicator that all DHHS divisions must attain, DHHS should first begin by focusing on the divisions below their own median. Moreover, NHDHHS' average span is either equal to or exceeding that of peer states Wyoming (1:4) and Rhode Island (1:3.5)<sup>38</sup> As we discussed previously, some of these departments could be experiencing a lower span of control purely because many services are contracted out as in the case of the DPH.

As shown in the table above, the vacancy rate also influences the span of control. In all divisions, the span increases (in some areas by a significant factor) if the division were fully staffed. This finding implies that part of the relatively lower span of control is tied to the vacancy rates. Indeed, if DHHS were fully staffed, the full capacity median span of control is 1:5 and an average of 1:5.7.

As DHHS explores further opportunities for efficiency, a blanket review of all divisions, offices, and bureaus under DHHS' median of 1:4 could yield some operational insights and further opportunities for efficiency.

### **Utility of Span of Control**

A&M recommends using these span of control indicators as a roadmap for further study of divisions. A&M does not recommend using span of control in isolation as an indicator of the level of efficiency of DHHS operations as certain factors either overly dilute the span amount or are not reflected in the ratio on its own. First, span of control is affected directly by the size of the division overall. Small divisions, bureaus, or offices, must have directorial and managerial positions filled to function at all. Second, department-wide span of control is altered directly by the level of subject matter expertise necessary to function; using the span ratio in isolation does not factor for the necessity of certain functions. For example, the various positions within the Division of Medicaid Services have very different functions. As such, consolidating some of these functions purely to increase the span of control would not likely lead to any real efficiencies. Low span ratios in some divisions do not, alone, indicate that they are ripe for reorganization or are more inefficient than other divisions.

Taken out of the abstract, the DHHS Office of Finance recently underwent an organizational redesign within the contracts division, in which the department formerly had 10 contracting positions and one manager. Facing operational difficulties as management was forced to spend time primarily on transactional and operational tasks, the office decided to add an additional layer, functionally cutting the span of control by a third. The subsequent operational improvements due to this organizational change were a boon for the overall efficiency of the organization and management functions.

### **Conclusion**

While this span of control study does not conclusively recommend specific structural changes, DHHS should consider a long-term span of control plan to transition low-span divisions, bureaus, and offices to a broader span in order to reduce managerial workload as a percentage of the entire division. Leadership should further study low-span divisions to identify programmatic needs and determine opportunities for improvement.

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<sup>38</sup> These spans were calculated through A&M engagements from 2017 (RI) and 2018 (WY)